3 West Road | Virks Building | Cranston, RI 02920

Attachment 6 - Notification of Discharge

This form must be completed and submitted immediately on the date of the patient's discharge to the OHA Case management agency.

____
Name and address of Assisted Living Residence

______________________________ ______________________________
Name of Resident (last, first, middle initial) SSN

______________________________ ______________________________
Case Manager Name and Number Contact Person and Phone Number

_____OHA Assisted Living _____RIHMFC Assisted Living

Reason for Discharge: Date of Discharge____________________

____ Hospitalization: ____
Name of Hospital

_____ Nursing Facility Admission: ________________________________
Facility Name

_____ Return to Community: ____________________________________
Community Address

_____ Death: ____
Date, if known

_____ Other: ____
Please explain

This placement is anticipated to be: _____ Permanent _____Temporary (less than 30 days)

____
Signature of Authorized Person at Assisted Living Residence

OHA Case Management Agency: Please return this form to the Office of Community Programs at OHHS.ocp@OHHS.ri.gov if discharge is permanent.

____

OCP Office use only:
On ___________ OCP sent to SSA ___________________ for closure.
(date) (office)