State of Montana Children's Mental Health Bureau
Therapeutic Group Home Transfer Form
(To be completed within one business day of transfer)

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

Youth Information	
NAME:	BIRTHDATE:
SSN:	MEDICAID NUMBER:
CUSTODY: ☐ Parent ☐ Child & Family Services ☐ Juvenile Probation ☐ Dept. of Corrections ☐ Tribal ☐ Other: *CUSTODIAN MUST BE NOTIFIED AND AGREE TO TRANSFER	
ADMISSION DATE:	TRANSFER DATE:
REASON FOR TRANSFER:	TRANSFERRED FROM: TRANSFERRED TO:

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