AUTHORIZATION FOR NURSING FACILITY REIMBURSEMENT

DATE OF RECEIPT

FOR DMA USE ONLY

SECTION I - IDENTIFICATION

NAME OF FACILITY [redacted]

CITY [redacted]

MEDICAID PROVIDER NO. [redacted]

SOCIAL SECURITY NO. [redacted]

RECIPIENT'S NAME [redacted]

RECIPIENT'S MEDICAID NO.

PRIMARY ICD-9-CM: N18.9

SECONDARY ICD-9-CM: E11.9

DATE OF BIRTH: 05 01 27 (M M D D Y Y)

SECTION II - ADMISSION

LEVEL OF CARE: 2 (1-Skilled, 2-IC, 3-IC/MR)

PATIENT ADMITTED FROM: D (A-Hospital, B-Nursing Facility (NF), C-State Instit., D-Own Home, E-Other_____, F-SNF Medicare)

ADMISSION DATE: 02 04 22 (M M D D Y Y)

VA AID & ATTENDANCE INCLUDED: ( )Yes $_____ ( )No

DMA-6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES: M M D D Y Y THRU M M D D Y Y

PATIENT INCOME

SECTION III - STATUS CHANGES

NEW LEVEL OF CARE: (1-Skilled, 2-IC, 3-IC/MR)

LOC EFFECTIVE DATE: M M D D Y Y

VA AID & ATTENDANCE INCLUDED: ( )Yes $_____ ( )No

DMA-6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES: M M D D Y Y THRU M M D D Y Y

PATIENT INCOME

SECTION IV - TERMINATIONS

REASON: (E - INELIGIBLE, F - DISCHARGED, G - DIED)

EFFECTIVE DATE: M M D D Y Y

DISCHARGE DESTINATION: (A-Home with a Health Plan, B-Hospital, C-Nursing Facility (NF), D-Other_____, E-Own Home, F-SNF Medicare, L-Limited Stay Expired)

SECTION V - FACILITY CERTIFICATION

I do hereby certify that the above statements are true and correct. I agree to submit to the County Department a status change request for any change in the monthly contributions by the recipient.

Signature of Facility Administrator: Bom X [redacted]

DATE: 03 18 22 (M M D D Y Y)

SECTION VI - AUTHORIZATION

Signature of Assistance Payments Worker X _____

County Code

DATE: M M D D Y Y

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