COORDINATED SYSTEM OF CARE

Note: This must be a SECURE email.

Magellan HEALTHCARE

LA CSoC Discharge Form

Referral Date:	*Discharge Date
Healthy LA Plan Name: Select one	WAA Discharging: Select one
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: Select one	
Other:	
Diagnosis (if known):	
Medical Issues:	
Current Medications:	
Goal Progress: Select one	Living Setting: Select one

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 Placement):		
Contact Name:	Contact #:	Other #:

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

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