Ohio | Department of Developmental Disabilities

STATE OF OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES (DODD)

DISCHARGE OF INDIVIDUALS FROM DEVELOPMENTAL CENTERS

DEVELOPED**: 3/16/15**
IMPLEMENTED**: 5/1/15**

Purpose: The following procedure will be used by the 10 Developmental Centers (DC) to complete discharge planning and transitioning into a home in the community. All state funded individuals living in a developmental center have an IO Waiver available to allow them to move out of the DC. This procedure is to ensure that each individual moving from a state operated developmental center has a thorough discharge and transition plan that addresses the individual, guardian and team input for a successful transition.

Prior to Referral to a home in the community

Guardians and Individuals will be educated regarding community placement options on an annual basis and as openings occur. Discharge and transition planning will be addressed at least annually in each individuals' IPP. All parties of the individuals choosing shall have a role in developing the person's transition plan, and shall comprise of the Individual Program Plan team. Based on the person's needs, the important relevant disciplines will be involved, such as Nursing, Psychology, Dietary, etc. All assessments and referral information will be updated to ensure accurate information prior to making referral.

Referral and Service Provider Search

Waiver: If the individual chooses to seek waiver services, the DC representative will follow the Developmental Center internal procedure requesting CB services. This will include contacting the county board Superintendent to ask for assignment of an SSA to assist in finding a home for the individual in their county. If more than one county is involved (example -one county is paying for the waiver and the individual is moving to another county) both counties must be contacted to participate in the transition. **Refer to Appendix DR5.** The DC representative will offer assistance to the county board in completing necessary information, *i.e.,* waiver application, Person Centered Plan, ODDP, Home Choice, etc., as requested by the SSA.

The facility representative will provide the County Board Service and Support Administrator (SSA) and the appropriate county board with a referral packet containing the release of information signed by the guardian, and the following:

- Current Individual Program Plan, which includes their Person Centered Transition Plan and Behavior Support Strategies, if applicable
- Special Team Meeting Minutes
- Essential Healthy Lifestyle Plan (EHLP)**Refer to Appendix DR4**
- Current assessments to include if applicable: 1) Psychological evaluation, 2) Social History, 3) Physical Examination, 4) Nutritional Assessment, 5) Occupational Therapy Assessment, 6) Physical Therapy Assessment, 7) Speech Assessment, 8) Vocational Assessment, 9) Psychiatric Assessment, 10) Any other specialized assessment that might be indicated/applicable.

If an individual is seeking placement in a waiver setting the provider search will begin and will include in addition to the person, the guardian, DC representative, SSA and other people chosen by the individual.

Once the individual and their guardian have chosen a potential provider the individual's chosen IPP team will begin the process of identifying a potential residence.

ICF: If the individual chooses to seek services in an ICF, the DC representative will send the referral packet (as identified above) to the ICF administrator, and the county board contact in which the ICF is located. The DC representative will offer assistance in completion of the Individual Assessment Form (IAF). The ICF may request assistance in securing the approval for the state funded IO waiver/domino waiver. For any individual who moves from the ICF to an IO Waiver setting in order for the current individual from the DC to move into the ICF, the state will provide a state funded waiver.

The DC representative will inform the guardian of the county board's or ICF's decision as to whether they will serve the individual.

For both Waiver and ICF placements, the DC representative will meet with the DC Director of Nursing (DON) or DON Designee to review the medical services and supports needed to ensure a successful residential placement. Several visits to the proposed new placement with the individual, guardian/family and a DC representative must occur to ensure the home and housemates (if applicable) are a good fit for the individual.

Action Steps Prior to Discharge

The provider will be advised that before the discharge of the individual from the DC can take place, the following must be in place/scheduled and verified to the facility DON or DON designee: 1) Initial appointment with Primary Care Physician, and 2) Initial appointment with Psychiatrist Services, as applicable. 3) and any other medical professionals, as applicable.

The individual and their IPP team will review the transition plan and EHLP to ensure current information is provided for a successful transition to their new home. At this time a tentative discharge date will be determined.

