PARENTCARE NAV · CAREGIVER CRISIS CHECKLIST

The first 10 things to do when a parent is hospitalized

A printable bedside reference. Use it in the first 48 hours.

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1. Get the discharge planner's name by Day 2. Ask the floor nurse: “Who is the discharge planner on this case?” They make the destination decision — not the doctor. Get their direct phone or email, not just the hospital main line.

2. Confirm inpatient vs observation status. Ask explicitly: “Is my parent inpatient or observation right now?” Observation does NOT count toward the Medicare 3-midnight rule for SNF coverage. If observation, push to convert — the social worker can help.

3. Find the “Important Message from Medicare” form. It should arrive within 2 days of admission and again before discharge. It lists your local QIO appeal phone number. Keep that number visible — it’s the freeze button on a rushed discharge.

4. Assign three family roles: Lead, Backup, Communicator. Lead = decision-maker. Backup = covers when Lead is unavailable. Communicator = handles extended family updates. Without these roles, Lead gets 47 calls a day by Day 3 and burns out.

5. Locate Power of Attorney documents — or start the process this week. Healthcare POA + Financial POA. If neither exists and your parent has capacity, fix it now. Conservatorship later costs $5,000–25,000+ and takes months.

6. Schedule the discharge planner conversation. Day 1 or 2, not Day 5. Walk in with five questions: (a) Which of the four paths — home alone, home with care, SNF, AL/MC? (b) What’s covered, for how long? (c) What’s NOT covered — what will we pay in 30 days? (d) What if family can’t provide assumed care? (e) What’s the appeal process?

7. Request PT and OT functional assessment notes in writing. Their assessment of what your parent can independently do heavily weights the SNF-vs-home decision. Get the notes before the discharge meeting, not after.

8. Pre-set the home. Clear paths, no throw rugs, phone charged, emergency numbers posted, walker accessible. Most falls in the first 72 hours come from environment, not function.

9. Get the full document handoff before leaving the hospital. Discharge summary, medication reconciliation, follow-up schedule, 24-hour callback line, prescriptions sent to pharmacy, home health referral details (if applicable). If anything is missing, ask the discharge nurse to print or email it before you walk out.

10. Schedule the PCP follow-up appointment within 7–14 days. Schedule before discharge, not after. Arrange transport. About 1 in 5 Medicare patients is readmitted within 30 days — this single appointment is the biggest readmission preventer.
