PerformCARE

TCM DISCHARGE REPORT

To be completed within 30 days of the discharge

When complete fax to 888-296-4002

REQUIRED FIELDS FOR DISCHARGES

TYPE OF CASE MANAGEMENT: ☐MH ☐ SA ☐ ICM ☐ RC ☐ BLENDED

PROVIDER: _____ DATE MEMBER DISCHARGED: _____

PHONE #: _____ FAX #: _____

MEMBER NAME: _____ MAID#: _____

DOB: _____ SS#: _____

CASE MANAGER: _____ PHONE #: _____

CURRENT DIAGNOSIS CODE:

Axis I: ☐☐☐.☐☐/☐☐☐.☐☐/☐☐☐.☐☐

Axis II: ☐☐☐.☐☐/☐☐☐.☐☐

DISCHARGE INDICATORS: (MUST MEET ONE)

I._____Member determines that TCM services are no longer needed/wanted and Member no longer meets continued stay criteria.

OR

II. ____ Determination by targeted CM that TCM is no longer necessary/appropriate and Member no longer meets continued stay criteria.

OR

III. ____ Member determines that TCM is no longer wanted but Member continues to meet continued stay criteria.

OR

IV.____ Member moved outside of current geographical service area.

OR

V.____ Member undergoing long-term incarceration, hospitalization, skilled-nursing care without a discharge or anticipated discharge date (Adults Only).