The DC representative will coordinate training for the new provider staff ensuring that all of the following is given to, and thoroughly reviewed with the receiving provider:

- Current Individual Program Plan, which includes their Person Centered Transition Plan and Behavior Support Strategies if applicable
- Special Team Meeting Minutes
- Essential Healthy Lifestyle Plan
- Current assessments to include if applicable: 1)Psychological evaluation, 2) Social History, 3) Physical Examination, 4) Nutritional Assessment 5) Occupational Therapy Assessment 6) Physical Therapy Assessment 7) Speech Assessment 8) Vocational Assessment 9) Psychiatric Assessment 10) Medication List and all applicable Medical Information

This training will involve communication between the QIDP or designee and nursing staff from the developmental center, and the provider. The individual will not be discharged from the developmental center until the provider and designated staff has been trained. This training for the provider staff is to be evidenced with supporting documentation.

The DC representative will schedule the Pre- Discharge Meeting to finalize the discharge plan, and ensure that the discussion is properly noted in the *Pre-Discharge Meeting Format*. **Refer to Appendix DR6.** This meeting will be held within 2-4 weeks prior to the planned discharge-date. The Discharge/Follow-up Consent **Refer to Appendix DR1** will be completed at this meeting or prior to discharge.

Day of Discharge

The DC representative will ensure that an **up to date** copy of the following information is provided to the county board SSA, if applicable and the provider. Information to include:

- Current Individual Program Plan, which includes their Person Centered Transition Plan and Behavior Support Strategies, as applicable
- Special Team Meeting Minutes
- Essential Healthy Lifestyle Plan
- Pre-Discharge Meeting Minutes
- Discharge/Follow-up Consent
- Discharge Checklist
- Current assessments to include if applicable: 1)Psychological evaluation, 2) Social History, 3) Physical Examination, 4) Nutritional Assessment 5) Occupational Therapy Assessment 6) Physical Therapy Assessment 7) Speech Assessment 8) Vocational Assessment 9) Psychiatric Assessment 10) Current Medication List and Supply 11) All Medical Information as deemed applicable

On the day of discharge, an informal meeting will be held. The DC representative will review pertinent information with the new provider, to ensure that all of the individual's needs are met prior to discharge.

A signature verifying receipt of this information will need to be obtained from the receiving Provider, and the County Board SSA, if applicable. The provider will be required to sign the *Discharge Checklist* indicating receipt and understanding of this information listed above. **Refer to Appendix DR7.**

Upon Discharge

Contact (call/email) will be initiated by the Community Resource Coordinator to the service provider and the guardian within one week of discharge from the Developmental Center to discuss transition of the individual.

Reviews will be scheduled at 30 days, 90 days, 180 days, 1 year, 1 ½ years, 2 years and 3 years from discharge, and as needed. These reviews will be scheduled by the Community Resource Coordinator. The Community Resource Coordinator will schedule discharge follow-ups involving face-to-face visits with the individuals and the residential service provider in the individual's home. The CRC will invite the County Board if there are concerns. If the visit cannot be completed in the individual's home, rationale will be included in the summary. During the visit the CRC will request information regarding areas identified on the *Discharge Review Summary* **Refer to Appendix DR2** to discuss general well-being and general satisfaction.

1-week after discharge	**30 days after discharge**	**90 days after discharge**	**180 days after discharge**
Phone call/email is to be mad to provider & guardian on th progress of the individual	Complete full discharge revie with individual and guardian Enter into database	Complete full discharge revie with individual and guardian Enter into database	Complete full discharge revie with individual and guardian Enter into database

• Enter into case note database.			
• **1 year after discharge** Complete full discharge review with individual and guardian • Enter into database	• **1 ½ yrs. after discharge** Complete full discharge review with individual and guardian Enter into database	• **2 years after discharge** Complete full discharge review with individual and guardian • Enter into database	• **3 yrs. after discharge** Complete full discharge review with individual and guardian • Enter into database

An individual who stays at a Developmental Center for 180 days or more would be subject to a 1-week phone review and visits at 30 days, 90 days, 180 days, 1 year, 1 ½ years, 2 years and 3 years following discharge.

Any individual staying at a Developmental Center 179 days or less would be subject to a 1-week phone review and then a 30 day review.

Special discharge reviews can be requested by the provider, county board or guardian and completed at any time a concern may arise.

