South Florida Behavioral Health Network, Inc.

Care Coordination Non-Enrollment/Discharge Form

Today's Date: **Date of Non-Enrollment/Discharge:**

I. Provider Information

Discharging Agency:	**Name of Care Coordinator (CC):**
CC Direct Office Line:	**CC Work Cell Phone Number:**
CC Email Address:	

II. Client Information

Legal Name:	**Date of Birth:**
Preferred Name:	**Social Security Number:**
Gender: □ **Male** □ **Female** □ **Transgender** ☐ **M** / ☐ **F** □ **Other**_____	**Phone Number:**
Race:	**Ethnicity:**

☐ **Consumer meets non-enrollment criteria** ☐ **Consumer meets discharge criteria**

The following consumers are NOT eligible for Care Coordination:

□ **Currently receiving FACT services** ☐ **Followed by the SFBHN Forensic Team** □ **Diagnosed with a Developmental Disability**

□ **Not funded by SFBHN** □ **Participating in the Navigate program** □ **Participating in Family Intensive Treatment Team Program**

III. Non-Enrollment/Discharge Criteria

Please choose at least one option below:

□ **Declined Care Coordination services**
(List contact attempts below including one face to face contact attempt)

□ **Moved out of region or out of State**

□ **Deceased**

□ **Unable to Contact**
(List contact attempts below including at least one face to face attempt)

□ **Receiving referred services not funded by SFBHN**

□ **Uncooperative with treatement and services after 3 documented attempts for reengagement**

□ **Successfully linked with needed services and/or case management**

□ **Incarcerated and unable to receive services**

□ **Has not had an acute care readmission in 180 days while receiving Care Coordination**

□ **Admitted to SMHTF**
(List date of admittion below)

IV. Non-Enrollment/Discharge Summary

Please elaborate on previous selection:

Staff Signature: _____ **Date:** _____

□ Continues to next page

Continued:

Staff Signature: _____ Date: _____