Intensive Care Coordination (ICC) Discharge Form

Today's date: _____/_____/_____

Please use this form to notify Tufts Health Plan that you are discharging a Tufts Health Public Plans member from ICC. Please fill the form out completely and fax to 888.977.0776. For Tufts Health Unify the completed form can be faxed to 857.304.6304.

MEMBER INFORMATION

Member name: _____ Member ID #: _____DOB: ___/___/_____

Start date: ___/___/_____ Discharge date: ___/___/_____ Was this a planned discharge? ☐ Yes ☐ No

COMMUNITY SERVICE AGENCY (CSA) INFORMATION

CSA name: _____

Tufts Health Public Plans Provider ID#: _____

CSA phone: _____-_____-_____ CSA fax: _____-_____-_____

ICC coordinator name: _____ ICC coordinator phone: _____-_____-_____

REASON(S) FOR DISCHARGE

Please check all that apply.

☐ The youth no longer meets the criteria for serious emotional disturbance (SED).

☐ The care-planning team determined the youth has substantially met documented individual care plan (ICP) goals and objectives, and that the youth does not need continued services to prevent worsening of their behavioral health (BH) condition.

☐ The parent/caregiver has withdrawn consent for treatment.

☐ The youth and parent/caregiver are not engaged in treatment despite multiple, documented attempts to address engagement. This lack of engagement makes treatment ineffective and/or unsafe and implies withdrawn consent for treatment.

☐ The youth is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting, and is unable to return to a family home environment or a community setting with community-based supports or ICC.

☐ The youth has turned 21.

☐ The youth has disenrolled from Tufts Health Public Plans.

☐ Other. Please specify: _____

DISCHARGE PLAN

Please check all services the youth will continue to have.

☐ Outpatient therapy practice name _____

Provider name _____ Provider phone _____-_____- _____

Modality: ☐ Individual ☐ Family ☐ Group ☐ Other. Please specify: _____

☐ Medication management

Practice name _____

Provider name _____ Provider phone _____-_____-_____

☐ In-home therapy services

☐ In-home behavioral services

☐ Therapeutic mentoring services

☐ Other. Please specify: _____