CalOptima Health

CBAS MEMBER DISCHARGE PLAN AND REASON

CBAS CENTER NAME: _____

Long-Term Services and Supports/CBAS
Phone: (855) 227-1314 Fax: (714) 481-6423

Please Type or Print Legibly

Member Information	Name:	Date Last Attended: Date Discharged:
	Client Identification Number (CIN):	Date of Birth:
	Address:	Name of Physician(s):
	City, State, ZIP:	CBAS Authorization Number:
Discharge Plan	Most Recent Multidisciplinary Team (MDT) Meeting Date: _____ Discharge Plan: _____ _____ _____ *CBAS Representative Signature:* _____ Date:_____	
Discharge Reason	**Discharge Reason (mark appropriate answer):** ☐ Death ☐ Moved out of plan area ☐ Ineligible with CalOptima ☐ Long-term nursing facility placement ☐ Transferred to a different CBAS center ☐ Behavioral problems ☐ 30-day no-show ☐ Member chooses to leave CBAS program (e.g., poor attendance, unable to contact, unwillingness, declined health, too weak, etc.) ☐ Receives other services (e.g., assisted living, board and care, PACE, IHSS, MSSP, hospitalization, etc.) _____	
Signature	*Signature of Center Representative:* _____ Date: _____	

Notify CalOptima within five business days of discharge.