Note: This must be a **SECURE** Email.

COORDINATED SYSTEM OF CARE

LA CSoC Discharge Form

Magellan HEALTHCARE

Referral Date:	*Discharge Date:	Healthy LA Plan Name:	Healthy Blue
WAA Discharging: Region 1- NCFS	Phone #:	Email:	

Youth Name:	DOB:	Medicaid #:	
Legal Guardian(s) Name:		Relationship to Youth:	
Legal Guardian(s) Phone #1:	☐ Cell	☐ Home	☐ Work
Legal Guardian(s) Phone #2:	☐ Cell	☐ Home	☐ Work
Legal Guardian(s) Address:			
Parish:	☐ Consent Form Attached		

*Reason for Discharge: Family decision - achieved goals	Other:
Diagnosis (if known):	
Medical Issues:	Goal Progress: Successful 75% - 100% of goals complete
Current Medications:	Living Setting: Home

Behavioral Health Provider #1 Name:	Phone #:
Service Type:	
Behavioral Health Provider #2 Name:	Phone #:
Service Type:	
Behavioral Health Provider #3 Name:	Phone #:
Service Type:	
Behavioral Health Provider #4 Name:	Phone #:
Service Type:	

Name of Facility (If Out Of Home Setting):		
Contact Name at Facility:	Contact #:	Other #:

IMPORTANT: Submit CSoC Discharge Form to Email Address: CSoCdischarges@magellanhealth.com