CFC 804A

Choices for Care

Nursing Facility (or Hospital Swing Bed) Discharge Notice Form

Complete this form for discharges of individuals who are <u>on</u> the Choices for Care program: Active or Pending Medicaid. This notice does not in any way replace or change any of the nursing home regulatory requirements for discharge or transfers.

Individual Name: _____
SSN: _____ Date of Birth:_____
Legal Representative (if any):_____
Nursing Facility: _____ Phone:_____

A. TYPE OF DISCHARGE: Discharge Date: _____

☐ *Discharge WITHOUT Choices for Care Services – ***complete signature below and section B***
☐ Discharge WITH Choices for Care in a different setting – ***complete section B & C***
☐ Death (*skip remaining sections*)

***I am voluntarily withdrawing from Choices for Care, long-term care Medicaid services. I understand I may still access other services that I am eligible for. I understand that I may reapply for the Choices for Care program at any time.**

_____ _____
Individual/Legal Representative Signature *Date*

B. DISCHARGED TO:

☐ Own Home
☐ Home of Another: (name)_____
☐ Hospital Swing Bed: (name)_____
☐ Nursing Facility: (name)_____
☐ Residential Care Home: (name)_____

Address discharged to:_____
_____ Phone Number:_____

C. CHOICES FOR CARE Case Management Agency:
The individual or legal representative must choose a Choices for Care case management agency/consultant. ***The nursing facility or hospital swing bed provider must make a referral to the chosen case management/consultant agency prior to discharge.***

☐ Area Agency on Aging_____*(agency name)*
-OR-
☐ Home Health Agency_____*(agency name)*

☐ Consultant Agency (Flexible Choices ONLY)_____*(agency name)*

Person Completing Form (print): _____
Signature: _____ Date: _____

<u>DO NOT SEND TO DVHA!!</u> SEND TO: LOCAL DAIL LTCCC and DCF ADPC FAX:802-241-0514

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