

Personal Care Home Placement: Discharge Planning Checklist

jadely.

For hospital social workers, case managers and placement agencies • Georgia

Case ID / initials: _____

Date: _____

Prepared by: _____

1 Screen early

- ☐ Flag patients likely to need post-hospital support at admission, not at the point of medical readiness.
- ☐ Identify the decision-maker: the patient, a healthcare agent, or a legal representative. Note any power of attorney.
- ☐ Ask about the patient's goals: where do they want to live, and who matters to them in that decision?

2 Assess functional needs honestly

- ☐ Activities of daily living: bathing, dressing, toileting, eating, grooming.
- ☐ Mobility and transfers: walks independently, walker or wheelchair, or needs hands-on help.
- ☐ Medications: can the patient take their own with reminders or supervision?
- ☐ Cognition and behavior: wandering or elopement risk, aggression, need for a secured unit.
- ☐ Skilled needs: wound care, injections, tube feeding, oxygen titration, anything requiring a nurse.

3 Personal care home fit test

Generally appropriate when the patient:

- ☐ Is an adult who needs help with daily activities and supervision.
- ☐ Is ambulatory (walks or self-propels) and can get out in an emergency with minimal staff help.
- ☐ Can manage medications they take themselves, with help or supervision.
- ☐ Does not need continuous skilled nursing.

Red flags: a personal care home is usually NOT the right setting if the patient:

- ☐ Needs a two-person assist or full hands-on help to evacuate.
- ☐ Needs skilled nursing care on an ongoing basis.
- ☐ Is a wandering risk and the home has no state memory care certificate.
- ☐ Has behaviors the home isn't staffed or permitted to manage.

4 Settle payment early

- ☐ Who is paying, and how? Confirm before sending referrals; it decides which homes are realistic.
- ☐ Ask each home for its rates and what's billed separately.
- ☐ If a public program may apply, start that conversation with the family and your financial counselor right away.

5 Build the referral packet

- ☐ Face sheet and demographics.
- ☐ Recent history and physical; discharge summary or clinical notes.
- ☐ Current medication list.
- ☐ Functional and mobility assessment, plus fall history.
- ☐ Cognitive and behavioral notes.
- ☐ The physician medical evaluation form the home requires (ask which version it wants).
- ☐ Payer or guardianship documents.

6 Vet the homes before you refer

- ☐ Verify the license and inspection history on DCH's GaMap2Care tool.
- ☐ Read the most recent inspection report and plan of correction.
- ☐ Confirm vacancy, room availability, and that the home can meet needs on day one.
- ☐ Confirm staffing, especially overnight.
- ☐ Check marketing: a personal care home not licensed as an assisted living community may not use that term.

7 Refer broadly and track it

- ☐ Send the packet to several appropriate homes at once, not one at a time.
- ☐ Log who you contacted, when, and the response (see the log on page 2).
- ☐ Present realistic options to the patient and family; arrange tours or virtual tours.

8 Plan the transition

- ☐ Confirm admission date, time, and who receives the patient.
- ☐ Arrange transportation appropriate to the patient's mobility.
- ☐ Send the discharge summary and medication list; confirm the home has the prescriptions it needs.
- ☐ Arrange follow-up: primary care, specialists, and any home health or hospice at the home.
- ☐ Give the family a contact for first-week questions.

9 Document

- ☐ The patient's goals and preferences.
- ☐ Options discussed and the choice made.
- ☐ Referrals sent and responses received.
- ☐ The final discharge plan and handoff.

Referral tracking log

Record every referral so delays and denials are documented. Send to several homes at once.

Home name	Contact / phone	Date sent	Response	Tour / admit date

Notes

Choice lists and documentation. Under 42 CFR 482.43, hospitals must present a list of available home health agencies, skilled nursing facilities, inpatient rehabilitation facilities and long-term care hospitals when those services are indicated, and document that it was presented. Personal care homes are not on that list, but the discharge plan must still reflect the patient's goals and preferences. Present options based on needs and preferences, do not steer, and document the choice. Check your hospital's policy.

Need open beds faster? Hospital social workers and placement agencies can post a placement request on Jadely and let matching care homes respond, instead of calling down a list. jadely.co/PlacementRequests