HMI Home Health
1025 Vermont Avenue, NW
Washington, DC 20005
Tel 202-829-1111
Fax 202-829-9192

Discharge from Agency Form / 1 of 2

❑ Discipline ❑ Agency

Patient Name: _____ **Client ID:** _____ **Planned Discharge Date:** _____

Start of Care: _____ **Case Manager:** _____

Medicare Number: _____ **Medicaid Number:** _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Discipline of Person Completing Request:

❑ 1. Registered Nurse ❑ 2. Physical Therapist ❑ 3. Occupational Therapist ❑ 4. Speech Therapist

Indicators Discharge:

❑ Goal Met
Describe: _____
_____

❑ Inappropriate living conditions
Describe: _____
_____

❑ Unsafe living condition
Describe: _____
_____

❑ Need for Increase level of care > than 8 hours
Describe: _____
_____

❑ Other
Describe: _____
_____

Additional Comments: _____
_____

Clinical Staff's Signature: _____ Date: _____

Acknowledgment of Notification for Discharge:

❑ Doctor's Name: _____

❑ Doctor's Signature: _____

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