OREGON DEPARTMENT OF Human Services
Aging and People with Disabilities

Discharge Planning Checklist (updated March 24, 2026)

Personal information
Name:_____ Prime number:_____ Phone number:_____ Additional contact person (If applicable): _____ Relationship to person: _____ Phone number: _____
Communication
Discharge planning start date:_____ Transition coordinator assigned:_____ Current case manager:_____ Is case transferring to a new branch? ☐ Yes ☐ No If yes, local office number:_____ Case Manager Assigned:_____ Has the local office manager been notified? ☐ Yes ☐ No Date notified:_____ Has coordination been established with the receiving local office? ☐ Yes ☐ No Briefly describe coordination plan: _____

Housing			
Current placement			
Type of residence: □ NF □ Own Home □ Relative Home □ Apartment □ ALF □ RCF □ AFH □ SLF □ DD Group home current address:_____Phone number: _____			
New placement			
Type of residence: □ Own Home □ Relative Home □ Apartment □ ALF □ RCF □ AFH □ SLF □ DD Group home new residence address:_____Phone number:_____			
Section 8 application submitted: □ Yes □ No □ N/A Projected time on wait list:____ Is a subsidy required? □ Yes □ No			
Task	**Date scheduled**	**Person responsible**	**Date completed**
Home walk through			
Home License application (if applicable)			

Home repairs or modifications required	**Who's responsible**	**Projected completion**	**Date completed**
Task:_____	Name:_____	Date:_____	Date:_____
Task:_____	Name:_____	Date:_____	Date:_____
Task:_____	Name:_____	Date:_____	Date:_____
Task:_____	Name:_____	Date:_____	Date:_____
Task:_____	Name:_____	Date:_____	Date:_____
Household furnishings needed: (kitchen appliances, furniture, pots, pans, etc.)			
Individual needs (linens, clothing, toiletries, etc.)			

Assistive technology				
Assistive technology assessment	☐ Yes ☐ No ☐ N/A	Assessor:	Date scheduled	Date completed
Identified need	Who's responsible		Projected completion date	Date completed
Identified need	Who's responsible		Projected completion date	Date completed
Identified need	Who's Responsible		Projected completion date	Date completed
Identified need	Who's Responsible		Projected completion date	Date completed
Identified need	Who's Responsible		Projected completion date	Date completed

Medical needs

1. Is the person eligible for Medicare? ☐ Yes ☐ No
2. Is the person enrolled in a managed care plan? ☐ Yes ☐ No

If yes, name of plan:_____

If no, do you plan to enroll them in managed care? ☐ Yes ☐ No

- Community doctors identified (name): _____
  Has doctor accepted patient? ☐ Yes ☐ No
- Dentist (name):_____
  Has dentist accepted patient? ☐ Yes ☐ No
- RN Services (If applicable) Name:_____
- Are other Specialists needed? ☐ Yes ☐ No
  (If yes, list below)
- Type of specialty:_____ Name of specialist:_____
- Type of specialty:_____ Name of specialist :_____
- Type of specialty:_____Name of specialist :_____
- Type of specialty:_____ Name of specialist :_____
- Type of specialty:_____ Name of specialist :_____
- Pharmacy identified (name):_____

Additional medical support questions

1. Does new home know of all scheduled appointments and need for lab work? □ Yes □ No □ N/A
2. Are there medication and treatment orders written? □ Yes □ No □ NA
3. Is there at least a three-day supply of medications immediately available? □ Yes □ No □ N/A
4. Are there ongoing medication orders written? □ Yes □ No □ N/A
5. Does the person have any allergies or reactions to medications? □ Yes □ No □ N/A
6. Have Nursing needs been identified? (if yes, answer 6a-6c—if no, skip) □ Yes □ No □ N/A
    a. Have nursing services been arranged? □ Yes □ No □ N/A
    b. Has the new nurse received the current nursing plan? □ Yes □ No □ N/A
    c. Has any needed nursing delegation already occurred? □Yes □ No □ N/A

    If no, date scheduled:_____

7. Does the person require a special diet (restrictions, texture, etc.)? □Yes □ No □ N/A
8. Is there a plan for fire safety (smoking, evacuation)? □Yes □ No □ N/A
9. Are there ongoing treatment orders written? □Yes □ No □ N/A

Durable medical equipment					
1. Does the home have all needed equipment (hospital bed, mobility device, shower chair, special eating tools, etc.) or supplies (diabetic, incontinence, wound, etc)? □Yes □ No □ N/A **List needed equipment below**					
Need	RX written?	Provider name	Date requested	Date received	If denied, why?
Need	RX written?	Provider name	Date requested	Date received	If denied, why?
Need	RX written?	Provider name	Date requested	Date received	If denied, why?
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Mental health and behavior support	
1. Do documents indicate a history of behaviors that have been injurious to self or others? □ Yes □ No □ N/A	
2. Does the new provider know about the person's challenging behaviors and know how to respond and where to turn for help? □ Yes □ No □ N/A	
3. Is provider training necessary? (If yes, please list in staff training section) □ Yes □ No □ N/A	
Staff training/trial visits	
1. Does the new provider know how the person communicates changes in health and distress? □ Yes □ No □ N/A	
2. Does the new provider know how the person accesses fluids and the type of preferred drinks? □ Yes □ No □ N/A	
3. Does the new provider know how to assist the person to move (walk, fall, prevention, transfer, positioning in bed)? □ Yes □ No □ N/A	
4. Does the new provider know how to support the person with any other needs? □ Yes □ No □ N/A	
5. Are there any staff training needs? □ Yes □ No □ N/A (list below)	
Training:	Date scheduled
Training:	Date scheduled

Are there any staff visits scheduled? ☐ Yes ☐ No ☐ N/A	Date scheduled

Transportation

1. What type of transportation will the person use to access their community (including Doctor's appointments, shopping, social activities, etc.)? Type(s):_____
2. On the day of transition, does everyone agree to the time of transfer and the type of transportation? ☐ Yes ☐ No

Financial supports

Task	Person responsible	Date completed
NF plan of care closed		
Social Security notified of move		
Medical card updated		
Bank account		

Developmental Disabilities specific tasks	
➢ Needs assessment meeting scheduled	Date scheduled:_____
➢ Risk tracking record meeting scheduled	Date scheduled: _____
➢ Protocols needed (including fatal four)	***List below in the Issue/Task table***
➢ Entry Individual Service Plan (ISP) meeting scheduled	Date scheduled: _____
➢ Initial OTAC/OIS training scheduled (if needed)	Date scheduled: _____

Identify issues to be resolved, other equipment to be ordered, tasks to be completed prior to discharge. (Person responsible and timelines?)

Issue/task	Person responsible	Completion date

First review prior to discharge from nursing facility

(to be completed prior to Nursing Facility 30-day notice)

Date of review:_____ ☐ Approved to submit notice ☐ Not approved to submit notice

Comments:

_____

_____ _____

Transition coordinator signature **Management signature**

Second review prior to discharge

Date of Review: _____ ☐ Approved to submit notice ☐ Not approved to submit notice

Comments:_____

_____

_____

_____ _____

Transition coordinator signature **Management signature**

Final review

Date of review:_____ ☐ Approved to transition ☐ Not approved

Comments:_____

_____

_____

_____ _____

Transition coordinator signature **Management signature**