



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 1-408-874-1985 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 facility from which patient is discharged: _____

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)

Signature: _____ Date: _____

Name: _____ Phone: _____ Fax: _____

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