Department of Human Services
Med-QUEST Division

Community Integration Services (CIS+)
Medical Respite Provider Discharge Form

(Appendix L)

This form is to be completed by Medical Respite Providers upon the member's discharge from Medical Respite and shared with the member's Health Plan.

Part 1: Member Information

1. Name (as shown on Medicaid or QI Health Plan Card):	
2. Medicaid or Health Plan ID # (If known):	3. Birthdate (MM/DD/YYYY):
4. If applicable, name of Guardian or Legal Authorized Representative:	
5. Contact Phone Number (indicate cell or home):	6. Contact Email Address:
7. Admission Date:	8. Discharge Date:

Part 2: Member Discharge Information

9. Reason for Discharge (Check main reason):

- ☐ Completed recovery/medically stable
- ☐ Needs higher level of care
- ☐ Secured housing/care elsewhere
- ☐ Left against medical advice/voluntary disenrollment
- ☐ Time limit reached/met Medical Respite benefit limit
- ☐ Behavioral/safety concerns
- ☐ No longer qualify for Medicaid
- ☐ Deceased
- ☐ Other: _____

10. Discharge Location (Select one):

- ☐ Permanent Housing (HP)
- ☐ Transitional Housing (HT)
- ☐ Emergency Shelter (HT)
- ☐ Place not meant for habitation (HH)
- ☐ Staying with family/friend temporarily (HT)
- ☐ Staying with family/friend permanently (HP)
- ☐ Institutional healthcare setting (e.g., hospital, nursing facility; HM)
- ☐ Other institutional setting (e.g., prison, jail; HM)
- ☐ Other: _____ (HM)

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(Appendix L)

11. Referrals Made:

- ☐ CIS+ Housing Navigation
- ☐ Behavioral health services
- ☐ Substance use treatment
- ☐ Case management
- ☐ Primary care
- ☐ Health Plan Health Coordination Services
- ☐ Med-QUEST Nutrition Supports
- ☐ Non-cash benefits (e.g. SNAP, WIC)
- ☐ Benefits assistance (SSI/SSDI/TANF/GA/other)
- ☐ Other: _____

Part 3: Medical Respite Provider Contact Information

Medical Respite Facility Name: _____

Medical Respite Facility Phone Number: _____

Medical Respite Facility Email Address: _____

Medical Respite Provider Name (print): _____ Date: _____