

LCDAC *Client Discharge Form*

ALL FIELDS ARE TO BE COMPLETED

Provider Name: _____

DDAP License #: _____

Client SCA #: _____

First Name: _____ MI: _____ Last Name: _____

Admit Date: _____ Discharge Date: _____

Last Treatment Date: _____ Discharge Reason: _____

Following discharge, will the client be participating in another LCDAC funded treatment service? If so, answer the following:

Agency referred to: _____ Requested Service/LOC: _____

Reason for continued LCDAC funding: _____

Additional Information/Comments: