Long-Term Services & Supports (LTSS)
Long-Term Care (LTC)
Phone: 714-246-8600
Fax: 714-246-8843

CalOptima Health

DISCHARGE DISPOSITION FORM

Notify CalOptima within three (3) business days of discharge.

Please Type or Print Legibly

Nursing Facility Name		
Member Information	First Name:	Last Name:
Admission Date:	Discharge/Expired Date: ☐ Expired?	
Client Identification Number (CIN):	Date of Birth:	
Address: (Discharge Destination)	Phone Number:	
Name of Physician(s):	LTC Authorization Number:	
DISCHARGE DIAGNOSES	ICD-10 Code:	Description:

IF EXPIRED, STOP HERE.

Discharge Plan

Most Recent Interdisciplinary Care Team (ICT) Meeting Date:		
Discharge Plan:		
Facility or Family Address Where Discharged:		
Selected Community PCP:		
First Name:	Last Name:	NPI/PID from Provider Directory:
Address:		

DISCHARGE REASON/ DISPOSITION (check all that apply)

- ☐ Discharged to acute hospital/higher level of care
- ☐ Discharged to another SNF/ICF/SA
- ☐ Discharged to residence/home of another
- ☐ Discharged to board and care
- ☐ Discharged to motel
- ☐ Ineligible with CalOptima Health
- ☐ Left Against Medical Advice (AMA)
- ☐ No longer needs nursing facility services
- ☐ Poses risk to the health or safety of individuals in the nursing facility
- ☐ Other (specify):

NURSING FACILITY OFFERED MEMBER HOME- AND COMMUNITY-BASED SERVICES (HCBS) (check all that apply)

- ☐ 2-1-1 Orange County
- ☐ Aging & Disability Resource Connection
- ☐ AIDS Services Foundation
- ☐ Alzheimer's Association
- ☐ Assisted Living
- ☐ Board and Care Facility
- ☐ Case Management (CM) Program
- ☐ Community-Based Adult Services (CBAS)
- ☐ Community Care Transition (CCT)
- ☐ Dental
- ☐ Food Stamps
- ☐ Genetically Handicapped Person's Program (GHPP)
- ☐ Hemophilia Program
- ☐ Health Insurance Counseling & Advocacy Program (HICAP)
- ☐ Hospice
- ☐ Independent Living System
- ☐ In-Home Operations
- ☐ In-Home Supportive Services (IHSS)
- ☐ Legal Aid Society
- ☐ Meals on Wheels/Food Resource
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Orange County Housing
- ☐ Program of All-Inclusive Care for the Elderly (PACE)
- ☐ Regional Center of Orange County
- ☐ Shelter
- ☐ Transportation
- ☐ Waiver Program
- ☐ Other (specify):

Print Member/Representative Party Name:		Post Discharge Phone No:
Facility Representative Signature:		Date: