

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)

Monthly Cost: _____

(E) FACILITY/HOSPITAL INFORMATION

Admission Date: _____ Discharge Date: _____

(1) Facility/Hospital Name: _____

(Address)

(City) KY _____ (Zip) _____ (Phone)

(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.