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Client Discharge/Change Notice

TO: Dept. of Children & Families ESS, _____ (location) Date: _____	**FROM:** _____ (facility name) Contact Name: _____ Enter extension, if applicable Telephone #: _____
Patient: _____ Date of Birth: _____	SS#: _____ Medicaid ID #: _____

THIS IS TO ADVISE YOU OF THE STATUS OF THE ABOVE PATIENT:

I. PATIENT DISCHARGED FROM THE FACILITY ON _____ (date) TO:

☐ ALF ☐ Home ☐ Hospital ☐ Other (specify): _____

Address: _____

☐ Due to Death on _____ (date of death)

II. TEMPORARY ABSENCE BEGINNING ON _____ (date) DUE TO:

☐ Hospital Admission ☐ Therapeutic Home Visit ☐ Other (specify): _____

III. EXPECTED TO RETURN ON _____ (date)

IV. READMITTED TO FACILITY ON _____ (date)

V. OTHER STATUS CHANGE:

☐ Medicare coverage began on _____ (date) and ended on _____ (date)

☐ Change in income: Type: _____ Amount: _____

TO: _____ (Facility Name)	**FROM DCF:** _____ (Economic Self-Sufficiency Specialist)
ATTENTION: _____ (Facility Contact)	PHONE #: _____ Enter extension, if applicable
DATE: _____	

COMMENTS: