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

_____________________________________

Medicaid Number

_____________________________________

Community Navigator

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

Revised: 11/28/2017
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CTS Discharge Form
DOM Form CTS.8