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:_____