

Tufts Health Plan

SNF Discharge Planning Form

TUFTS  Health Plan

www.tuftshealthplan.com/providers
 Provider Services - 888-884-2404
 Tufts Health Plan Medicare Preferred - 800-279-9022

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

Today's Date: _____

Member Name: _____

Member ID#: _____ Date of Birth: _____

Facility: _____

Facility Case 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
- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech therapy
- ☐ Social worker
- ☐ Home health aide
- ☐ Other: _____

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: _____

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