# 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** | ☐ **Specialist** | ☐ **Other** |
|---|---|---|
| Name: _____ | Name: _____ | Name: _____ |
| Date: _____ | Date: _____ | Date: _____ |
| Time: _____ | Time: _____ | Time: _____ |