Areas of concern/follow-ups will be addressed with the guardian, service provider, County Board, and/or other involved parties as needed. Previous areas of concern/follow-ups will continue to be assessed at future visits.

Copies of the completed *Discharge Review Summary* with the *Individual Satisfaction Summary* **Refer to Appendix DR2** and *Guardian Satisfaction Summary* **Refer to Appendix DR3** will be sent to the County Board, Residential Resources Director, designated staff at the Developmental Center of discharge and the guardian if applicable.

Ginnie Whisman, Deputy Director

Appendix DR1

Ohio | Department of Developmental Disabilities

Consent for Continued Review after Discharge

To assist in the safety, happiness and success of Fname Lname, following his/her move to his/her new home from the Name of DC Developmental Center; we will complete *Discharge Review Summary* and *Guardian/Individual Satisfaction Summary*. Depending on length of stay, these reviews will be scheduled at various times (30-day, 90-day, 180-day, 1 year, 1 ½ years, 2 years, and 3 years) and as needed. The *Discharge Follow-Up Summary* will consist of a face to face visit involving FName, the residential service provider and the Community Resource Coordinator. The Community Resource Coordinator will also contact the guardian to complete a *Guardian Satisfaction Summary,* to gather information and identify any areas of success, dissatisfaction or concern. The Community Resource Coordinator will complete follow-up on any identified issues and/or concerns.

I hereby grant the Ohio Department of Developmental Disabilities permission for continued review after discharge from Name of Developmental Center. Permissions for review include interviews with individual, all documents pertaining to individual's programming, medical, behavior, mental status, UIs/MUIs, as well as general wellbeing. I also grant permission for the Discharge Report to be shared with the Residential Service Provider, the County Board and the Developmental Center. This consent for continued review may be revoked at any time by my written notice to the Ohio Department of Developmental Disabilities at the address below:

Community Resource Coordinator
CRC Fname Lname
Name of DC Developmental Center
Address 1
City, OH XXXXX
CRC Phone Number

_____
(Signature of individual or person authorized to consent)

Relationship: _____

Date Signed: _____

Witness: _____

Appendix DR2

Ohio Department of Developmental Disabilities
Discharge Review Summary

___30-day ___90-day ___180-day ___1-yr ___1.5-yr ___2-yr ___3-yr ___Special

Date of Interview: _____ **Date of Discharge from (_____DC):** _____

Name of Individual: _____

Provider/Address: _____ **Provider County:**_____

Type of Interview: In Person: _____ Phone: _____ Other: _____ **Funding:** __ICF; __Waiver; __Other

Person Conducting Follow-Up: _____

Person(s)/Phone #(s) contacted if not a personal visit: _____

	COMMENTS
I. ENVIRONMENTAL	
Is home clean and well kept? Yes or No	
Are personal affects in individual's bedroom? Yes or No	
Are there any noticeable safety issues? Yes or No	
II. PERSONAL APPEARANCE	
Is individual's personal appearance clean and neat? Yes or No	
III. INDIVIDUAL'S AFFECT	
Did individual interact or respond during visit? Yes or No	
Did staff interact with individual during visit? Yes or No	
Was staff present & able to share information about individual? Yes or No	
IV. MEDICAL	
Have there been any significant medication changes? Yes or No	
Any apparent aversive effects of medication changes? Yes or No	
Have there been any significant changes in weight? Yes or No	
Have there been any health related issues or problems? Yes or No	
Has person been able to access necessary consultants (medical, dental. psych) Yes or No	

Revised 9/14

Appendix DR2 – continued

V. Program Services	
Are staff aware of individual needs? Yes or No	
Is individual involved in activities at home? Yes or No	
Is individual involved in activities away from home? Yes or No	
Have there been any behavior support concerns? Yes or No	
Is individual currently attending Day Services? Yes or No	
VI. Health and Safety:	
Have there been any noteworthy incidents (if so describe)? Yes or No	
Have there been any MUIs (if so describe)? Yes or No	
Does individual have all recommended adaptive equipment/devices? Yes or No	
Is individual's current diet order being followed? Yes or No	
Current supervision level being maintained? Yes or No	
VII Individual Satisfaction:	
Are you happy living in your home? Yes or No	
Do you feel safe in your home? Yes or No	

Additional Comments/Information:

Revised 9/14

Appendix DR3

Guardian Satisfaction Summary

Individual Name: _____ Date: _____

Name of Person Being Interviewed: _____ Phone: _____

The following questions should be asked of the guardian (or of the individual if able). Describe the rating scale and circle the corresponding answer.

1. How do you feel about the individual's current home?

Highly Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Highly Dissatisfied
☐	☐	☐	☐	☐

2. How do you feel about their daily routine (meals, activities, visitation, etc.?)

Highly Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Highly Dissatisfied
☐	☐	☐	☐	☐

3. How do you feel about the people who are currently providing their service (direct care staff and management)?

Highly Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Highly Dissatisfied
☐	☐	☐	☐	☐

4. How do you feel about the people who are providing habilitation services (Workshops, Day Program, Supported Employment)?

Highly Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Highly Dissatisfied
☐	☐	☐	☐	☐

5. How do you feel about the Service and Support Administrator (SSA) and other services from the County Board or QIDP?

Highly Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Highly Dissatisfied
☐	☐	☐	☐	☐

6. How do you feel about the individual's degree of independence?

Highly Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Highly Dissatisfied
☐	☐	☐	☐	☐

7. How do you feel about the individual's behavioral progress?

Highly Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Highly Dissatisfied
☐	☐	☐	☐	☐

8. How do you feel about the individual's safety at home and/or their day program?

Highly Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Highly Dissatisfied
☐	☐	☐	☐	☐

9. Is there anything else that you would like to tell?

_____

_____

_____

10. Additional Comments/Action Taken: _____

_____

_____

11. Is follow-up required based on Guardian's input? ☐ YES ☐ NO

Revised 9/9/14

Appendix DR4

Ohio | Department of Developmental Disabilities

DEVELOPMENTAL CENTER
Essential Healthy Life Style Plan (EHLSP)

Date of Admission: _____ Date of Annual from _____ to _____ Date of Discharge: _____

GENERAL				
Name of Individual:	DOB:	Sex:	Height:	Weight:
Name of DC:	Name of PCP:	Name of Nurse Completing Form:		

MEDICAL

Check here ONLY IF Ohio **DNR or DNR-**CC is attached_____ (a properly authorized DNR-DNR-CC must be attached to be valid)

IMMUNIZATIONS:	DATE LAST GIVEN:	DATE NEXT DUE:	IMMUNIZATIONS:	DATE LAST GIVEN:	DATE NEXT DUE:	IMMUNIZATIONS:	DATE LAST GIVEN:	DATE NEXT DUE:
D.P.T			Hep. B			P.P.D.		
Shingles			Flu			Pneumonia		
D.T./T.T.								

MEDICAL OVERVIEW

ALLERGIES:

DIAGNOSIS CURRENT:

DIAGNOSIS HISTORY:

MY MEDICAL AND HEALTH INFORMATION	**DETAILS AND EXPLANATIONS OF MY HEALTH INFORMATION**	**PERSON-CENTERED ACTIONS MY TEAM AND I WANT OR NEED TO TAKE**
*(Include any known **dates** of **original diagnosis**; most **recent evaluations** and **outcomes**, lab tests, screenings; current treatments and appliances/adaptive devices; list names of **specialists** and **other** related **providers**)* *Additional prompts are in RED italics- prompts are clarifications/reminders; to include but not limited to* *DELETE PROMPTS as you complete each section-*	*(Include explanations of diagnosis and conditions; important considerations for monitoring, treatment and support; include what is important TO the individual including supports and preferences that may be contraindicated; describe the functional presentation of the diagnosis/condition and implications of condition and responses to condition/treatments; Personal adaptive behavior, device usage indications; safety concerns;*	(bullet point action steps) • Include date of appointments that are scheduled • or date next due • action steps for accommodating what is important TO the person • steps FOR health and safety • address accommodations of TO vs FOR • include functional coping and support strategies and steps
ALLERGIES: *current and past medication and environmental allergies; date of last reaction*	*How allergies present; treatments; avoidance and interventions; individual's awareness and self-protection; last known reaction*	*Urgent/emergent actions, prescriptions and avoidance*
VISION: *includes diagnoses and*		

corrections		
DENTAL: *conditions, devices, and presentations including special hygiene if applicable, chewing swallowing and other oropharyngeal issues*		
EAR (HEARING)/NOSE/THROAT: *current functions including hearing; swallowing and other oropharyngeal issues (if not applicable to or listed in to dental); ENT related appliances*		
NEUROLOGY: *seizures, strokes, neuro related sleep disturbances, hyper/hypo sensitivities*		
PSYCHIATRY: *include psych related sleep issues*		
CARDIOLOGY:		
RESPIRATORY: *include sleep apneas;*		
SKIN: *include podiatry if applicable*		
GI / DIETARY: *appliances*		
MUSCULAR/SKELELTAL: *orthotics, mobility, orthopedics, podiatry*		
REPRODUCTIVE/URINARY: *includes toileting*		
ENDOCRINE / HORMONAL / METABOLISM: *includes lymphatic*		
MEDICATIONS:		
TREATMENTS:		

RESOURCES (*DC nursing, specialists, clinics etc.***):**	**RESOURCE CONTACT INFORMATION:**

RN/LPN Signature / Date

DON Review and Approval Signature / Date

Appendix DR5

DC INTERNAL USE ONLY

Requesting County Board SSA Services for Individuals who want to utilize an IO Waiver Funded by DODD

1. Developmental Center (DC) Team, which includes the individual and/or guardian, indicates a desire to move from the DC to a home using a Home and Community Based (HCBS) Waiver.

2. DC Team determines which county the individual would like to move to. This decision should be based on proximity to family/friends or length of time living in area, current community connections such as job, etc.

3. DC Team sends a formal notice via mail or email stating the request for an SSA to be assigned to work with the team and individual on the transition planning process. The CB is informed if the individual qualifies for an IO waiver funded by DODD. The letter **(Attached Exhibit A)** will explain why the individual wants to move to their county. Please keep in mind the County Board (CB) can only bill for TCM 180 days prior to the actual move.

4. If the CB still feels they cannot assign an SSA, the DC Superintendent will contact the Superintendent of the county denying services to discuss the case and to get an understanding of the county's reason for denial. If the CB denies assigning an SSA, the DC Superintendent will inform the Deputy Director (DD) of Residential Resources of the denial prior to requesting in writing that we will be asking for a formal letter outlining why they cannot assign an SSA. If the CB Superintendent and Deputy Director cannot work out an acceptable solution or alternative, the DC Superintendent will then request the CB issue a formal denial in writing to DODD. –The County Board Superintendent will be asked to outline the reason services are being denied, as well as a notice of due process to the individual if the CB is unwilling to provide targeted case management. If requested, the DC will assist the individual and/or guardian to appeal the process. To appeal the denial the individual and/or guardian will need to ask for a state hearing and call the Bureau of State hearings at 1-866-635-3748. See Notice of Denial form (**Attached Exhibit B**). As appropriate, the DD will notify the Office of Provider Standards and Review regarding the denial.

   For more information about appeal rights:
   http://www.odjfs.state.oh.us/forms/file.asp?id=1043&type=application/pdf

5. Once an SSA is assigned, the DC will invite the SSA to all team meetings for the individual that is interested in moving out on a waiver.

Appendix DR5 – Continued

6. Together the team develops a Person Centered Individual Service Plan (ISP) and complete an ODDP to determine the individual's funding range. The CB will utilize the Cost Projection Tool (CPT) within the Medicaid Services System (MSS) to project service costs. If the needed services cannot be funded within the funding range assigned to the individual through the ODDP process, then the CB will submit a Prior Authorization

request once the waiver has actually been approved. The discharge date cannot precede the waiver effective date, and the waiver effective date cannot be established until DODD approves the initial waiver application.

7. After completing the ODDP and ISP, if the CB declines participating in the process of administering the Individual Options Waiver funded by DODD due to health and safety concerns, the DC Superintendent may complete the same procedure identified in Number 4 after consulting with the Residential Resource Administrator and Deputy Director

8. The SSA is responsible to help the individual and/or guardian choose a qualified and willing provider and housing options. The right for individuals to choose among all willing and qualified providers is a basic tenet of HCBS waivers.

9. The DC will provide all needed information for the SSA to complete a waiver enrollment packet and assist in finding a provider. CB SSAs complete the enrollment process with the individual and/or their family/representative.

