Long-Term Care (LTC) – Discharge Disposition Form

The Alameda Alliance for Health (Alliance) Long-Term Care (LTC) Department – Discharge Disposition Form is confidential. Filling out this form will help us better serve our members.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Please fax the completed form to the Alliance LTC Department at **1.510.747.4191**.

For questions, please call the Alliance LTC Department at **1.510.747.4516**.

SECTION 1: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____ Alliance Member ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Client Identification Number (CIN): _____

Language: _____ Gender: ☐ Male ☐ Female ☐ Other

SECTION 2: DISCHARGE DISPOSITION

Where will the member be discharged? Please select all that apply:

- ☐ Discharged home with Home Health
- ☐ Discharged to acute hospital/higher level of care at different facility/ Subacute/Acute Rehab Facility (ARF)
- ☐ Discharged to board and care/Assisted Living Facility (ALF)
- ☐ Discharged to Intermediate Care Facility (ICF)
- ☐ Discharged to motel/Medical Respite/shelter
- ☐ Discharged to residence/home of another
- ☐ Discharged with hospice
- ☐ Ineligible with the Alliance
- ☐ Left Against Medical Advice (AMA)
- ☐ No longer need nursing facility services
- ☐ Poses a risk to the health or safety of individuals in the nursing facility
- ☐ Transition from custodial to skilled level of care
- ☐ Other (specify): _____

If discharged to a facility:

Name of Facility: _____

Address where the member was discharged: _____

City: _____ State: _____ Zip Code: _____

Phone number where the member can be reached: _____

SECTION 3: DISCHARGING FACILITY INFORMATION

Nursing Facility Name: _____

Admission Date: _____ Discharge Date: _____

Nursing Home Physician Name(s): _____

LTC Authorization #: _____

Discharge Diagnoses: _____ ICD-10 Code: _____

Description: _____

IF EXPIRED, STOP HERE.

SECTION 4: HIGH-RISK CONDITIONS

Does the member have one (1) or more of the following high-risk conditions? Please select all that apply:

- ☐ A fib
- ☐ AKF/AKI/Hyperkalemia
- ☐ Anticoagulation recently started
- ☐ Asthma (moderate/severe)
- ☐ Cancer complication
- ☐ Cellulitis
- ☐ CHF
- ☐ Cirrhosis
- ☐ COPD
- ☐ COVID-19
- ☐ CVA
- ☐ Diabetes
- ☐ ESRD/Dialysis
- ☐ ETOH
- ☐ HIV/AIDS
- ☐ Pneumonia
- ☐ PVD
- ☐ Sepsis
- ☐ Sickle Cell Disease
- ☐ STEMI/NSTEMI
- ☐ SUD
- ☐ Other (specify): _____

SECTION 5: DISCHARGE BARRIERS

Does the member have one (1) or more of the following discharge barriers? Please select all that apply:

- ☐ At Risk for Re-Institutionalization
- ☐ At Risk for Re-Rehospitalization
- ☐ Behavioral (i.e., wandering, aggressive)
- ☐ Caregiving Needs (i.e., 24/7)
- ☐ Change in Mobility
- ☐ Change in Cognitive Function
- ☐ Complex Care Coordination
- ☐ Complex Wound Care
- ☐ Destabilization of a Mental Health Condition
- ☐ Food Insecurity
- ☐ Homeless/Housing Insecurity
- ☐ Isolation Needs (MDRO/TB)
- ☐ Morbid Obesity
- ☐ Substance Use Disorder Relapse
- ☐ SMI
- ☐ Other (specify): _____

SECTION 6: FOLLOW-UP APPOINTMENT INFORMATION

PCP Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

NPI #: _____ TIN: _____

Does the member have a discharge appointment scheduled? ☐ Yes ☐ No

If yes, date: _____ Time: _____

Mode of transportation to appointment: _____

Does the member need dialysis? ☐ Yes ☐ No

Dialysis Provider Name: _____ Dialysis Provider Phone Number: _____

Are dialysis arrangements confirmed? ☐ Yes ☐ No

SECTION 7: CalAIM RESOURCES

Community Supports (CS) Referral: _____

Enhanced Care Management (ECM) Referral: _____

SECTION 8: NURSING FACILITY OFFERED MEMBER HOME AND COMMUNITY-BASED SERVICES (HCBS)

Please select all that apply:

- ☐ AIDS Services Foundation
- ☐ Assisted Living Waiver (ALW)
- ☐ Cal Medi Connect (CMC)
- ☐ Community-Based Adult Services (CBAS)
- ☐ Community Care Transition (CCT)
- ☐ Home and Community-Based Alternatives (HCBA) Waiver
- ☐ Home and Community-Based Services (HCBS) Waiver
- ☐ Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) Waiver
- ☐ In-Home Supportive Services (IHSS)
- ☐ Managed Long-Term Supports and Services (MLTSS)
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Program of All-Inclusive Care for the Elderly (PACE)
- ☐ Self Determination Program (SDP)
- ☐ Other (specify): _____

SECTION 9: SIGNATURE

Member/Representative Party Full Name: _____

Member Post Discharge Phone Number: _____

Facility Representative Signature: _____ Date: _____

Member Last Name: _____ Member First Name: _____ CIN #: _____