

Member's Current Level of Care	Treatment Foster Care (TFC)
	Residential Treatment Center (RTC)
Member Name	
Member DCN	
Member DOB	
Reporting Provider Name	
Date of Event(s) <i>(Hospital admit date, or 1st date of member elopement, or Overnight Therapeutic Home Visit or detention)</i>	
Agency and/or Provider Contact <i>for additional questions (Name, Phone, Email)</i>	
Expected Discharge Date, If applicable	
Date of Member's Return, If applicable	
Facility name in which member has been hospitalized, if applicable	
Barriers to members return	Yes No
Additional details / notes:	