



County

DISCHARGE EVALUATION

Member Name			
	<i>Last</i>	<i>First</i>	<i>Middle</i>
Medicaid #			
Contact Name <small>(if other than the Member)</small>		Telephone	
Relationship to Member			

A. ABBREVIATIONS				
NF - Nursing Facility	LoC - Level of Care	PC - Personal Care	UNK - Unknown	CM - Case Manager

B. EVALUATION	
1. Reason/Member status at discharge:	Date of Occurrence _____
<input type="checkbox"/> Death <input type="checkbox"/> NF <input type="checkbox"/> Hospice <input type="checkbox"/> Hospitalization <input type="checkbox"/> No longer NFlOC <input type="checkbox"/> Financially ineligible <input type="checkbox"/> Moved out of service area <input type="checkbox"/> Other (<i>specify</i>) _____	
2. If discharged because of improved status and no longer NFlOC , indicate the appropriate service delivery system:	
<input type="checkbox"/> PC <input type="checkbox"/> Eldercare/AoA services <input type="checkbox"/> Family <input type="checkbox"/> UNK <input type="checkbox"/> None	
3. If financially ineligible , indicate service delivery system referred into:	
<input type="checkbox"/> Eldercare/AoA Services <input type="checkbox"/> Adult Day Care <input type="checkbox"/> Hospice <input type="checkbox"/> Family <input type="checkbox"/> UNK <input type="checkbox"/> None	
4. If still NFlOC , indicate precipitating incident leading to eventual discharge:	
<input type="checkbox"/> Injury <input type="checkbox"/> Illness/acute crisis <input type="checkbox"/> Loss of informal caregiver <input type="checkbox"/> Loss of formal caregiver <input type="checkbox"/> Other (Previously described as High Risk? Yes <input type="checkbox"/> No <input type="checkbox"/>) Describe precipitating incident:	
5. Was this precipitating incident resulting from a problem with the service plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	
6. Time between incident and CM knowledge of situation: _____ day(s).	
7. Source of CM knowledge of event:	
<input type="checkbox"/> Informal caregiver/Member <input type="checkbox"/> Formal caregiver <input type="checkbox"/> CM attempted contact <input type="checkbox"/> Other (<i>who</i>) _____	
8. Was the Member new to ADvantage less than 3 months? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, was Member: <input type="checkbox"/> Already Medicaid? <input type="checkbox"/> New to Medicaid ?	
9. Any additional comments regarding this case:	

Case Manager/Agency		
	Signature	Date