

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: DualConnect 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: _____

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