Request to Discontinue Skilled Services Form

Please follow the process below:

- Submit your request form three days prior to expected date of discharge.
- Include Task/Update Summary (Page 2 & 3 of this form.) with most current therapynotes and any other clinical to support discontinuation of skilled services.

MediGold will respond within 24 hours of receipt of the request.

Submit completed form via fax to Health Services at 1-833-263-4865 or email SNF@MediGold.com.

Member Information

Member's Name	**Member's ID**
Facility Name	**Contact Name**
Contact Phone Number	**Contact Fax Number**
Expected Date of Discharge	**Plan to Discharge to**

Tasks/Update Summary

Task Codes:

Independent – I	Modified Independent – MI	Supervision – S	Set Up - SU
Min Asst – Min	Contact Guard Asst – CGA	Mod Asst - Mod	Max Asst - Max
Total Asst - T	Dependent - D		

Physical Therapy	**PLOF**	**Initial Eval**	**Goals**	**Prev. week ( )**	**Current date ( )**
Bed Mobility supine<>sit sit<>stand					
Transfers SPT chair<>bed sit<>stand					
Ambulation Asst					
distance					
device					
Stairs up/down					
Strength upper/lower					
Balances stand S/D sit S/D					
Endurance act tolerance					

Member's Name	**Member's ID**

Tasks/Update Summary continued

Task Codes: Independent – I; Modified Independent – MI; Supervision – S; Set Up - SU; Min Asst – Min; Contact Guard Asst – CGA; Mod Asst - Mod; Max Asst - Max; Total Asst - T; Dependent - D

Occupational Therapy	**PLOF**	**Initial Eval**	**Goals**	**Prev. week ( )**	**Current date ( )**
Grooming					
UB Bathing/dress					
LB bathing/dress					
Toileting hygiene/transfer					
Self feeding					

Speech Therapy	**PLOF**	**Initial Eval**	**Goals**	**Prev. week ( )**	**Current date ( )**
Swallowing					
Articulation					
Dysphagia					
Cognitive abilities (STM, LTM)					
Other					

Pertinent nursing information (IV, PEG tube, vent, wounds, wound vac, etc.):

Current acute process or fall:

Precautions/restrictions:

Member's Name	**Member's ID**

Discharge living environment (# steps and/or floors in home, bed/bath accessible on main floor, lives alone or with support):

Discharge plan: (Estimated DC date & disposition)

DME:

Home evaluation:

Additional comments:

Planner Name and Contact Information

Planner's Name	
Contact Phone Number	**Contact Fax Number**