



Commonwealth of Kentucky  
Cabinet for Health and Family Services  
Department for Medicaid Services

Admittance, Discharge or Transfer of an Individual in the ABI/SCL Program

Re: CLIENT NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

**(D) PRIMARY PROVIDER INFORMATION**

**(1) Primary Provider**

\_\_\_\_\_  
(Provider Name) (Provider #)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City) KY \_\_\_\_\_ (Zip) \_\_\_\_\_ (Phone number)

Monthly Cost: \_\_\_\_\_

**(E) FACILITY/HOSPITAL INFORMATION**

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

**(1) Facility/Hospital Name:** \_\_\_\_\_

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City) KY \_\_\_\_\_ (Zip) \_\_\_\_\_ (Phone number)

**(2) Reason for Admission**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(3) Discharge Outcome**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(F) WAIVER PROGRAM DISCHARGE**

Voluntary:  Involuntary:

**(1) Reason for Program Discharge**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*IF DISCHARGE IS VOLUNTARY, SUBMISSION OF DOCUMENTATION SIGNED BY THE GUARDIAN/LEGAL REPRESENTATIVE IS REQUIRED CONFIRMING INTENT TO DISCONTINUE SERVICES.