Important Reminder: Long-Term Care (LTC) Discharges

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We have an important reminder that we would like to share with you.

To help ensure the safety of our members and compliance with the California Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Population Health Management Policy Guide, all members must receive transitional care services when moving from one setting or level of care to another.

All long-term care (LTC) facilities must submit a completed Long-Term Care (LTC) – Discharge Disposition Form within 24 hours of the member's discharge from the LTC facility. This process ensures compliance with the requirement for transitional care services.

We appreciate your partnership in submitting requests in a timely manner. The Long-Term Care (LTC) – Discharge Disposition Form as well as other LTC-related request forms can be found on the Alliance website at **www.alamedaalliance.org/providers/calaim/long-term-care**. Please complete and fax these forms to the Alliance Long-Term Care (LTC) Department at **1.510.747.4191** for processing.

Thank you for providing high-quality care to our members and community. We are working together to ensure that all residents of Alameda County achieve optimal health and well-being at every stage of life.

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

LTC_PRVDR_DISCHARGE NOTICE 05/2024
FAXED 5/13/2024

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 #: _____