Tufts Health Plan SNF Discharge Planning Form

This form is to assist providers with discharge planning for Commercial, Tufts Medicare Preferred HMO and Tufts Health Plan members.

Today's date: _____

Member name: _____ Member ID#: _____ Date of birth: _____

Facility: _____ Facility care manager: _____

Phone #: _____ Fax #: _____

Name of discharge planner: _____ Phone #: _____

Anticipated discharge date: _____	
Stairs required for entry? ☐ Yes ☐ No	**If yes, how many stairs?** _____
Discharge destination: ☐ Home alone ☐ Home with family/friends ☐ Assisted living facility ☐ Custodial nursing home/LTC ☐ Other: _____	**Comments:**
Skilled needs upon discharge? ☐ Yes ☐ No ☐ Skilled nursing ☐ Social worker ☐ Physical therapy ☐ Home health aide ☐ Occupational therapy ☐ Other: ☐ Speech therapy _____	**Agency name:** **Comments:**
Durable medical equipment evaluation/needs? ☐ Yes ☐ No _____	
Potential barriers (e.g., physical, environmental, family)? ☐ Yes ☐ No _____	
Health care proxy/durable power of attorney? ☐ Yes ☐ No _____	
Medicaid application in process? ☐ Yes ☐ No ☐ N/A	
Medication review and reconciliation completed? ☐ Yes ☐ No **PLEASE ATTACH DISCHARGE MEDICATION LIST**	
Follow-up Appointments	
☐ **PCP** Name: _____ Date: _____ Time: _____	☐ **Specialist** Name: _____ Date: _____ Time: _____
☐ **Other** Name: _____ Date: _____ Time: _____	

Provider Services