

The purpose of this form is to report the discharge information of all persons who were evaluated through the U21 review process.

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

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Facility Name: \_\_\_\_\_

Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Discharge Location:

- Home/Family       Group Home       Foster Care
- Inpatient Psychiatric Admission       Inpatient Medical Admission
- Other (please specify): \_\_\_\_\_
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Submitted by: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Fax this document to Ascend at 1-877-431-9568**