Discharge Tool

NJ FamilyCare Community Based Palliative Care

Palliative care is extra support for people with serious illnesses. It helps manage symptoms, reduce stress, and works alongside other treatments. An interdisciplinary care team (IDT) listens to what matters to the member and supports their choices—so they can focus on quality of life.

The Community Based Palliative Care (CBPC) benefit provides team-based support for people with serious disease and helps members manage symptoms and navigate the care system. CBPC is not hospice care. Members do not need a terminal diagnosis to receive services and may continue curative or disease-directed treatments while enrolled in the benefit.

Provider Guidance

This discharge form is intended to support appropriate closure of services and continuity of care for members exiting the Community-Based Palliative Care (CBPC) benefit. Please review the following guidance carefully before completing and submitting this form. In addition to submitting this form to the member's health plan via their MCO's Provider Portal, providers must retain a copy in the member's electronic health record and make it available to the MCO and other treating providers (e.g., curative care provider) upon request.

This form is used to:

- Document the reason(s) a member is exiting the CBPC benefit
- Summarize key clinical, functional, and psychosocial changes since enrollment
- Confirm goals-of-care discussions and advance care planning status at discharge
- Support safe handoff and coordination with receiving providers or programs
- Ensure required documentation is complete for program oversight and audit purposes

The discharge form should be completed whenever a member leaves the CBPC benefit, including (but not limited to): transition to hospice, condition improvement, completion of goals, compassionate discharge, member or family preference, or transition back to primary or specialty care.

General Guidelines

- The discharge form must be completed by the CBPC provider entity when a member exits the benefit. The form may be completed by a licensed practitioner on the interdisciplinary team (IDT), with oversight from the Lead IDT Clinician
- Use legible handwriting or fill electronically
- Complete all fields, using 'N/A' where applicable
- Attach relevant documentation (e.g., POLST, final visit notes).
- If additional space is needed, use a separate page and label clearly.
- The discharge form must be submitted by the CBPC provider to the member's Managed Care Organization (MCO) via the MCO's Provider Portal. For FFS members, scan and email the

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completed form to MAHS.CBPC@dhs.nj.gov

- If a member is switching providers or MCOs, the current provider should transmit all relevant medical information, including assessments and care plans, to new provider or MCO

Section-by-Section Guidance

SECTION A: ADMINISTRATIVE INFORMATION

- Provide member, provider, and discharge information, including enrollment and discharge dates and reason for discharge

SECTION B: DISCHARGE SUMMARY

- Document member's clinical status at discharge, including diagnoses, functional status, and notable events during enrollment

SECTION C: GOALS OF CARE AND ADVANCE CARE PLANNING (ACP)

- Indicate the status of goals-of-care discussions and advance care planning documents at discharge

SECTION D: SERVICES PROVIDED

- Indicate which palliative care services were provided through discharge and note final service status as applicable

SECTION E: HANDOFF AND TRANSITIONS

- Provide information on referrals, receiving providers or programs, and materials shared to support continuity of care

SECTION F: CAREGIVER/FAMILY SUPPORT

- Indicate education, support, and follow-up provided to the member and caregiver at discharge

SECTION G: DOCUMENTATION CHECKLIST

- Confirm completion and attachment of required discharge documentation

SECTION H: AUTHORIZATION & SIGNATURES

- Obtain provider signature and date to finalize the discharge record

SECTION A: ADMINISTRATIVE INFORMATION		
Member Name: (last, first, mi)		Date: (mm/dd/yyyy)
Health Plan:	◯ Aetna Better Health of New Jersey ◯ Fidelis Care ◯ Fee-For-Service (FFS) ◯ Horizon NJ Health ◯ UnitedHealthcare (UHC) ◯ Wellpoint	Medicaid ID #: DOB: (mm/dd/yyyy) Age Cohort: ◯ Adult (over 19) ◯ Child
Primary Spoken Language		Interpreter Needed: ◯ Yes ◯ No
Member's Emergency Contact		
Name:		
Relationship:		Cell Phone Number:
Lead IDT Clinician		
Name:		NPI #:
Business Phone:		Medicaid ID #:
Provider Entity Information		
Name:		
Business Phone:		Medicaid ID #:
Organization Address: street address city state zip code		
Palliative Care Timeline		
Date of Initial Palliative Care Enrollment:		Date of Discharge:
Reason for Discharge:	☐ Transition to Primary Care ☐ Condition Improved ☐ Goals Completed ☐ Compassionate Discharge ☐ Member or Family Preference ☐ Transition to Hospice ☐ Other: _____	
Primary Care Provider		
Name:		
Phone:		Medicaid ID #:

SECTION B: DISCHARGE SUMMARY

Primary Disease Diagnosis(es)

Diagnosis	Primary ICD 10 Code	Date of Onset

Serious Illness Diagnoses

Diagnosis	Primary ICD 10 Code	Date of Onset

Functional Status at Discharge and Measurement

Measurement Tool:	Measurement:

Other Discharge Information

Clinical Events Since Enrollment:	☐ Emergency Room Visit	☐ Acute Care Utilization
	☐ Skilled Nursing Facility Stay	☐ Other: _____
Pain Management Status:	◯ Well-controlled ◯ Moderate	◯ Uncontrolled

SECTION C: GOALS OF CARE AND ADVANCE CARE PLANNING

Advance Directive on File:	◯ Yes (specify to the right) ◯ No	Date: (if applicable)
POLST on File:	◯ Yes (specify to the right) ◯ No	Date: (if applicable)
Approvals for Comfort Medications Needed:	◯ Yes (specify to the right) ◯ No	Description:
Preferred Care Setting Documented:	◯ Yes ◯ No	Discussed Prognosis and Goals with Member/Caregiver: ◯ Yes ◯ No

Health Power of Attorney (POA)

Health POA Identified: ◯ Yes ◯ No	
Contact Name:	Contact Email:
Contact Address: Street Address	City State Zip Code

SECTION D: SERVICES PROVIDED			
Pain Support:	◯ Yes ◯ No	Final Status/ Notes:	
Dyspnea Support:	◯ Yes ◯ No	Final Status/ Notes:	
GI Symptom Support:	◯ Yes ◯ No	Final Status/ Notes:	
Psychological Symptom Support:	◯ Yes ◯ No	Final Status/ Notes:	
Other Symptom Support:	◯ Yes ◯ No	Final Status/ Notes:	
Psychosocial Support:	◯ Yes ◯ No	Final Status/ Notes:	
Spiritual Support:	◯ Yes ◯ No	Final Status/ Notes:	
Caregiver Support:	◯ Yes ◯ No	Final Status/ Notes:	
Medication Reconciliation:	◯ Yes ◯ No	Final Status/ Notes:	
Home Visits:	◯ Yes ◯ No	Number per Month:	Final Status/ Notes:
Telehealth Check-ins:	◯ Yes ◯ No	Number per Month:	Final Status/ Notes:
Care Coordination: Service Provider(s) Contacted			
Care Coordination:	◯ Yes ◯ No	Final Status/ Notes:	
Name of Service Provider(s):			Contact Dates:
Email of Service Provider(s)			Phone Number of Service Provider(s)
SECTION E: HANDOFF AND TRANSITIONS			
Receiving Provider/Program (if applicable)			
Name:			Business Phone:
Organization:			Date of Referral Sent:
Referral Type:	◯ Long Term Services and Supports (LTSS) ◯ Home Health ◯ Hospice ◯ Primary Care Provider ◯ Specialist ◯ Skilled Nursing Facility ◯ Case Management ◯ Other: _____ ◯ N/A		

Materials Transferred			
Handoff Communication Sent	☐ Phone Call	☐ Summary Faxed	☐ Secure Email
	☐ EHR Message	☐ Other: _____	☐ N/A
POLST or Advance Directive Transferred	◯ Yes	◯ No	◯ Not Available
Medications Transferred/Updated	◯ Yes	◯ No	◯ N/A

SECTION F: CAREGIVER/FAMILY SUPPORT					
Final Education Provided:	◯ Yes (specify to the right) ◯ No ◯ N/A		Type Provided: (if applicable)		
Grief/Bereavement Resources Provided:	◯ Yes (specify to the right) ◯ No ◯ N/A		Type of Resource: (if applicable)		
Post-Discharge Follow-Up Call Scheduled	◯ Yes (specify to the right) ◯ No		Date: (if applicable)		
Signs of Distress Reviewed: (e.g., Pain, Dyspnea, Anxiety/Depression, etc.)	◯ Yes ◯ No ◯ N/A	Discharge Instructions:	◯ Yes ◯ No ◯ N/A	Emergency Contacts Provided:	◯ Yes ◯ No ◯ N/A

SECTION G: DOCUMENTATION CHECKLIST					
Final Visit Note:	◯ Yes	◯ No	POLST/Advance Directive:	◯ Yes	◯ No
Medication List:	◯ Yes	◯ No	Referral Documents:	◯ Yes	◯ No
Care Plan Summary:	◯ Yes	◯ No	Education Materials:	◯ Yes	◯ No

SECTION G: AUTHORIZATION & SIGNATURES	
Provider Signature:	Date: (mm/dd/yyyy)
Provider Name and Credentials:	