



MFP DISCHARGE DAY CHECKLIST



Discharge Date:		
MFP Field Personnel Print Name:		Phone #:
MFP Participant Housing at Discharge		
Participant Name:	Medicaid ID#	Date of Birth:
New Address:	City:	Zip: County:
Phone Number(s):	MFP Target Population (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	
Housing Type: <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"/> Lives with family (check for yes)		
Housing Subsidy: 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		
Services at Discharge: Item Key: N=Needed; O=Ordered; S = Secured; N/A=Not Applicable		
Items (provide items for all that apply): <input type="checkbox"/> Environmental Modifications; <input type="checkbox"/> Security Deposit; <input type="checkbox"/> Utility Deposits: _____; <input type="checkbox"/> Other: _____ <input type="checkbox"/> Household items: <input type="checkbox"/> Kitchen: _____; <input type="checkbox"/> Bath: _____; <input type="checkbox"/> Bed: _____ <input type="checkbox"/> Food & Nutrition: _____ <input type="checkbox"/> Health & Hygiene: _____ <input type="checkbox"/> RX Medications _____ <input type="checkbox"/> Medical Services/DME Equipment: _____ <input type="checkbox"/> Assistive Technology Devices: _____ <input type="checkbox"/> Life Skills/ Socialization: _____ <input type="checkbox"/> Financial: _____ <input type="checkbox"/> Transportation: _____ <input type="checkbox"/> 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)		
Follow-up Visits/Quality Management		
Home Visits: Provide schedule for follow up visits: <input type="checkbox"/> Field Personnel/TC: 1 st Scheduled Visit to complete Post-ITP: _____; 2 nd 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 st Scheduled visit: _____; 2 nd Visit, If Scheduled: _____ <input type="checkbox"/> Ombudsman Name: _____ Phone: _____ Email: _____ 1 st Scheduled F2F visit (or n/a): _____; 2 nd Visit, If Scheduled: _____		
Quality of Life Survey: <input type="checkbox"/> Baseline Survey - <input type="checkbox"/> Completed <input type="checkbox"/> Scheduled: _____ <input type="checkbox"/> Rescheduled: _____ <input type="checkbox"/> NA		
Participant Tracking		
<input type="checkbox"/> MFP Field Personnel Signature: _____		Date Sent to coordinating agency: