DISCHARGE INTERVIEW

OAR 309-035-0150(5) and 309-035-0370(6) require that prior to discharge or transfer, a staffing shall be held with the resident, appropriate agencies, relatives, and/or interested others to determine the appropriateness of the plan and to coordinate services needed by the resident following the move.

Resident Name: _____ Date of Birth: _____

Resident Prime #: _____ Resident CPMS #: _____

Facility/Provider Name: _____

Date of Admission to Facility: _____ Date of Discharge: _____

Resident moving to: _____
Facility Name Address

Type of housing resident is moving to: AFC/RTH/RTF ☐ SDSD ☐ Community ☐

1. Reason for move/transfer/termination:

_____

_____

_____

2. Coordinated plan for services:

_____

_____

_____

3. Appropriateness of move/transfer/termination:

_____

_____

_____

Per OAR 309-035-0157 and 309-035-0390, if a resident objects to discharge or transfer from the facility, the resident may appeal the decision of the facility administrator and request a hearing following the steps outlined in the rule.

Has resident requested a hearing? Yes ☐ No ☐

(continued on back)

MEDICATIONS:

Medications at time of discharge: (Please attach current copy of MAR)

Medications released to: (MAR to be signed by receiving person. If resident is to self-administer medications after discharge, attach copy of LMP order.)

Medications Released to:_____ Date:_____

FINANCIAL:

Per OAR 309-035-0150(7) and 309-035-0370(8) all residents shall, at the time of transfer or discharge, be given a final statement of account and return of any money, property, or things of value held in trust or custody by the facility.

Final Financial Statement provided: Yes ☐ No ☐

Balance of funds returned: Yes ☐ No ☐ (If no, please provide explanation below.)

If yes, amount returned: _____ _____

Paid by: Cash ☐ _____

Check ☐ Check #: _____

Money Released to_____ DATE:_____

PERSONAL INVENTORY:

All property returned: Yes ☐ No ☐

Property Returned To:_____ Date:_____

Resident: _____ Date: _____

Facility Administrator: _____ Date: _____

Mult. Co Residential: _____ Date: _____

Mental Health CM: _____ Date: _____

If the resident was unable to attend this interview, please state the circumstances below.

_____

_____

_____

cc: Resident Chart, Multnomah County
Provider Chart at site