CarePartners of Connecticut

SNF/HHA/CORF Discharge Summary Form

Complete this form for all SNF/HHA/CORF discharges.

Refer to the SNF/HHA/CORF Discharge Summary Form Instructions for information on how to complete this form.

Securely email completed form to CPCT_AppealsandGrievances@CarePartnersct.com.

I: Member name_____ID#_____

CM/DCM name_____Phone #_____Fax # _____

PCP name_____Medical group/IPA # _____

Facility/Provider name_____Facility/Provider phone # _____

Attending physician _____

II: Indicate type of services: ☐ SNF ☐ HHA ☐ CORF

Date skilled services should end _____

Date NOMNC issued to member/representative _____

Name of person who received NOMNC_____

III: Elements that need to be in place prior to discharge (Verify that the following information is documented in the record, if applicable)

☐ Physician note reflecting readiness for discharge
☐ Discharge plan discussed with member/family
☐ Therapy notes reflect discharge status and rationale
☐ Discharge plan discussed with attending physician
☐ Description of discharge plan in place

☐ Other (please be specific)

_____
_____
_____
_____

IV: The facts used to make this decision: See instructions

Fill in detailed and specific information about your patient's current medical condition and the reasons why services are no longer reasonable or necessary for this patient or are no longer covered according to Medicare or Medicare managed care coverage guidelines. (Use full sentences, plain nonmedical language and NO abbreviations):

1. You were admitted to (see facility above) on the following date _____from_____

For short-term skilled nursing/rehabilitation services, due to the medical diagnosis of

_____
_____
_____
_____

2. Your level of functioning prior to admission

_____
_____
_____
_____

3. You were evaluated by

_____

_____
_____
_____

4. Your treatment plan included

_____
_____
_____
_____

5. Your therapy goals for discharge were

_____
_____
_____
_____

6. You are now (list current medical/rehab status /new level of function or describe any barriers that have prevented reaching goals)

_____
_____
_____
_____

7. Your physician feels that you are medically stable at this time and no longer require skilled services. You are ready for discharge to

_____
_____
_____
_____

8. Your discharge plan and follow-up care includes

_____
_____
_____
_____

V:
Printed name of person completing the form _____
Signature of person completing the form _____
Phone # (cell or beeper) _____