Clear Form

Minnesota Department of **Human Services**

DHS-4905F-ENG 4-13

Minnesota Health Care Programs (MHCP)

Extended Psychiatric Inpatient Contract – Discharge Summary Review

Provider Information

CONTRACTING HOSPITAL	NPI/UMPI

Recipient Information

RECIPIENT NAME	DISCHARGE DATE

Discharge to:

- ☐ Private Residence/Home/Apartment
- ☐ Intensive Residential Treatment
- ☐ Foster Home
- ☐ Board and Lodge
- ☐ Nursing Home*
- ☐ Boarding Care*
- ☐ CD Residential Treatment
- ☐ Community Psychiatric Inpatient
- ☐ AWOL
- ☐ Regional Treatment Center*
- ☐ Community Behavioral Health Hospital (CBHH)
- ☐ Residential Crisis Facility
- ☐ Other (please specify) _____

* If patient was discharged or transferred to RTC/CBHH, Nursing Home, or MA Certified Boarding Care, please detail the following:

Treatment options that were employed to avoid discharge and transfer of care

Alternative discharge options that were considered

For RTC transfer: state reason(s) patient could not complete treatment in hospital (note: include physician notes and treatment plan information that support reason for transfer)

SIGNATURE	PHONE NUMBER
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Upon discharge, fax (secure) this form to medical review agent, MH-TCM, ACT team, or RTC/SOS Central Pre-Admissions Office/ other facility. If voluntary and patient consents/signs release, may contact MH-TCM or ACT team at time of discharge.