

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

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:	<input type="checkbox"/> Aetna Better Health of New Jersey <input type="checkbox"/> Fidelis Care <input type="checkbox"/> Fee-For-Service (FFS) <input type="checkbox"/> Horizon NJ Health <input type="checkbox"/> UnitedHealthcare (UHC) <input type="checkbox"/> Wellpoint
	Medicaid ID #: DOB: (mm/dd/yyyy) Age Cohort: <input type="checkbox"/> Adult (over 19) <input type="checkbox"/> Child
Primary Spoken Language	Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Transition to Primary Care <input type="checkbox"/> Condition Improved <input type="checkbox"/> Goals Completed <input type="checkbox"/> Compassionate Discharge <input type="checkbox"/> Member or Family Preference <input type="checkbox"/> Transition to Hospice <input type="checkbox"/> 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:	<input type="checkbox"/> Emergency Room Visit <input type="checkbox"/> Acute Care Utilization <input type="checkbox"/> Skilled Nursing Facility Stay <input type="checkbox"/> Other: _____	
Pain Management Status:	<input type="checkbox"/> Well-controlled <input type="checkbox"/> Moderate <input type="checkbox"/> Uncontrolled	
SECTION C: GOALS OF CARE AND ADVANCE CARE PLANNING		
Advance Directive on File:	<input type="checkbox"/> Yes (specify to the right) <input type="checkbox"/> No	Date: (if applicable)
POLST on File:	<input type="checkbox"/> Yes (specify to the right) <input type="checkbox"/> No	Date: (if applicable)
Approvals for Comfort Medications Needed:	<input type="checkbox"/> Yes (specify to the right) <input type="checkbox"/> No	Description:
Preferred Care Setting Documented:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Discussed Prognosis and Goals with Member/Caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No
Health Power of Attorney (POA)		
Health POA Identified: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Contact Name:	Contact Email:	
Contact Address:		
Street Address	City	State Zip Code

SECTION D: SERVICES PROVIDED			
Pain Support:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Final Status/ Notes:	
Dyspnea Support:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Final Status/ Notes:	
GI Symptom Support:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Final Status/ Notes:	
Psychological Symptom Support:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Final Status/ Notes:	
Other Symptom Support:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Final Status/ Notes:	
Psychosocial Support:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Final Status/ Notes:	
Spiritual Support:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Final Status/ Notes:	
Caregiver Support:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Final Status/ Notes:	
Medication Reconciliation:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Final Status/ Notes:	
Home Visits:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number per Month:	Final Status/ Notes:
Telehealth Check-ins:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number per Month:	Final Status/ Notes:
Care Coordination: Service Provider(s) Contacted			
Care Coordination:	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Long Term Services and Supports (LTSS) <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Specialist <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Case Management <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A		

Materials Transferred			
Handoff Communication Sent	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Summary Faxed	<input type="checkbox"/> Secure Email
	<input type="checkbox"/> EHR Message	<input type="checkbox"/> Other: _____	<input type="checkbox"/> N/A
POLST or Advance Directive Transferred	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Available		
Medications Transferred/Updated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
SECTION F: CAREGIVER/FAMILY SUPPORT			
Final Education Provided:	<input type="checkbox"/> Yes (specify to the right) <input type="checkbox"/> No <input type="checkbox"/> N/A	Type Provided: (if applicable)	
Grief/Bereavement Resources Provided:	<input type="checkbox"/> Yes (specify to the right) <input type="checkbox"/> No <input type="checkbox"/> N/A	Type of Resource: (if applicable)	
Post-Discharge Follow-Up Call Scheduled	<input type="checkbox"/> Yes (specify to the right) <input type="checkbox"/> No	Date: (if applicable)	
Signs of Distress Reviewed: (e.g., Pain, Dyspnea, Anxiety/Depression, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Discharge Instructions: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Emergency Contacts Provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
SECTION G: DOCUMENTATION CHECKLIST			
Final Visit Note:	<input type="checkbox"/> Yes <input type="checkbox"/> No	POLST/Advance Directive:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication List:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Referral Documents:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Care Plan Summary:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Education Materials:	<input type="checkbox"/> Yes <input type="checkbox"/> No
SECTION G: AUTHORIZATION & SIGNATURES			
Provider Signature:	Date: (mm/dd/yyyy)		
Provider Name and Credentials:			