10. The DC staff (CRC?) will assist the SSA in filling out and submitting the HOME Choice application if the CB is not a HOME Choice Transition Coordinator. The guardian will need to sign off on the application. The guardian/individual will select a Home Choice Transition Coordinator (TC) to help with start-up and transition services. The CB does not have to agree to be the TC, but they do have to be a part of the discharge planning process and work with the HOME Choice providers.

11. DC Team begins discharge process.

Please note that the waiting list statute does not apply in these circumstances due to the fact that these are all state match supported. In enrolling individuals, CBs must get an approval letter from the Administrative Professional from the Division of Residential Resources.

Appendix DR5 - Continued

Date

Name, Title of Recipient
Name of County Board
Address
City, State

Dear name of county board supt.,

As part of the Developmental Center Downsizing efforts, name of individual qualifies for a state funded IO Waiver. The guardian of individual's first name is in agreement that he/she would benefit from moving from name of DC Developmental Center into a smaller waiver setting. They have requested that individual's first name move to name of County due to Insert reason county was chosen .

On behalf of the individual and guardian, per Rule 5123:2-1-11(D)(1)(c) , we are requesting an SSA be assigned to assist individual's first name to move from the intermediate care facility to a community setting. Please inform us in writing of the SSA's name and contact information which will allow our DC team to work closely with the assigned SSA.

We look forward to hearing from you by 7 days from today's date. Please contact me with any questions or concerns.

Sincerely,

DC Supt.

Appendix DR6

_____DEVELOPMENTAL CENTER
PRE-DISCHARGE MEETING

Individual_____
_____

Date_____

Members Present:
(if conf call – fax sign-in or send for signature)

Discussion:

Person Centered Transition Plan and Essential Healthy Lifestyle Plan Review

Provider's input:

Info on visits to home

Staffing ratio

Sleep staff

Guardian/contact persons

Visitation Information

Day Hab/Vocational Plan, Schedule and Transportation:
Sidles (if applic)

Rev.IPPGoals/Objectives/BehaviorSupportStrategies/Guidelines/MedicalSupport Strategies/recommendations
(shared prior and copies sent)

Risks/Concerns: (identify priority concerns as applies/further explanation if/as needed)

Communication

Supervision Level

Sleep pattern/nighttime checks

Ambulation

Falls/Plan

Appendix DR6 - CONTINUED

Behavior Concerns

Noted re-enforcers/likes/preferences

Diet/Weight

Safety skills

Special Needs

Items that go with Individual (adapt eqpmt?) what items will be needed when moved? Who is responsible for ensuring individual has all needed items prior to moving?

Other issues…

List names – doctors/specialists for new home and follow-up appointment dates
Primary Care Physician
Eye Dr.
Dentist
Psychologist
Psychiatrist
Specialists/etc…

Nursing copy/send med chart info

Need 3 day supply of meds/30 day script?

What training took place with provider prior to move

Address of home
Phone#

Date of move

Follow-ups?

Cc: Medical Records
Provider Home
County Board of Origin
County Board of New Residence

Appendix DR7

_____DEVELOPMENTAL CENTER

Discharge Checklist

Name of Individual: _____ Date: _____

The provider has received a copy of the following:

Individual Program Plan (IPP) _____
(including Transition Plan and Behavior Support Strategies as applicable)

Special Team Meeting Minutes _____

Essential Healthy Lifestyle Plan
(including list of current medications) _____

Pre-Discharge Meeting Minutes _____

Continued Review after Discharge _____

Current Assessments (as applicable)

- Psychological Assessment _____
- Social Services/History _____
- Physical Examination _____
- Nutritional Assessment _____
- O.T. Assessment _____
- P.T. Assessment _____
- Speech Assessment _____
- Vocational Assessment _____
- Psychiatric Assessment _____
- Other_____ _____
- Other_____ _____

Discharge Inventory _____

Other: _____ SS Card; ___ Medicare Card; ____ Rx Card; ___ Medicaid Card; _____ Guardianship Papers; _____ Birth Certificate; ___ Burial/Funeral Plans

I have received a copy of the above and will contact _____ if any further information is needed.

_____ _____

New Provider/Representative **Date**

_____ _____

DC Staff **Date Completed**