Magellan Complete Care
PO Box 524083
Miami, FL 33152

Magellan COMPLETE CARE

SIPP/ STGC DISCHARGE NOTIFICATION

Enrollee Name: ____________________ **Enrollee DOB:** ____________ **Member#:** _____________ **Circuit:** _______

Date of Discharge:__________________

Dependent Child [ ] **Community Child** [ ]

Reason for Discharge:
____
____
____

Discharge into custody of: ____
Name of Legal Guardian:___________________ **Relationship:** __________________ **Contact #:**___________________________
Address: ____

Discharge Placement/Discharge Plan:

[ ] Home with parents with Outpatient services
[ ] Home with relatives with Outpatient services
[ ] Foster home with Outpatient services
[ ] Statewide Inpatient Psychiatric Program
[ ] Shelter with outpatient services
[ ] Specialized Therapeutic Group Care
[ ] Unknown, elopement
[ ] BHOS
[ ] Out of State
[ ] AMA
[ ] Transfer: ____
[ ] Other: ____

Discharge Primary Diagnosis: ____
Medical Diagnosis and Coordination:
____
____

Discharge Medication:

Medication	**Dosage**	**Start Date**

Appointments Made at Discharge:

Agency/Type	**Appt Date**	**Time**	**Phone #**	**Fax #**