Minnesota Department of **Human Services**

DHS-4905F-ENG 10-15

Minnesota Health Care Programs (MHCP)

Discharge Summary Review Extended Psychiatric Inpatient Contract

Please complete this form summarizing the discharge plan for the patient.

Provider Information

CONTRACTING HOSPITAL	NPI/UMPI

Recipient Information

PATIENT NAME	DISCHARGE DATE

Discharge to:

- ◯ Private residence, home, apartment
- ◯ Intensive residential treatment
- ◯ Foster home
- ◯ Board and lodge
- ◯ Nursing home*
- ◯ Boarding care*
- ◯ CD residential treatment
- ◯ AWOL
- ◯ Community psychiatric inpatient
- ◯ Regional treatment center* (RTC)
- ◯ Community behavioral health hospital* (CBHH)
- ◯ Residential crisis facility
- ◯ Other (please specify)*

* If patient was discharged or transferred to the RTC, CBHH, nursing home, Medical Assistance (MA) certified boarding care, or "other," please detail the following:

Treatment options that were employed to avoid discharge and transfer of care

Alternative discharge options that were considered

For RTC transfer: state reason(s) patient could not complete treatment in hospital (include physician notes and treatment plan information that support reason for transfer)

SIGNATURE	PHONE NUMBER

Upon discharge, fax (secure) this form to medical review agent, mental health targeted case management (MH-TCM), assertive community treatment (ACT) team, or RTC or direct care and treatment (DCT) central pre-admissions office or other facility. If voluntary and patient consents and signs a release, you may contact the MH-TCM or ACT team at time of discharge.