

Adult Day Health Care Center Involuntary Discharge Plan

Participant Name: _____ Record ID: _____ Medi-Cal Number: _____ DOB: _____
 Center Name: _____ Provider Number (NPI): _____
 Date: _____ Anticipated Date of Discharge from ADHC: _____

A. Skilled Nursing and Therapy Services Needed:

ICD9 code	Significant Diagnoses Requiring Skilled Intervention*	Describe Required Intervention	Recommended Frequency	Likely to Require ER, Hospitalization, SNF	Comments
				<input type="radio"/> Yes <input type="radio"/> No	
				<input type="radio"/> Yes <input type="radio"/> No	
				<input type="radio"/> Yes <input type="radio"/> No	
				<input type="radio"/> Yes <input type="radio"/> No	
				<input type="radio"/> Yes <input type="radio"/> No	
Total Number of Interventions:					

* Skilled services include: Nursing, Social Work, PT, OT, Speech, Mental Health and Dietary. Consider diagnoses likely to result in ER visits, hospitalization or skilled nursing facility without sufficient care.

B. Significant Risk Factors:

Risk Factor		Safety Concern / Comments
Inappropriate Affect, Appearance or Behavior	<input type="radio"/> Yes <input type="radio"/> No	
Poor Judgment	<input type="radio"/> Yes <input type="radio"/> No	
Medication Mismanagement	<input type="radio"/> Yes <input type="radio"/> No	
Self Neglect	<input type="radio"/> Yes <input type="radio"/> No	
Dementia Related Behavior Problems	<input type="radio"/> Yes <input type="radio"/> No	

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Risk Factor		Safety Concern / Comments
Fall Risk	<input type="radio"/> Yes <input type="radio"/> No	
Isolation	<input type="radio"/> Yes <input type="radio"/> No	
Frailty	<input type="radio"/> Yes <input type="radio"/> No	
Other (specify):	<input type="radio"/> Yes <input type="radio"/> No	
TOTAL # RISK FACTORS:		

C. Summary of Identified Needs and Potential Sources of Care in Community

Service Needs	Treatment / Intervention	Potential Agency / Provider	Date of Referral	Service Available	Adequate to Meet Current Service Need (sufficient & sustainable)
				<input type="radio"/> Yes <input type="checkbox"/> Start Date: _____ <input type="checkbox"/> Unknown Start Date <input type="checkbox"/> Wait List: ____ days <input type="radio"/> No, not available	<input type="radio"/> Yes <input type="radio"/> No If No, explain:
				<input type="radio"/> Yes <input type="checkbox"/> Start Date: _____ <input type="checkbox"/> Unknown Start Date <input type="checkbox"/> Wait List: ____ days <input type="radio"/> No, not available	<input type="radio"/> Yes <input type="radio"/> No If No, explain:
				<input type="radio"/> Yes <input type="checkbox"/> Start Date: _____ <input type="checkbox"/> Unknown Start Date <input type="checkbox"/> Wait List: ____ days <input type="radio"/> No, not available	<input type="radio"/> Yes <input type="radio"/> No If No, explain:

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				<input type="radio"/> Yes <input type="checkbox"/> Start Date: _____ <input type="checkbox"/> Unknown Start Date <input type="checkbox"/> Wait List: ____ days <input type="radio"/> No, not available	<input type="radio"/> Yes <input type="radio"/> No If No, explain:

1. Total Number of Ongoing Service Needs: _____
2. Total Number of Unmet Service Needs: _____
3. Will all needs be met by alternative resources? Yes No If No, why not? _____
4. Overall prognosis for successful outcome post-ADHC: Poor Fair Good Excellent
5. MDT Recommendation for Involuntary Discharge: Community with supports Residential Care for the Elderly Skilled Nursing Facility

D. Summary

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E. Discharge Summary Signatures of ADHC Multi-Disciplinary Team (OPTIONAL):

MDT Members	Printed Name	Signature	Date of Signature
Physician			
Program Director			
Registered Nurse			
Social Worker			
Activities Coordinator			
Physical Therapist			
Occupational Therapist			
Speech Therapist			
Registered Dietitian			
Mental Health Services			