MAGELLAN HEALTH SERVICES
Getting Better All the Time™

Interagency PNO Client Transfer Form

(for title XIX/XXI and HB Children Only)

Form 3.17.1

To the Clinical Director/Single Point of Contact of: (Agency Name) _____ Fax Number: _____

Please accept this fax as notification that on (date)_____, the following consumer was referred to your agency for on-going care and transfer of the clinical responsibilities for the following reason: _____

Consumer Full Name: _____ DOB: _____ CIS ID #: _____

Discharge/Transfer Note

Consumer is currently on medications: ☐ Yes - Number of days of medication remaining _____ ☐ No
Consumer needs psychiatric evaluation: ☐ Yes ☐ No
Outpatient Counseling: ☐ Yes ☐ No If yes frequency: _____
Child and Family Team Established: ☐ Yes ☐ No
Medical Management appointment scheduled: ☐ Yes ☐ No
Consumer is currently: ☐ Title 19 ☐ Title 21 ☐ HB funded
Treatment Start Date: _____ Treatment End Date: _____
Consumer receives Court-Ordered Treatment: ☐ Yes ☐ No
Other Comments: _____

Attached Documentation

☐ Face Sheet (include all important contact names and phone numbers)
☐ Intake & Treatment/Service Plan ☐ Crisis Safety Plan
☐ Progress Notes/CFT Notes ☐ Strength & Culture Discovery
COT Petition MH #: _____ Effective Date:_____ Expiration Date: _____
☐ Medical Documents (Psychiatric evaluation, psychiatric progress notes, medication administration records)
☐ Release of Information Form (signed by parent/guardian if under 18)

Provider Utilization Data

Number of hours and/or amount of funds expended: _____
Flex Funds for current Calendar Year (not to exceed $1525) _____
Respite Services for current Fiscal Year (not to exceed 30 days or 720 hours) _____
Special Needs: ☐ Yes ☐ No Please Explain: _____

Transferring Clinical Director/Single Point of Contact

Name: _____ Phone: _____

Signature: _____ Date: _____