

BH CASE MANAGEMENT STATUS CHANGE NOTIFICATION

Please send via FTP

Notification Type: <input type="checkbox"/> Request for Discharge <input type="checkbox"/> Unable to Contact	
Member	
Ohana Member ID:	PROPOSED DISCHARGE DATE:
Member Last Name:	Member First Name:
Member Phone Number:	Date of Birth:
Home Address:	Primary Contact:
Mailing Address:	Phone Number:
Treating Case Management Provider	
Provider ID:	
Case Management Agency:	
Phone Number:	Fax Number:
Case Manager Name:	Case Manager Phone Number:
Diagnosis	
ICD-10 Diagnosis Code:	Description:
ICD-10 Diagnosis Code:	Description:
Medical Conditions:	
Current LOCUS:	
Status Change Summary	
Reason for Discharge:	
<input type="checkbox"/> Admitted to Hawai'i State Hospital (HSH)	<input type="checkbox"/> Treatment Goals Achieved
<input type="checkbox"/> Deceased	<input type="checkbox"/> Transferred to a Long Term Care (LTC) Nursing Facility/DDID Facility
<input type="checkbox"/> Incarceration	<input type="checkbox"/> Wait-listed for a Long Term Care (LTC) Bed at an Acute Hospital
<input type="checkbox"/> Medicaid Ineligible	<input type="checkbox"/> Released on Conditions
<input type="checkbox"/> Moved Out of State	<input type="checkbox"/> Conditional Release
<input type="checkbox"/> No Contact for 1 Month**	<input type="checkbox"/> Mental Health Court
<input type="checkbox"/> No Longer Meets CCS Criteria*	<input type="checkbox"/> Jail Diversion
<input type="checkbox"/> Member Refused Services	<input type="checkbox"/> Other*
*if selected as reason, provide explanation in the Additional Information area below.	
** For no contact for one month, please indicate dates and methods for all attempts. Also indicate date and place mbr was last seen.	
Additional Information:	
The following documents must be included with the request for disenrollment:	
<input type="checkbox"/> Most Recent Behavioral Health Assessment	
<input type="checkbox"/> Most Recent Individualized Treatment Plan (Must be submitted for all, even UTC.)	
<input type="checkbox"/> Most Recent LOCUS	

If the required documentation is not attached, provide summary of the explanation/justification.

Referrals made upon discharge:

BH Case Manager Name: _____

Date of Submission : _____

If member's disenrollment is incomplete, your agency is still responsible for meeting the CM visit requirement according to acuity.

Unless member is incarcerated, the agency continues to be responsible through the last day of the month in which discharge is requested.