Discharge Planning Checklist

Personal Information
Name:____ Prime Number:________________________________
Phone Number:_______________________________________
Additional Contact Person (If applicable):____________________ Relationship to Person: ________________________
Phone Number: _______________________________________
Communication
Discharge Planning Start Date:_________________________
Transition Coordinator Assigned:________________________ Current Case Manager:_________________________
Is case transferring to a new branch? Yes No If yes, local office number:_____ Case Manager Assigned:_______________
Has the Local Office Manager been notified? Yes No Date notified:__________
Has coordination been established with the receiving local office? Yes No
Briefly describe coordination plan: ____
____

Housing

Current Placement

Type of Residence: **(circle)** NF Own Home Relative Home Apartment ALF RCF AFH SLF DD Group Home

Current Address:____ Phone Number: ______________________

New Placement

Type of Residence: **(circle one)** Own Home Relative Home Apartment ALF RCF AFH SLF DD Group Home

New Residence Address:________________________________ Phone Number:________________________

Section 8 application submitted: Yes No N/A Projected time on wait list:___________ Is a subsidy required? Yes No

Task	**Date Scheduled**	**Person Responsible**	**Date Completed**
Home Walk Through			
Home License Application (if applic)			

Home Repairs/Modifications Required	**Who's Responsible**	**Projected Completion**	**Date Completed**
Task:______________________________	Name:_____________________	Date:________________	Date:________________
Task:______________________________	Name:_____________________	Date:________________	Date:________________
Task:______________________________	Name:_____________________	Date:________________	Date:________________
Task:______________________________	Name:_____________________	Date:________________	Date:________________
Task:______________________________	Name:_____________________	Date:________________	Date:________________
Task:______________________________	Name:_____________________	Date:________________	Date:________________

Household Furnishings Needed: (Kitchen Appliances, Furniture, Pots, Pans, etc.)

Individual Needs (Linens, Clothing, Toiletries, etc.)

Assistive Technology				
Assistive Technology Assess	Yes No N/A	Assessor:	Date Scheduled	Date Completed
Identified Need	Who's Responsible		Projected Completion Date	Date Completed
Identified Need	Who's Responsible		Projected Completion Date	Date Completed

Identified Need	Who's Responsible	Projected Completion Date	Date Completed
Identified Need	Who's Responsible	Projected Completion Date	Date Completed
Identified Need	Who's Responsible	Projected Completion Date	Date Completed

Medical Needs

1. Is the person eligible for Medicare? Yes No
2. Is the person enrolled in a managed care plan? Yes No

If yes, name of plan:___________________________

If no, do you plan to enroll them in managed care? Yes No

- Community Doctors Identified (Name): ____________________________ Has Doctor Accepted Patient? Yes or No
- Dentist (Name):____ Has Dentist Accepted Patient? Yes or No
- RN Services (If applicable) Name:________________________________
- Are other Specialists needed? Yes No

(IF YES, LIST BELOW)

- Type of Specialty:__________________________________ Name of Specialist:___________________

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- Type of Specialty:_________________________________ Name of Specialist :___________________
- Type of Specialty:_________________________________ Name of Specialist :___________________
- Pharmacy Identified (Name):_________________________

Additional Medical Support Questions	Yes	No	N/A
1. Does new home know of all scheduled appointments and need for lab work?			
2. Are there medication and treatment orders written?			
3. Is there at least a three day supply of medications immediately available?			
4. Are there ongoing medication orders written?			
5. Does the person have any allergies or reactions to medications?			
6. Have Nursing needs been identified? (if yes, answer 6a-6c—if no, skip)			
a. Have nursing services been arranged?			
b. Has the new nurse received the current nursing plan?			
c. Has any needed nursing delegation already occurred? **If no, date scheduled:_____________________**			
7. Does the person require a special diet (restrictions, texture, etc)?			
8. Is there a plan for fire safety (smoking, evacuation)?			
9. Are there ongoing treatment orders written?			

Durable Medical Equipment							
1. Does the home have all needed equipment (hospital bed, mobility device, shower chair, special eating tools, etc.) or supplies (diabetic, incontinence, wound, etc)? **List needed equipment below**					**Yes**	**No**	**N/A**
Need	RX Written?	Provider Name	Date Requested	Date Received	If denied, why?		
Need	RX Written?	Provider Name	Date Requested	Date Received	If denied, why?		
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Need	RX Written?	Provider Name	Date Requested	Date Received	If denied, why?		

Mental Health and Behavior Supports	Yes	No	N/A
1. Do documents indicate a history of behaviors that have been injurious to self or others?			
2. Does the new provider know about the person's challenging behaviors and know how to respond and where to turn for help?			
3. Is provider training necessary? (If yes, please list in the Staff Training Section)			
Staff Training/Trial Visits	**Yes**	**No**	**N/A**
1. Does the new provider know how the person communicates changes in health and distress?			
2. Does the new provider know how the person accesses fluids and the type of preferred drinks?			
3. Does the new provider know how to assist the person to move (walk, fall, prevention, transfer, positioning in bed)?			
4. Does the new provider know how to support the person with any other needs?			
Staff Training Needs? Yes No (List Below)			

Staff Training Needs? (List Below)	Date Scheduled?

	Date Scheduled? Date Scheduled?
Staff Visits (If applicable)	Date(s) Scheduled? Date(s) Scheduled?

Transportation

1. What type of transportation will the person use to access their community (including Doctor's appointments, shopping, social activities, etc.)? Type(s):____
2. On the day of transition, does everyone agree to the time of transfer and the type of transportation? Yes No

Financial Supports

Task	**Person Responsible**	**Date Completed**
NF Plan of Care Closed		
Social Security Notified of Move		
Medical Card Updated		
Bank Account		

Developmental Disabilities Specific Tasks	
➢ Needs Assessment Meeting Scheduled	Date Scheduled:______________________________
➢ Risk Tracking Record Meeting Scheduled	Date Scheduled: ______________________________
➢ Protocols Needed (including fatal four)	***List below in the Issue/Task table***
➢ Entry Individual Service Plan (ISP) Meeting Scheduled	Date Scheduled: ______________________________
➢ Initial OTAC/OIS Training Scheduled (if needed)	Date Scheduled: ______________________________

Identify issues to be resolved, other equipment to be ordered, tasks to be completed prior to discharge. (Person responsible and timelines?)

Issue/Task	Person Responsible	Completion Date

FIRST REVIEW PRIOR TO DISCHARGE FROM NURSING FACILITY (To be completed prior to Nursing Facility 30-day notice)

Date of Review:______________________________________ □ Approved to Submit Notice □ Not Approved to Submit Notice

Comments:____

____

_________________________________ _________________________________

Transition Coordinator Signature **Management Signature**

SECOND REVIEW PRIOR TO DISCHARGE

Date of Review:______________________________________ □ Approved to Submit Notice □ Not Approved to Submit Notice

Comments:____

____

_________________________________ _________________________________

Transition Coordinator Signature **Management Signature**

FINAL REVIEW

Date of Review:______________________________________ □ Approved to Transition □ Not Approved

Comments:____

____

_________________________________ _________________________________

Transition Coordinator Signature **Management Signature**