



# Discharge Disposition Form CalOptima Health

<b>Nursing Facility Name</b>			
<b>Member Information</b>		First Name:	Last Name:
Admission Date:		Discharge/Expired Date: <input type="checkbox"/> Expired?	
Client Identification Number (CIN):		Date of Birth:	
Address: (Discharge Destination)			Phone Number:
Name of Physician(s):		LTC Authorization Number:	
<b>Discharge Diagnoses</b>	ICD-10 Code:	Description:	
<b>IF EXPIRED, STOP HERE.</b>			
<b>Discharge Plan</b>			
Most Recent Interdisciplinary Care Team (ICT) Meeting Date:			
Discharge Plan:			
Facility or Family Address Where Discharged:			
Selected Community PCP:	First Name:	Last Name:	
Phone:	NPI/PID from Provider Directory:		
Address:			

Discharge Reason/ Disposition (check all that apply)	
<input type="checkbox"/> Discharged to acute hospital/higher level of care <input type="checkbox"/> Discharged to another SNF/ICF/SA <input type="checkbox"/> Discharged to residence/home of another <input type="checkbox"/> Discharged to board and care <input type="checkbox"/> Discharged to motel	<input type="checkbox"/> Ineligible with CalOptima <input type="checkbox"/> Left Against Medical Advice (AMA) <input type="checkbox"/> No longer needs nursing facility services <input type="checkbox"/> Poses risk to the health or safety of individuals in the nursing facility <input type="checkbox"/> Other (specify):
Nursing Facility Offered Member Home- and Community-Based Services (HCBS) (check all that apply)	
<input type="checkbox"/> 2-1-1 Orange County <input type="checkbox"/> Aging & Disability Resource Connection <input type="checkbox"/> AIDS Services Foundation <input type="checkbox"/> Alzheimer's Association <input type="checkbox"/> Assisted Living <input type="checkbox"/> Board and Care Facility <input type="checkbox"/> Case Management (CM) Program <input type="checkbox"/> Community-Based Adult Services (CBAS) <input type="checkbox"/> Community Care Transition (CCT) <input type="checkbox"/> Dental <input type="checkbox"/> Food Stamps <input type="checkbox"/> Genetically Handicapped Person's Program (GHPP) <input type="checkbox"/> Hemophilia Program <input type="checkbox"/> Health Insurance Counseling & Advocacy Program (HICAP)	<input type="checkbox"/> Hospice <input type="checkbox"/> Independent Living System <input type="checkbox"/> In-Home Operations <input type="checkbox"/> In-Home Supportive Services (IHSS) <input type="checkbox"/> Legal Aid Society <input type="checkbox"/> Meals on Wheels/Food Resource <input type="checkbox"/> Multipurpose Senior Services Program (MSSP) <input type="checkbox"/> Orange County Housing <input type="checkbox"/> Program of All-Inclusive Care for the Elderly (PACE) <input type="checkbox"/> Regional Center of Orange County <input type="checkbox"/> Shelter <input type="checkbox"/> Transportation <input type="checkbox"/> Waiver Program <input type="checkbox"/> Other (specify):

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