(Rev.02/2015)

Personal Assistance Services/Community First Choice
Unable to Admit /Agency Discharge

☐ AB-CFC ☐ SD-CFC ☐ ABPAS ☐ SDPAS

Submit Form to Mountain Pacific Quality Health (Fax 1-800-268-5767)

Member Name: _____ _____

(Last) **(First)** **(MI)**

Medicaid Id#: _____ **Discharge Date:** _____

Discharge Code: (Check all that apply)

_____ **Death**

_____ **Nursing Home Placement**

_____ **Hospital Placement**

_____ **Medicaid Ineligibility**

_____ **Member Request**

_____ ***Moved From Service Area**

_____ ***Agency Not Able to Meet Needs**

_____ ***Requested Services from Another Agency**

_____ **Goals Met**

_____ **Other (Specify)**

_____

***** **Member requests referral sent to:**

_____

(Agency) **(City)**

Unable to Admit Code: (Check all that apply)

_____ **Death**

_____ **Member's Location**

_____ **Member Moved**

_____ **Member Refused Service**

_____ **Hospitalization**

_____ **Medicaid Ineligible**

_____ **Nursing Home Placement**

_____ **Selected Another Provider**

_____ **Selected Another Service Option**

_____ **Too Few Hours Authorized to Staff**

_____ **Unable to get HCP Authorization**

_____ **Unable to get PR**

_____ **Unable to Reach Member**

_____ **Unable to Schedule Intake Visit**

_____ **Unable to Staff**

_____ **Other (Specify)**

_____

Narrative: (If necessary)

Signature: _____ **Date:** _____

Agency: _____