Santa Clara Family Health Plan™

Long-Term Care Discharge Notification Form

This form is for long-term care (LTC) discharge notification only. Please complete and fax to Santa Clara Family Health Plan (SCFHP) Utilization Management (UM) Department at **1-408-874-1957** within 24 hours of any LTC discharge. This does NOT include transfers to acute settings. If you have any questions, please call UM Department at **1-408-874-1821**.

Today's Date: _____

Member Name: _____ Member ID: _____

Date of Birth: _____ Plan: ☐ Cal MediConnect ☐ Medi-Cal

Original Admit Date: _____ Discharge Date: _____

Facility (From which resident is discharged): _____

Discharge Reason (Check all that apply):

☐ Hospice ☐ Death ☐ Last Covered Day ☐ Sent to Other Location

☐ Other (Describe): _____

Location (To which resident is discharged for discharges other than death):

☐ Member's Residence
☐ Assisted Living Facility
☐ Board and Care
☐ Family's Residence
☐ Shelter
☐ Other: _____

Location Name (If not a residence): _____

REQUIRED CHECKLIST BEFORE SUBMISSION

☐ Discharge Plan is attached, ***or*** ☐ Discharge Summary is attached.

Signature: _____ Date: _____

Name: _____ Phone: _____ Fax: _____

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