

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) LTC 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** or refer to the [LTC Discharge Notification Form FAQs](#).

Today's date: _____

Member name: _____ Member ID: _____

Date of birth: _____ Plan: Cal MediConnect Medi-Cal

Admission date: _____ Discharge date: _____

Name of skilled nursing facility this patient was discharged from: _____

Discharge reason (check all that apply): Hospice Death Last covered day Sent to other location Hospital / exceeded bed hold – reason Sent to hospital (describe): _____ Other (describe): _____**Discharge destination (other than death):** Member's residence Family's residence Assisted living facility Shelter Board and care Other: _____ Location name (if not a residence): _____**REQUIRED CHECKLIST BEFORE SUBMISSION** Discharge plan is attached **OR** Discharge summary is attached Medication list (if applicable for discharge type) Face Sheet (when transferring to another facility or out-of-county)

Signature: _____ Date: _____

Name: _____ Phone: _____ Fax: _____

Confidentiality Notice: This electronic fax transmission (including any documents, files or previous email messages attached to it) may contain confidential information that is intended for a specific individual and purpose and that is privileged or otherwise protected by law. If you are not the intended recipient, or a person responsible for delivering it to the intended recipient, please delete this fax and notify SCFHP UM of the error. Any disclosure, copying or distribution of this message, or taking of any action based on it, is strictly prohibited.