1915(i) MEMBER DISCHARGE FORM
Submit to nd1915i@nd.gov
(4.2024)

NORTH Dakota Be Legendary.
Health & Human Services

Individual name:	Individual Medicaid ID#:

Individual contact information (phone number and/or email):

Agency name:

Agency contact (name, phone number and email):

Select the applicable service and enter the Service Authorization Number:

- ☐ Care Coordination SA#
- ☐ Housing Support* SA#
- ☐ Peer Support* SA#
- ☐ Benefits Planning* SA#
- ☐ Family Peer Support* SA#
- ☐ Non-Medical Transportation* SA#
- ☐ Supported Education* SA#
- ☐ Suported Employment* SA#
- ☐ Respite* SA#
- ☐ Pre-Vocational Training* SA#
- ☐ Training and Support for Unpaid Caregivers* SA#

Effective date of discharge:	How and when was individual notified:

Briefly describe reason for discharge:

Describe efforts to connect individual with another provider of their choice:

*Date and method used to notify care coordinator of discharge: