AHI Health Home Care Management Discharge Summary (for member use at discharge)

(Courtesy of the Warren-Washington Association for Mental Health)

Client Name: ________________________
Discharge Date: ______________________
Date Enrolled: _______________________
Date of Last Billable Service: ___________

Instructions: Complete at Discharge: Discuss post-care services, provider, and contact information for each area with next known appointment date and time. Include who to call to re-engage in Health Homes services if needed and give a copy to the member.

Mental Health	
Medical	
Substance Use Disorder	
Housing	
Family/Social	
Community Supports	
Care Management	
Other	

Reason for Discharge Summary: ____
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___ Met Goals ___ Disenrolled ___ Refused to Continue ____ Lost Contact

POST DISCHARGE CONTACTS: If you have problems or questions after leaving this program, please contact the person listed below:

Name: _________________________________Title: _______________________ Phone: ______________