EASA PROGRAM – QUARTERLY OUTCOME - DISCHARGE FORM

(Use only if client discharged out of the program <u>after</u> Intake Visit was completed)

AGENCY IDENTIFIERS – *Entered at 'Participant' level – please update any 'Unknown' or 'Missing' values*

Client (Agency) ID # _____ **Prime # (OHP ID)** _____

County of Residence _____ **Agency Name** _____

HIPAA IDENTIFIERS - *Entered at 'Participant' level – please update any 'Unknown' or 'Missing' values*

Full Name _____ **DOB** __ __ / __ __ / __ __

FORM DETAILS

Year | | | | | **Quarter** ○ 1 Jan-Mar ○ 2 Apr-Jun ○ 3 Jul-Sep ○ 4 Oct-Dec

DISCHARGE TRANSFER

Discharge Date __ __ / __ __ / __ __ **Last Date Client Received Services** __ __ / __ __ / __ __

Did Client have a Transition Plan when they were Discharged?

- ○ Yes
- ○ No
- ○ Unknown

Primary Reason for Discharge from EASA

- ○ Completed Program – Achieved all or most of program goals
- ○ Completed Program – Achieved some program goals
- ○ Completed Program – Achieved few or none of program goals
- ○ Moved, specify where*_____ } **Complete questions to right**
- ○ Discharged/ Lost Contact
- ○ Chose other services, specify _____

  _____
- ○ Not appropriate for the program
- ○ Incarceration
- ○ Suicide
- ○ Death (not suicide)
- ○ Other, specify

  _____
- ○ Unknown

***Referred to a Different EASA County/ Agency?**

- ○ Yes
- ○ No
- ○ Unknown

***Agency Name Client Referred To**

_____