



COORDINATED  
SYSTEM OF CARE

Note: This must be a **SECURE** Email.

Magellan  
HEALTH<sup>SM</sup>

## LA CSoC Discharge Form

Referral Date:	*Discharge Date:	Healthy LA Plan Name:
WAA Discharging:	Phone #:	Email:

Youth Name:	DOB:	Medicaid #:
Legal Guardian(s) Name:	Relationship to Youth:	
Legal Guardian(s) Phone #1:	<input type="radio"/> Cell	<input type="radio"/> Home
Legal Guardian(s) Phone #2:	<input type="radio"/> Cell	<input type="radio"/> Home
Legal Guardian(s) Address:		
Parish:	<input type="radio"/> Consent Form Attached	

*Reason for Discharge:	Other:
Diagnosis (if known):	
Medical Issues:	
Current Medications:	

Behavioral Health Provider #1 Name:	Phone #:
Service Type:	
Behavioral Health Provider #2 Name:	Phone #:
Service Type:	
Behavioral Health Provider #3 Name:	Phone #:
Service Type:	
Behavioral Health Provider #4 Name:	Phone #:
Service Type:	

Name of Facility (If Out Of Home Placement):		
Contact Name at Facility:	Contact #:	Other #:

**IMPORTANT:** Submit CSoC Discharge Form to Email Address: [CSoCdischarges@magellanhealth.com](mailto:CSoCdischarges@magellanhealth.com)

CSoC Discharge Form: Version 3 August 23, 2016

\*If this is a transfer, please enter the word "transfer" next to the Discharge Date.

\*\*If the Reason for Discharge is "relocation", please indicate in the blank next to "other" if member will not be transferring to a new region and why (i.e. moved out of state, did not want to continue CSoC, etc.)