

NOTIFICATION OF ADMISSION, STATUS CHANGE, OR DISCHARGE FOR FACILITY CARE

Provider Name and Address:		Parish:
Telephone #:	Fax #:	Provider #:

I. Applicant/Recipient Information

Name:		SSN:
Medicare #:	Medicaid #:	DOB:
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced/Separated	Parish/County:
Address:		Telephone:
Insurance Company Name:		Policy #:
At admission is applicant receiving Waiver services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list current waiver program:		
Contact Person:		Relationship:
Home Phone:	Cell Phone:	Daytime Phone:
Address:		E-mail:

Note: If Section III is used when the person leaves the facility, use Section III when they return. If Section IV is used when the person leaves the facility, use Section II when they return. Use Section III instead of Section IV when applicable.

II. Admission Information

A. Date of Admission:	Is this the first time being admitted to a facility? <input type="checkbox"/> Yes <input type="checkbox"/> No
B. Source of admission (Section V): Has the applicant been admitted to an acute care setting in the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
C. Intended payment source (Section VI):	D. Medicaid Co-Pay date (if applicable):

Note: For Section III, A-D, send form 148 to the Medicaid office only. For E-H, send form to the Medicaid office and the Office of Aging and Adult Services (OAAS) or the Office for Citizens with Development Disabilities (OCDD). For I, send form to Medicaid office and OCDD.

III. Status Change

A. <input type="checkbox"/> Hospital Leave <input type="checkbox"/> Home Leave <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare billing stopped on:	
B. Return from <input type="checkbox"/> hospital leave <input type="checkbox"/> home leave	Date of Return: (Note: Also complete box C or D)
C. Resumed billing to (section VI):	Resume billing date:
D. Change payment source from (section VI) to Effective date of change: Medicaid Co-Pay date (if applicable): If this is a request for a change from private pay to Medicaid status, what was the original date of admission?	
E. <input type="checkbox"/> Still in facility but transitioning to waiver. Waiver program transitioning to: Waiver services begin date	
F. <input type="checkbox"/> Waiver Services for transitioning ended. Discharged from waiver. Date:	
G. <input type="checkbox"/> Waiver discharged. Permanent Placement in facility. Date:	
H. Application for extension of medical eligibility from (dates) to	
I. Agency custody ends	(date). Applying for Medicaid effective: (date)

IV. Transfer, Discharge, or Notice of Death

A. Transfer to (Section V):	Transfer Date:
B. Discharge to (Section V):	Discharge Date:
C. Do you anticipate that he/she will return to your facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Death:

V. Places Specify name & address

Own home	Friend's home	Psychiatric hospital/unit	An ICF-DD	A residential program or group home for mentally ill
Apartment	Nursing Facility	Rehabilitation hospital	Temp placement while on waiver	
Family member's home	General hospital	A Medicare distinct unit	Incarceration	Other (specify)

VI. Payment Sources

Medicaid only	TDC Medicaid	Medicare only (insurance or private co-pay)	Medicare with Medicaid Co-Pay
VA contract (indicate how many months)	Workman's Compensation	Private Pay (i.e. LTC insurance, personal funds)	
NRTP Medicaid (specify): A. Complex B. Rehabilitation			
Other (i.e. OCS Agency- specify)			

Facility Representative

Date