TOP AID
HEALTHCARE, INC

DISCHARGE/TRANSITION PLAN

Members Name: _____

Date of Plan: _____ Discharge/Transition Plan Date: _____

Reason for Discharge:

- ❑ Member transitions to another AFC provider
- ❑ Member selects another service that is duplicate of AFC
- ❑ Member's needs cannot be met by the AFC provider
- ❑ Member demonstrates behavioral or other problems that may endanger the member, the AFC caregiver, or AFC provider staff
- ❑ Member's clinical needs are beyond the scope of AFC
- ❑ Member does not reside in an AFC qualified setting
- ❑ Member no longer meets the clinical eligibility criteria for AFC
- ❑ Other_____

Referrals:_____

_____

_____

Transition Plan (Include plan to ensure continuity of care by the member, including during transitions of care as specified in the AFC plan of care; coordinate the discharge and transition with the member, member's family or legal guardian, and staff of the program or agency to which the member is to be transferred; provide assistance to the member in identifying and locating another provider; maintain current level of services until the member is admitted with a new provider or caregiver).

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_____	_____	_____
Name of Member/Guardian	Signature of Member/ Guardian	Date
_____	_____	_____
Name of Case Manager	Signature of Case Manager	Date
_____	_____	_____
Name of Nurse	Signature of Nurse	Date
_____	_____	_____
Name of AFC Supervisor	Signature of AFC Supervisor	Date