Home Health Services Discharge Planning

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

Dear [Patient/Family Member's Name],

As part of your discharge planning from [Facility Name], we are committed to ensuring a smooth transition to home health services. Your health and well-being remain our top priority.

Home Health Services Overview

Your home health team will provide the following services:

- Skilled nursing care
- Physical therapy
- Medication management
- Occupational therapy
- Home health aide assistance

Transition Details

Your estimated discharge date is [Insert Date]. Before this date, please ensure the following:

- Arrange for transportation home.
- Prepare a suitable living environment for care services.
- Confirm your home health service provider: [Insert Provider Name].

Contact Information

If you have any questions or need assistance, please do not hesitate to contact:

[Case Manager's Name]
[Case Manager's Phone Number]
[Case Manager's Email]

Thank you for trusting us with your care. We look forward to supporting you in your recovery journey.

Sincerely,

[Your Name]
[Your Title]
[Facility Name]