COORDINATED SYSTEM OF CARE

Note: This must be a SECURE email.

Magellan HEALTHCARE®

LA CSoC Intent to Discharge Form

Patient Information:

Referral Date:	WAA Region: Select one
First Name:	Last Name:
Date of Birth:	Medicaid #:
Healthy Louisiana Plan: Select one	

Reason for Intent to Discharge: (Select only one reason and complete that section only.)

☐	**No face to face within 45 days**
	Last date of face to face:

☐	**Non-HCBS setting for 70 days**		
	Date of admit to Non-HCBS Setting:	Day 70 of Non-HCBS Setting :	
	Name of Non-HCBS Setting:		
	Type of Non-HCBS Setting: O Inpatient Psychiatric Hospital O Psychiatric Residential Treatment Facility	O Non-Medical Group Home O Therapeutic Group Home	O Other (Enter below):

☐	**Detention for 12 consecutive days**	
	Date of admit to detention:	Day 12 of detention:
	Name of Detention Center:	

☐	**Reassessment CANS/IBHA not completed by end of waiver**
	Date of last day of waiver:

☐	**Relocated out of state**	
	Date WAA notified of relocation:	State:

☐	**Death**	
	Date of death:	Date WAA notified of death: