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IF I AM HOSPITALIZED: HOME-FIRST DISCHARGE CARD

Patient: _____ **DOB:** _____
Hospital / unit: _____
This form last reviewed: _____ **Hospitalization date (if in use):** _____
Healthcare agent (POA): _____ **Phone:** _____
Backup agent: _____ **Phone:** _____
Care manager: _____ **Phone:** _____
Attorney / firm: Monty L. Donohew, LPA, (330) 896-0300 **After-hours:** _____

The patient's written goal

This patient wants to return home, or to the least institutional setting that can meet medical needs. A skilled-nursing "rehab" stay is not the default. It is appropriate only if home with services cannot safely meet the discharge needs. The agent may accept or refuse a SNF placement consistent with the patient's AIP directive and healthcare POA.

Before any SNF referral, the discharge planner should:

1. Put the medical needs in writing (nursing hours, therapy, equipment, meds, wound care, supervision).
2. State whether those needs can be met at home with home health, private duty, family care, or outpatient follow-up.
3. Give the proposed SNF name, expected length of stay, and whether the stay is Medicare inpatient or observation.
4. Do not treat family fatigue or an empty house tonight as a medical finding that home is impossible.

Observation vs. inpatient: ask and write the answers

- **Inpatient or observation?** _____
- **If observation for more than 24 hours:** ask for the MOON (Medicare Outpatient Observation Notice) in writing. The hospital must deliver it no later than 36 hours after observation begins. ☐ MOON received
- **Three-day inpatient qualifying stay?** ☐ Yes ☐ No ☐ Unknown

Will Medicare cover a later SNF stay? Traditional Medicare generally requires three inpatient days; observation usually does not count. Medicare Advantage plans vary: check the plan's own rules and prior-authorization process.

Home-first checklist (agent)

☐ Who is in the house the first 72 hours: _____
☐ Home health contacted: _____
☐ Private-duty / family caregiver hours: _____
☐ Home available (keys, heat, food, equipment) ☐ Meds reconciled and filled
☐ Follow-up physician set ☐ DME ordered ☐ Ride home set

If a box is empty, that is a planning gap, not automatic proof that a nursing facility is required.

Who may sign

The agent may sign as agent for the patient, not individually. No one should sign personally as guarantor of payment. A person who is not the agent should not sign admission, payment, or arbitration papers. Medicare- or Medicaid-certified nursing facilities may not require a third party to guarantee payment personally, 42 U.S.C. § 1395i-3(c)(5)(A)(ii); 42 C.F.R. § 483.15, or require binding pre-dispute arbitration, 42 C.F.R. § 483.70(n), as a condition of admission.

If the hospital says the SNF bed is "for tonight"

Ask for the written discharge order, the list of needs that supposedly cannot be met at home, enough time to stand up home services, and the care manager's participation. Say: *"We are not refusing medically necessary care. We are refusing an unnecessary change of residence. Put the medical reasons for SNF placement in the chart."*

First 72 hours at home

Confirm the first home-health visit. Secure extra medication. Watch for confusion or another fall. Call the physician if the promised level of care is not actually in the house.

PCP: _____ **Ph:** _____ **Home health:** _____ **Ph:** _____
Pharmacy: _____ **Ph:** _____ **Fallback only if home fails:** _____

This card implements the patient's existing legal documents. It is not a substitute for those documents or for medical judgment.