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ADULT DAY HEALTH CARE BRANCH  
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DATE: September 23, 2011

TO: Adult Day Health Care (ADHC) Center Administrators and Program Directors

FROM: The California Department of Aging (CDA) ADHC Branch

**SUBJECT: ADHC DISCHARGE PLAN SUBMISSION AND PAYMENT / INVITATION TO ATTEND WEBINAR ON DISCHARGE PLAN FORM COMPLETION**

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**PURPOSE**

This letter provides information regarding requirements for the submission of ADHC Medi-Cal participant discharge plans for reimbursement by Medi-Cal. In addition, this letter invites interested ADHC center staff to attend an upcoming webinar session focused on completing the *ADHC Discharge Plan* form.

**BACKGROUND**

To facilitate assessment of ADHC participants by Medi-Cal managed care plans and the State's care management contractor, APS, Inc., ADHC providers will receive payment for completion and submission of the attached *ADHC Discharge Plan* form to the Sacramento Medi-Cal Field Office. This form is a revised version of the draft form circulated by the California Association of Adult Day Services (CAADS), and requires a list of current medications, a signature of the Registered Nurse completing the *ADHC Discharge Plan* form, and an *Authorization for Release of Protected Health Information* form signed by the ADHC participant or authorized representative.

The Department of Health Care Services (DHCS) will share the *ADHC Discharge Plan* forms with managed care plans and APS, Inc., to ensure that relevant clinical and service information is incorporated with the comprehensive assessments into each ADHC participant's individualized plan of care (IPC). This is why DHCS has included the *Authorization for Release of Protected Health Information* form as part of the discharge planning process. In addition to sharing the *ADHC Discharge Plan* forms with managed care plans and APS, Inc., DHCS will extract demographic, clinical, and service information from the forms to

establish a baseline database for tracking participant health status and health outcomes (e.g., utilization of emergency rooms, hospital admissions, nursing home placements, etc.).

**INSTRUCTIONS**

1. Complete the *ADHC Discharge Plan* form for each Medi-Cal participant currently enrolled at your center.
2. Ask the ADHC participant/authorized representative to sign the *Authorization for Release of Protected Health Information* form. If a participant chooses not to allow the release of his or her information, the ADHC center representative should cross out the form and note "*Declined to Sign*" on the top of the form.
3. Retain a copy of the *ADHC Discharge Plan* form and *Authorization for Release of Protected Health Information* form submitted to the Sacramento Medi-Cal Field Office in the ADHC participant's health record.
4. Send the original *ADHC Discharge Plan* form to:

**Sacramento Medi-Cal Field Office  
1501 Capitol Avenue, MS 4510  
P.O. Box 997427  
Sacramento, CA 95899-7427  
Attn: ADHC Discharge**

**DEADLINES FOR  
SUBMISSION  
AND RATE OF  
REIMBURSEMENT**

Fully completed *ADHC Discharge Plan* forms postmarked:

- Now through October 15, 2011: Reimbursement \$60
- October 16 – November 30, 2011: Reimbursement \$30
- December 1, 2011, or later will NOT be reimbursed.

Appropriate reimbursement for the submission of the *ADHC Discharge Plan* forms will be sent to the center's address listed on the provider master file, and the ADHC center will not be required to submit a separate claim for payment.

**WHERE TO  
OBTAIN  
THE ADHC  
DISCHARGE  
FORM**

A printable electronic copy of the *ADHC Discharge Plan* form may be obtained on the DHCS ADHC Transition website at: <http://DHCS.ca.gov/ADHCtransition>. Copies of the *Authorization for Release of Protected Health Information* form in Medi-Cal's threshold languages will be posted on the website the week of September 26, 2011.

**WEBINARS  
ON ADHC  
DISCHARGE  
PLAN FORM**

CDA and DHCS will jointly conduct two webinar sessions on the *ADHC Discharge Plan* form. ADHC centers may attend the webinar on September 28 or September 29 from 2:00 to 3:00 p.m. More information about registering for the webinar is available online at: <http://DHCS.ca.gov/ADHCtransition>.

