

**Discharge Notification: Home Health Care**

Attn: HHC Coordinator

Toll Free Phone Number: 1-800-891-2520

Fax: 567-661-0843

From (Agency Name): \_\_\_\_\_ NPI: \_\_\_\_\_

Member Name: \_\_\_\_\_ Paramount ID #: \_\_\_\_\_

Paramount Secondary ID# \_\_\_\_\_  
(If applicable)

Date of Birth \_\_\_\_\_ Authorization #: \_\_\_\_\_

Start of Care Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Provider Billing Tax ID# (TIN): \_\_\_\_\_

Number of actual visits provided during the home care episode:

(If billing PDGM, only need to check the service and not provide visit count)

SN \_\_\_\_\_ PT \_\_\_\_\_ OT \_\_\_\_\_ ST \_\_\_\_\_ HHA \_\_\_\_\_ MSW \_\_\_\_\_

**Fall Risk Assessment at Discharge for Medicare Patients:** (Check all that apply)

- Age 65 or older
- Decreased Functional Status
- Prior History of falls within last 3 months
- Environmental Hazards observed
- Cognitive Impairment
- Incontinence
- Taking 4 or more medications
- Poor or impaired vision
- Pain affecting level of function
- 3 or more co Existing diagnoses

**Total Score:** \_\_\_\_\_ **SOC score:** \_\_\_\_\_

Home Care Case Manager: \_\_\_\_\_ Date: \_\_\_\_\_

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