



# MFP DISCHARGE DAY CHECKLIST



<b>Discharge Date:</b>		
MFP Field Personnel Print Name:		Phone #:
<b>MFP Participant Housing at Discharge</b>		
Participant Name:	Medicaid ID#	Date of Birth:
New Address:	City:	Zip: County:
Phone Number(s): ;	<b>MFP Target Population</b> (check only one): <input type="checkbox"/> OA (65+yoa) <input type="checkbox"/> PD <input type="checkbox"/> TBI <input type="checkbox"/> DD <input type="checkbox"/> MH	
<b>Housing Type:</b> <input type="checkbox"/> 01-Home owned by Participant <input type="checkbox"/> 02-Home owned by Family Member <input type="checkbox"/> 03-Apt/House Leased by Participant, Not Assisted Living <input type="checkbox"/> 04-Apt. Leased by Participant, Assisted Living <input type="checkbox"/> 05-Group Home of No More Than 4 People/PCH <input type="checkbox"/> <b>Lives with family (check for yes)</b>		
<b>Housing Subsidy:</b> If H3-Apt/House Leased by Participant, check box for housing subsidy used: <input type="checkbox"/> HS1- Sec8 HCV, <input type="checkbox"/> HS2-Project Based Rental Assistance/ Based On Income, <input type="checkbox"/> HS3- Low Income Housing Tax Credit , <input type="checkbox"/> HS4- Other Subsidy (specify) <input type="checkbox"/> HS5-No Subsidy/Market Rate		
<b>Services at Discharge: Item Key: N=Needed; O=Ordered; S = Secured; N/A=Not Applicable</b>		
<b>Items</b> (provide items for all that apply): _____ Environmental Modifications; _____ Home Inspections; _____ Security Deposit; _____ Utility Deposits: _____, _____, _____; _____ Household items: _____; _____ Kitchen: _____, _____ Bath: _____, _____; _____ Bed: _____, _____, _____ _____ Food & Nutrition: _____ _____ Health & Hygiene: _____ _____ RX Medications _____ _____ Medical Services/DME Equipment: _____ _____ Assistive Technology Devices: _____ _____ Life Skills Coaching/ Socialization: _____ _____ Financial: _____ _____ Transportation: _____ _____ Other:(list) _____		
Waiver:	Waiver Case Manager/Care Coordinator/Planning List Admin/Case Expeditor:	Phone:
Waiver services ordered at discharge: _____; _____; _____; _____; _____; _____;		
Are providers identified to begin services upon discharge?: <input type="checkbox"/> Yes <input type="checkbox"/> No* If no, explain:		
Name of Community Pharmacy:	Name of Community Doctor/Clinic:	
24/7 Emergency plan reviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:		
Identify participant's unmet needs upon discharge and the plan to meet these unmet needs: (attach additional sheets as needed)		
<b>Follow-up Visits/Quality Management</b>		
<b>Home Visits:</b> Provide schedule for follow-up visits: <input type="checkbox"/> Field Personnel/TC: 1 <sup>st</sup> Scheduled Visit to review ITP: _____; 2 <sup>nd</sup> Visit, If Scheduled: _____ <input type="checkbox"/> Waiver Case Mgr, <input type="checkbox"/> Care Coordinator, <input type="checkbox"/> Support Coordinator, <input type="checkbox"/> PLA Name: _____ Phone: _____ 1 <sup>st</sup> Scheduled visit: _____; 2 <sup>nd</sup> Visit, If Scheduled: _____ <input type="checkbox"/> HC Ombudsman Name: _____ Phone: _____ 1 <sup>st</sup> Scheduled F2F visit (or NA): _____; <input type="checkbox"/> Peer Supporter Name: _____ Phone: _____ 1 <sup>st</sup> Scheduled F2F visit (or NA) : _____;		
<b>Quality of Life Survey:</b> <input type="checkbox"/> Baseline Survey - <input type="checkbox"/> Completed <input type="checkbox"/> Scheduled: _____ <input type="checkbox"/> Rescheduled: _____ <input type="checkbox"/> NA		
<b>Participant Tracking</b>		
<input type="checkbox"/> MFP Field Personnel Signature: _____		Date Sent to coordinating agency: _____