MISSISSIPPI DIVISION OF MEDICAID

CTS Discharge

Fax To: (601) 359-6294 Attn: CTS
Or
Mail to: Division of Medicaid Attn: CBS
550 High Street, Suite 1000
Jackson, MS 39201

To: Division of Medicaid, CBS Staff

From: _____
CTS Provider

Re: _____
Participant's Name

_____
Community Navigator

_____
Medicaid Number

_____
Contact Number

The above CTS participant is discharged from the CTS program effective _____.

THE REASON FOR Pre-CTS DISCHARGE:

☐ Individual transitioned to community without assistance of CTS

☐ Individual's physical, mental, or other needs greater than what could be accommodated in community or current waiver programs

☐ Individual could not find affordable, accessible housing or qualified residence

☐ Individual changed his/her mind, uncooperative in planning, preferred to remain in institution

☐ Individual's family member or personal representative/guardian refused services

☐ Other, please specify _____

THE REASON FOR CTS DISCHARGE:

☐ Completed 30 days of participation

☐ Eligibility Suspended

☐ Re-institutionalized

☐ Died

☐ Moved

☐ No longer needed services

☐ Other, please specify _____

_____ _____
Signature of Authorized CTS Provider Date

_____ _____
Signature of Participant Date

_____ _____
Signature of Personal Representative/Guardian Date

_____
Date Faxed to DOM CTS