State of Montana Children's Mental Health Bureau
Discharge Notification Form
Form #005

☐ Therapeutic Group Home (TGH), must be submitted within 5 business days
☐ Home Support Services (HSS), must be submitted within 5 business days

All fields must be completed. Please type or print clearly.

Failure to properly discharge a youth may prevent the youth from receiving proper services because a new prior authorization approval and prior authorization number cannot be issued until the Department or its designee receives a *Discharge Notification* form from the previous provider.

Youth Information	
NAME:	BIRTHDATE:
SSN:	MEDICAID NUMBER:
CUSTODY: ☐ Parent ☐ Child & Family Services ☐ Juvenile Probation ☐ Dept. of Corrections ☐ Tribal ☐ Other:	
ADMISSION DATE:	DISCHARGE DATE:
REASON FOR DISCHARGE: ☐ Completed treatment. ☐ No longer meets criteria. ☐ Need for higher level of care. ☐ Provider terminating services. ☐ Parent/Guardian withdrawal. ☐ Other:	DISCHARGED TO: ☐ Home ☐ Hospital Acute/Partial ☐ Other TGH ☐ In-State PRTF ☐ Out-of-State PRTF ☐ Other:

Provider Information				
PROVIDER NAME:		PROVIDER ID NUMBER:		
NAME OF PERSON SUBMITTING FORM:	PHONE NUMBER:	FAX NUMBER:	EMAIL:	
ADDRESS:		CITY:	STATE:	ZIP:

Responsible Party Information* (list Child & Family Services worker or probation officer when applicable)			
NAME:		PHONE:	
ADDRESS:	CITY:	STATE:	ZIP:
RELATIONSHIP TO YOUTH: ☐ Parent/Legal Guardian ☐ Government Agency/Legal Representative ☐ OTHER:			

*The Responsible Party is the person authorized to consent for medical/psychiatric treatment and involved in the discharge plan.

Transmit form to Telligen by fax at 1-833-574-0650 OR create request using Telligen Qualitrac. DO NOT SEND THROUGH REGULAR E-MAIL AS IT IS NOT SECURE.
NOTE: Processing may be delayed if information submitted is illegible or incomplete.

♦ Phone: 1-800-219-7035 ♦ Fax: 1-833-574-0650