

APS Discharge Notification
FAX 800-762-1639
Phone 800-762-1560

Client Name: _____
(Last name) (First name) (M)
DOB: ____ / ____ / ____ **RID:** _____

Please complete section that applies:

Discharge Date ____ / ____ / ____ **Level of Care** _____

Discharging Facility _____

Outpatient Referral to _____
(name of provider)

Appointment date and time

Reason for Discharge: (please check the box that applies)

- Adoption
- Agency (DHS or OJA) withdrew from services
- APS has determined this consumer no longer needs mental health services
- Consumer deceased
- Consumer discharged to less intensive/restrictive level of care
- Consumer moved from service area
- Consumer refuses services either orally or in writing
- Consumer transferred to less intensive/restrictive level of care
- Consumer transferred to a new provider
- Independent Living Skills (child ages out of the system)
- Parent or Guardian of consumer withdrew the consumer from services
- Provider is unable to contact/locate consumer (lost to follow-up)
- Reunification
- Terminated from behavioral health treatment due to becoming ineligible for Medicaid
- The consumer and provider agree the consumer no longer needs mental health services
- Unknown reason why consumer left services
- Other

If a consumer transfers, please enter the appropriate facility name in the admit and discharge area.