**INQUIRIES**

Additional information, forms, and helpful links can be found at:

- ADHC page on the CDA website at [www.aging.ca.gov](http://www.aging.ca.gov)
- DHCS ADHC website at <http://DHCS.ca.gov/ADHCtransition>
- DHCS ADHC Email: [adhc-transition@dhcs.ca.gov](mailto:adhc-transition@dhcs.ca.gov)
- CDA ADHC Branch: (916) 419-7545

Attachment: *ADHC Discharge Plan* form

# Adult Day Health Care Center Discharge Plan

Participant Name: \_\_\_\_\_ Record ID#: \_\_\_\_\_ Medi-Cal Client Index No: \_\_\_\_\_ DOB: \_\_\_\_\_

Center Name: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Provider Number (NPI): \_\_\_\_\_

Date: \_\_\_\_\_ Anticipated Date of Discharge from ADHC: \_\_\_\_\_

Gender:  Male  Female Primary Language Spoken: \_\_\_\_\_

ADHC Participant Resides:  Alone  With Caregiver(s)  Board and Care / Residential Care Facility  Intermediate Care Facility

ADHC Attendance Schedule:  Mon  Tue  Wed  Thu  Fri  Sat  Sun TOTAL DAYS/WEEK: \_\_\_\_\_

## A. Skilled Services Needed:

1	2	3	4	5	6	7
ICD9 code	Significant Diagnoses Requiring Skilled Intervention*	Describe Required Intervention	Recommended Frequency	Likely to Require Immediate ER, SNF Hospitalization, without Sufficient Care (Check one) <input type="radio"/> Yes <input type="radio"/> No	Clinical Service Area (e.g., PT, OT Nursing)	Evidence
				<input type="radio"/> Yes <input type="radio"/> No		
				<input type="radio"/> Yes <input type="radio"/> No		
				<input type="radio"/> Yes <input type="radio"/> No		
				<input type="radio"/> Yes <input type="radio"/> No		
				<input type="radio"/> Yes <input type="radio"/> No		
<b>Total Number of Interventions:</b>						

\* Skilled services include: Nursing, Social Work, PT, OT, Speech, Mental Health and Dietary. Consider diagnoses likely to result in ER visits, hospitalization or skilled nursing facility without sufficient care.

# Adult Day Health Care Center Discharge Plan

Participant Name: \_\_\_\_\_ Record ID#: \_\_\_\_\_ Medi-Cal Client Index No: \_\_\_\_\_ DOB \_\_\_\_\_

**B. Significant Risk Factors:**

1	2	3
Risk Factor	(Check one)	Evidence to Support
Inappropriate Affect, Appearance or Behavior	<input type="radio"/> Yes <input type="radio"/> No	
Poor Judgment	<input type="radio"/> Yes <input type="radio"/> No	
Medication Mismanagement	<input type="radio"/> Yes <input type="radio"/> No	
Self Neglect	<input type="radio"/> Yes <input type="radio"/> No	
Dementia Related Behavior Problems	<input type="radio"/> Yes <input type="radio"/> No	
Fall Risk	<input type="radio"/> Yes <input type="radio"/> No	
Isolation	<input type="radio"/> Yes <input type="radio"/> No	
Frailty	<input type="radio"/> Yes <input type="radio"/> No	
Two or More Chronic Conditions	<input type="radio"/> Yes <input type="radio"/> No	
Lives alone with no caregivers	<input type="radio"/> Yes <input type="radio"/> No	
Other:	<input type="radio"/> Yes <input type="radio"/> No	
Other:	<input type="radio"/> Yes <input type="radio"/> No	
<b>TOTAL # of "Yes" RISK FACTORS:</b>		

# Adult Day Health Care Center Discharge Plan

Participant Name: \_\_\_\_\_ Record ID#: \_\_\_\_\_ Medi-Cal Client Index No: \_\_\_\_\_ DOB: \_\_\_\_\_

## C. Summary of Identified Needs and Potential Sources of Care in Community

1	2	3	4	5	6	7
Service Needs	Provider Category	Potential Agency / Provider	Recommended Treatment / Intervention	Date of Referral	Service Available At Time of Discharge (Check one)	Adequate to Meet Current Service Need (sufficient & sustainable) (Check one)
					<input type="radio"/> Yes <input type="checkbox"/> Start Date: _____ <input type="radio"/> No <input type="checkbox"/> Wait List: _____ days <input type="checkbox"/> Unknown Start Date	<input type="radio"/> Yes <input type="radio"/> No If No, describe evidence:
					<input type="radio"/> Yes <input type="checkbox"/> Start Date: _____ <input type="radio"/> No <input type="checkbox"/> Wait List: _____ days <input type="checkbox"/> Unknown Start Date	<input type="radio"/> Yes <input type="radio"/> No If No, describe evidence:
					<input type="radio"/> Yes <input type="checkbox"/> Start Date: _____ <input type="radio"/> No <input type="checkbox"/> Wait List: _____ days <input type="checkbox"/> Unknown Start Date	<input type="radio"/> Yes <input type="radio"/> No If No, describe evidence:
					<input type="radio"/> Yes <input type="checkbox"/> Start Date: _____ <input type="radio"/> No <input type="checkbox"/> Wait List: _____ days <input type="checkbox"/> Unknown Start Date	<input type="radio"/> Yes <input type="radio"/> No If No, describe evidence:
					<input type="radio"/> Yes <input type="checkbox"/> Start Date: _____ <input type="radio"/> No <input type="checkbox"/> Wait List: _____ days <input type="checkbox"/> Unknown Start Date	<input type="radio"/> Yes <input type="radio"/> No If No, describe evidence:
<b>Total #:</b>					<b>C8. Total Number of "No":</b>	<b>C9. Total Number of "No":</b>

# Adult Day Health Care Center Discharge Plan

Participant Name: \_\_\_\_\_ Record ID#: \_\_\_\_\_ Medi-Cal Client Index No: \_\_\_\_\_ DOB \_\_\_\_\_

1. Total Ongoing Service Needs (from Section C, total number of "Service Needs" entered in Column #1): \_\_\_\_\_
2. Total Number of Unmet Service Needs (from Section C, total number of "No" entries in Column #6) \_\_\_\_\_
3. Total Number of "Yes" Risk Factors (from Section B4): \_\_\_\_\_
4. Overall prognosis for successful outcome post-ADHC:  
 Poor    Fair    Good    Excellent
5. In Absence of ADHC Services, MDT Recommendation for Discharge:  
 Community with supports    Board and Care/Residential Care Facility    Skilled Nursing Facility

# Adult Day Health Care Center Discharge Plan

Participant Name: \_\_\_\_\_ Record ID#: \_\_\_\_\_ Medi-Cal Client Index No: \_\_\_\_\_ DOB \_\_\_\_\_

**D. List of Current Medications (attach a separate list if additional space is needed)**

Number	Medication Name (Brand and/or Generic)	Prescription Required		Dosage Strength	Dosage Frequency
		Yes	No		
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

# Adult Day Health Care Center Discharge Plan

Participant Name: \_\_\_\_\_ Record ID#: \_\_\_\_\_ Medi-Cal Client Index No: \_\_\_\_\_ DOB \_\_\_\_\_

15. Total Number of Current Medications from Previous Page (and any attachment) \_\_\_\_\_

E. Summary/Additional Comments

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F. Discharge Summary Signature of ADHC Registered Nurse (MANDATORY):

Printed Name	Signature	RN License Number	Date of Signature

G. Release of Medical Information

Please have the ADHC participant sign the Authorization for Release of Protected Health Information on page 7 and ensure that it is returned as part of this ADHC Discharge Plan.

Note: you may have in your ADHC Center participant file a copy of Proof of Guardianship and/or Healthcare Power of Attorney documents. If so, you may make copies of those documents and submit them to DHCS without the need for the ADHC participant to provide you with additional copies.

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_ to release  
(Name of Patient) (Name of ADHC Center)

health information regarding my care and medical conditions to the managed care plan,

\_\_\_\_\_ that I am enrolled in and/or APS Healthcare, a contractor  
(Name of Managed Care Plan)

of DHCS that is providing health assessments and referrals for continuation of needed medical services. This managed care plan and/or APS Healthcare may provide my information to other Medi-Cal programs that offer medical services. This health information may include information on mental health, alcohol and/or drug treatment and sexually transmitted diseases or HIV/AIDS. This information will only be used to help me get medical care and services that I may need. All health information will be kept private and will not be released unless authorized or required by law.

I understand that by signing this authorization:

- I authorize the use or disclosure of my health information, including information on mental health, alcohol or substance abuse and HIV/AIDS, as described above for the purpose listed. This authorization is valid for one year from the date of signature.
- I am signing this authorization voluntarily. I can withdraw this authorization at any time.
- I understand that withdrawing my authorization will not be effective where the managed care plan or APS Healthcare have already acted on my authorization in good faith.
- I understand that my treatment, payment, and eligibility for Medi-Cal benefits will not be affected if I do not sign this authorization.
- I also understand that the managed care plan and/or APS Healthcare cannot further disclose my information unless another authorization is obtained from me or unless such disclosure is required or permitted by law.

\_\_\_\_\_  
Print Name of Beneficiary

\_\_\_\_\_  
Medi-Cal Number

\_\_\_\_\_  
Signature of Beneficiary or Legal Representative

\_\_\_\_\_  
Date

Legal Authority:

\_\_\_ Legal Guardian/Custodian. Attach a copy of proof of guardianship.

\_\_\_ Healthcare Power of Attorney. Attach a copy of power of attorney.