Banner University Health Plans
Banner – University Family Care

Behavioral Health Inpatient Discharge Plan

Member Name:______________________________________ **AHCCCS ID:** _________________**DOB:**___________

For BH Hospital/Sub Acute: Initial proposed discharge plan is completed within 48 hrs of admission. It is updated when there is a change in needed services. The Final Plan is due 24 hours before discharge. Place in the facility's designated area for inclusion in the inpatient record. ☐ Initial d/c plan ☐ Updated d/c plan ☐ Final d/c plan Date: ________________

For final DC plan: Date of Discharge:______________ Facility:____

Admit Date: ________________ Outpatient PROVIDER:____

PROVIDER Staff Name:____

Outpatient PROVIDER Phone # and Email address: ____

Criterion for d/c per facility:____Estimated Discharge:_________________

Barriers to Discharge: ____

Progress toward addressing d/c barriers: ____

SMI Determination Requested	☐ Yes	☐ No	☐ NA	☐ Already SMI Date of SMIT Det:____________

Identified Need **Specific Services and Frequency (if not currently in place, identify steps to obtain)**

☐ Home/Community ☐ Facility Name, if applicable:_____________ Level of Care_ ________________

Discharge Residence: ____
Street Address City State Zip

Substance Use Tx:	☐ Yes	☐ No	☐ NA Date:___________________Time:____________________

Other BH Services: ☐ No ☐ Yes Type Date:________________Date:________________Time:_____________
☐ No ☐ Yes Type Date: ________________Date:________________Time:_____________

F/U Psychiatric Appt: Date:____________Time:____________BHMP Name:_______________________________
____
Street Address City State Zip

Med Compliant: ☐ Yes ☐ No How addressed: ____

Meds needing PA: ☐ Yes ☐ No Meds:____

Provider has Coordinated Medical Needs with the Inpatient Facility: ☐ No ☐ Yes Details:
____
____

Coordination with other Health plan(s) occurred: ☐ No ☐ Yes Details: _________________________________
____

Date of next ART/CFT:____________________Case Manager's Name:_______________________________________

Crisis plan updated: ☐ Yes – Copy to the B-UFC BH Team ☐ No Date Update Planned:___________________________

Transportation needs addressed: ☐ Yes ☐ No Plan to Address when:______________________________________

☐ Yes, I was provided the opportunity to invite a designated representative/advocate to participate in my discharge planning.

☐ I agree with the services included in my discharge plan ☐ I do *not* agree with the services included in my plan

	Name (Print)	Signature	Date
Member/Guardian:	____________	____________	____________
Provider Representative:	____________	____________	____________
Inpatient Representative:	____________	____________	____________

Send with current Crisis Plan to BUHP via Fax # (520) 874-3411