Please return form to:
Fax number 1-508-368-9014
Attn: UM Staff

SNF/Acute rehab request for continued stay

Fallon Health case manager: _____

Member name: _____ Authorization number: _____

Facility: _____ Contact: _____ Phone: _____

Admission date: _____ Current authorization expiration date: _____

Date of request: _____ Discharge date, if applicable: _____

Qualifiers
Ongoing:

New: Start date:
Discontinued: End date:

Short-term goals
Progress made toward short-term goals:
- ☐ On target
- ☐ Date revised: _____

Long-term goals
Progress made toward long-term goals:
- ☐ On target
- ☐ Date revised: _____

Additional pertinent clinical information necessary to make level of care determination:

Discharge planning
Barriers to discharge:

Family meeting date: Home evaluation date: Approved discharge date:

Training needs: Training date:

Patient to be discharged to:
- ☐ Home
- ☐ LTC
- ☐ Assisted living
- ☐ Rest home
- ☐ Lives alone
- ☐ Lives with: _____

Anticipated services needed at home:

Services to be provided by:

Attached:
- ☐ PT
- ☐ OT
- ☐ SLP
- ☐ Nursing notes/med sheets (if skilled nursing)
- ☐ New skilled MD orders
- ☐ Care management/social work notes (family meetings, discharge planning)
- ☐ Discontinuation of skilled MD orders

_____ _____
Signature of licensed staff member completing form Title