COORDINATED SYSTEM OF CARE

Note: This must be a SECURE email.

Magellan HEALTHCARE

LA CSoC Intent to Discharge Form

Patient Information:

Referral Date:	WAA Region: Select one
First Name:	Last Name:
Date of Birth:	Medicaid #:
Healthy Louisiana Plan: United Healthcare Community Plan	

Reason for Intent to Discharge: (Select only one reason and complete that section only.)

☐	**No face to face within 60 days**	
	Last date of face to face:	

☐	**Non-HCBS setting for 90 days**	
	Date of Admit to Non-HCBS Setting:	Day 90 of Non-HCBS Setting :
	Name of Non-HCBS Setting:	
	Type of Non-HCBS Setting: ○ Inpatient Psychiatric Hospital ○ Non-Medical Group Home ○ Other (Enter below): ○ Psychiatric Residential Treatment Facility ○ Therapeutic Group Home	

☐	**Detention for 30 consecutive days**	
	Date of admit to detention:	Day 30 of detention:
	Name of Detention Center:	

☐	**Reassessment CANS/IBHA not completed by end of waiver**	
	Date of last day of waiver:	
	Attempts to complete reassessment: 1)	2) 3)

☐	**Relocated out of state**	
	Date WAA notified of relocation:	State:

☐	**Death**	
	Date of death:	Date WAA notified of death:

