Region 4 Re-Hospitalization / Incarceration Notice

Client Name: _____

CSB/BHA: _____

Case Manager/Liaison: _____

Date of Re-hospitalization/Incarceration: _____

Name of Facility: _____

Date of Request: _____

Amount of Approved IDAPP Plan: _____

Request to Hold for (choose one): ☐ 30 days ☐ 90 days

Brief Description:

_____
_____
_____
_____
_____

Regional Office Approval Date: _____

Deadline for 90 Day Hold Request: _____

Plan Re-Initialization Date: _____

Plan Termination Date: _____