Notification of Admission, Status Change, or Discharge for Facility Care

BHSF Form 148

Purpose:

BHSF Form 148 is used by certified nursing facilities and ICF/DD facilities to notify the Medicaid ~~Local~~ office and the Office of Aging and Adult Services (OAAS) or the Office for Citizens with Developmental Disabilities (OCDD) of:

1.) any patient's admission;
   - Medicaid office: those patients with intent to apply for Medicaid or those already Medicaid eligible.
   - Regional OAAS or OCDD: regardless of payment source.

2.) a patient's request for an application for Medicaid; and
3.) a change in a Medicaid recipient's status.
4.) a patients transfer, discharge, or death.

Use of this form is required:

1.) to notify the Medicaid office of:
   a. all certified nursing home (NH) or ICF/DD admissions, with an intent for Medicaid to be the payment source for the Medicaid or Medicare with Medicaid co-pay benefit period;
   b. an application for Medicaid benefits in the facility anytime thereafter;
   c. any change in use of Medicaid benefits as payment source;
   d. when a Medicaid recipient has exhausted hospital or home leave days but is not discharged and billing for Medicaid vendor payment has been discontinued;
   e. when a Medicaid recipient returns following hospitalization or home leave, when the patient's leave days were exhausted but the patient had not been discharged
   f. Medicaid recipient in a facility is transitioning to waiver
   g. Medicaid recipient in a facility is no longer receiving waiver services for transitioning
2.) to notify the Office of Aging and Adult Services (OAAS) or the Office for Citizens with Developmental Disabilities (OCDD) of:
   a. all admissions to a certified nursing home (NH) or ICF/DD, regardless of the payment source;
   b. an application for Medicaid benefits in the facility anytime thereafter;
   c. any change in use of Medicaid benefits as payment source to the NH such as conversion to hospice.
3.) to notify the Medicaid office (if a Medicaid recipient) and OAAS or OCDD (regardless of payment source) of:
   a. a nursing home (NH) or ICF/DD recipient's transfer to another facility.
   b. a nursing home (NH) or ICF/DD recipient's discharge from the facility.
   c. a NH or ICF/DD recipient's death.

Preparation:

The form is completed by the facility administrator or his/her authorized representative. Each section shall be completed as indicated.

The top section of the form is to be completed with the facility's Identifying information.

Section I Applicant/Recipient Information

Enter **accurate and current** demographic information on the Applicant/recipient and the name and contact information of the personal representative and/or curator.
NOTE: The question regarding the receipt of Waiver services must be completed.

Section II Admission Information

A. Enter Date of Admission to the facility and if first time admission to any facility.
B. Enter, from Section V., the place the applicant resided prior to being admitted to the facility. If the applicant received waiver services at time of admission and this is a temporary stay, not being discharged from waiver, enter **'temp placement while on waiver'** from Section V. (Contact with the recipient's support coordinator may be required to determine status.)
C. Enter, from Section VI, payment source.
D. Enter projected Medicaid Co Pay date if applicable.

Section III Status Change

A. Complete if resident go on Hospital or Home Leave and date Medicaid or Medicare billing stopped.
B. Complete when resident returns from Hospital or Home Leave.
C. Indicate type and date of billing resumed. If applicable.
D. Indicate change in payment source and date. If applicable.
E. Indicate if resident is receiving services to transition from facility to waiver and date services began.
F. Indicate if resident was receiving services to transition from facility to waiver and the resident will not be transitioning and date services ended.
G. Indicate if waiver recipient temporarily placed in facility has been discharged from waiver and facility stay will be permanent and date permanent placement began.
H. Indicate dates extension for medical eligibility has been requested.
I. Indicate date an Agency Custody ends and name of Agency. Enter date requesting Medicaid.

Section IV Transfer, Discharge, or Notice of Death

A. Indicate if Transferred and location of transfer. See section V.
B. Indicate if Discharged and location of discharge. See section V.
C. Indicate possible return or Date of Death.

Disposition:

Form 148 is forwarded to the Medicaid office and Regional OAAS or OCDD for action. The facility shall maintain a copy for its files.

Any information on Form 148 which conflicts with information available from other sources shall be cleared and documented by Medicaid Program personnel. Information that is found to be incorrect on the form need not be corrected, but the agency's case records must clearly record the correct information in the absence of a corrected Form 148.

Copies of the form are maintained in the Medicaid Electronic Case Record and by Regional OAAS or OCDD staff.