Discharge Form

The Primary Care Health Home Discharge Form must be completed in full. Please complete the form, save a copy, and submit it in a secure/encrypted email to PCHH@dss.mo.gov. Indicate "PCHH DISCHARGE" and the number of forms attached (maximum of 15) in the **subject line** of the email.

PART 1

Date: _____ Health Home: _____ HH Provider #: _____
(Must contain 9 digits)

PART 2

MO HealthNet ID/DCN #: _____
(Must contain 8 digits)

Date of Birth: _____

Participant Name: _____
Last First MI

PART 3

DISCHARGE REASON

Please select ONE reason for discharge:

- ☐ OO – Opt Out (participant or guardian request for discharge)
- ☐ NC – No contact (No response to attempted contacts)
- ☐ PI – Participant no longer receives care at Facility/HCH
- ☐ SD – Spend Down not met 3 or more consecutive months
- ☐ HD – Health Home request for discharge (if different from reasons listed above):

_____

- ☐ PM - Moved
- ☐ PD - Deceased
- ☐ MI – Medicaid inactive or ineligible (including hospice, nursing homes and incarceration.

PART 4

MO HEALTHNET USE ONLY:

Discharge Request: ☐ Approved ☐ Denied Date Form Received: _____

Date Approved/Denied: _____ Effective Date of Discharge: _____

Reason Request Denied: _____

Request Processed by: _____