YOUTH LIPOS FUNDING DISCHARGE FORM

Today's Date: _____ EHR # _____

Client Information

First Name: _____ MI ____ Last Name _____

Admitting Hospital: ☐ Dominion ☐ North Spring ☐ Poplar Springs ☐ Snowden ☐ Other: _____ **OR**

PHP: ☐ Dominion ☐ North Spring

Authorizing CSB:

☐ Alexandria ☐ Arlington ☐ Fairfax ☐ Loudoun ☐ Prince William

Reason for no insurance:

☐ Not eligible ☐ Not signed up ☐ Benefits pending ☐ No MH benefits in plan

☐ Other: _____

This is to certify that inpatient psychiatric or Partial Hospitalization services have been rendered to the individual listed above by the hospital / program identified above, under the terms and conditions of the LIPOS Acute Bed Purchase Agreement. This also certifies that the hospital/program identified above has sent verification to the CSB indicating that individual listed above has no insurance that will cover this hospitalization.

Dates of Approved Service: _____

LIPOS Start Date - _____ (date individual discharged or transferred)

If PHP, Total Days _____

Clinical Status at Discharge / Transfer:

Ongoing Follow Up / Treatment Arrangements

Project Discharge Approval

CSB LIPOS Discharge Planner Name: _____ Date: _____

Last Updated: 6/23/23

Fax to NVRPO, attention Xiuping Cheung and Dana Johnson @ 703-653-9562 **OR**
Email to xiuping.cheung2@fairfaxcounty.gov and dana.johnson@fairfaxcounty.gov