

## SNF/HHA/CORF Discharge Summary Form

Complete this form for all SNF/HHA/CORF discharges.

Refer to the [SNF/HHA/CORF Discharge Summary Form Instructions](#) for information on how to complete this form.

Securely email completed form to: [TMP\\_Appeals\\_Requests@point32health.org](mailto:TMP_Appeals_Requests@point32health.org)

<b>I:</b> Member name _____ ID# _____ CM/DCM name _____ Phone # _____ Fax # _____ PCP name _____ Medical group/IPA # _____ Facility/Provider name _____ Facility/Provider phone # _____ Attending physician _____
<b>II:</b> Indicate type of services: <input type="checkbox"/> SNF <input type="checkbox"/> HHA <input type="checkbox"/> CORF Date skilled services should end _____ Date NOMNC issued to member/representative _____ Name of person who received NOMNC _____
<b>III:</b> Elements that need to be in place prior to discharge (Verify that the following information is documented in the record, if applicable) <input type="checkbox"/> Physician note reflecting readiness for discharge <input type="checkbox"/> Discharge plan discussed with attending physician <input type="checkbox"/> Discharge plan discussed with member/family <input type="checkbox"/> Description of discharge plan in place <input type="checkbox"/> Therapy notes reflect discharge status and rationale <input type="checkbox"/> Other (please be specific) _____ _____ _____ _____
<b>IV:</b> The facts used to make this decision: See instructions Fill in detailed and specific information about your patient's current medical condition and the reasons why services are no longer reasonable or necessary for this patient or are no longer covered according to Medicare or Medicare managed care coverage guidelines. (Use full sentences, plain non-medical language and NO abbreviations): 1. You were admitted to (see facility above) on the following date _____ from _____ For short term skilled nursing/rehabilitation services, due to the medical diagnosis of _____ _____ _____ _____ _____ 2. Your level of functioning prior to admission _____ _____ _____ _____ _____ 3. You were evaluated by _____ _____ _____ _____ _____

4. Your treatment plan included

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5. Your therapy goals for discharge were

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6. You are now (list current medical/rehab status /new level of function or describe any barriers that have prevented reaching goals)

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7. Your physician feels that you are medically stable at this time and no longer require skilled services. You are ready for discharge to

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8. Your discharge plan and follow-up care includes

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**V:**

Printed name of person completing the form \_\_\_\_\_

Signature of person completing the form \_\_\_\_\_

Phone # (cell or beeper) \_\_\_\_\_

[Provider Services](#)