QMB Eligible Client

Original Copy

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING STATUS OF NURSING FACILITY CARE

Last Name First Name MI County State ID Proof Discharge Cupy	. CLIENT INFORMATI	ON:		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Corrected Copy County Transfer Copy Change Pt. Pmt. Copy	
Cilents Own S.S. Number S. S. Claim Number/Suffix R. R. Claim Number V. A. Claim Number Name and Address of Responsible Party Relationship		First Name	MI	County	State ID		
Facility Information:	CBMS H.H. No.	_/Cat	Client D.O.B.	Gender	Date of Medicaid Application	Patient Level-of-care	
Facility Information:	Client's Own S.S. Number	S. S. 0	Claim Number/Suffix	R. F	R. Claim Number	V. A. Claim Number	
Facility Information:	lame and Address of Re	esponsible Pa	artv			Relationship	
Nursing Facility:					Provider Number:		
Financial Arrangement: Patient Income B. Monthly Income Adjustments C. Patient ayment Calculations	Nursing Facility:						
B. Monthly Income Adjustments ayment Calculations Soc. Sec. Personal Needs Total Income \$ SSI Trustee/Maintenance Fees Total Deductions \$ SSI Trustee/Maintenance Fees Total Deductions \$ RR Income Taxes LTC Insurance payment \$ VA Community Spouses Allowance Patient Payment \$ Interest Dependent Care Allowance Total Income Total	Address:				Medicaid	Per Diem Rate \$	
Soc. Sec. Personal Needs Soc. Sec. Personal Needs SSI Trustee/Maintenance Fees Total Deductions \$ SRR Income Taxes LTC Insurance payment \$ VA Community Spouses Allowance Patient Payment \$ Interest Dependent Care Allowance "If patient payment is -0-, give reason Other Home Maintenance Allowance "If patient payment is -0-, give reason Other Home Maintenance Allowance "If patient payment is -0-, give reason Other (See Note Below) Admit Month \$ Total Deductions "Admit Month \$ Total Deductions "First Full Month \$ Check Note: Medicare Part B Premium Deductions "First Full Month \$ Check Note: Medicare Part B Premium Deductions "First Full Month \$ Check Note: Medicare Part B Premium Deductions "First Full Month \$ Check Note: Medicare Part Decontinuous, if applicable." Month \$ Check Note: Medicare Part Decontinuous, if applicable. Month \$ Check Note: Medicaid Nursing Facility Care for the Above Patient: Description of the Note Patient Paymer Note Note Note: Not	I: Financial Arranç	gement:					
Soc. Sec. Personal Needs Tustee/Maintenance Fees Income \$ SSI Trustee/Maintenance Fees Income Taxes Income Total Power (See Note Below) Patient Payment is -0-, give reason Other Other 'See Note Below) Interest First Full Month Seed M			B. Mon	thly Incor	ne Adjustments	C. Patient	
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VA				e Fees		otal Deductions \$	
Interest				: Allowance			
Other Total Income	<u> </u>						
Total Income						o payo 10 0 ; g 10 0000	
Check	Total Income				A	Admit Month \$	
Check			Total Deductions	•	F	-irst Full Month \$	
If Client has Health Insurance Part D continuous, if applicable. Month \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$					2	Z ^{iu} Month \$	
If Client has Health Insurance Part D continuous, if applicable. Month \$ Health Insurance Part D continuous, if applicable. Month \$ S	☐ Check		* Note: Medicare Pa	art B Premium	D.	Change in Patient Payment	
Health Insurance Part D continuous, if applicable. Month \$ We Request Medical Authorization for Medicaid Nursing Facility Care for the Above Patient: Original Admission Date to Nursing Facility	If Client has		deductible for the 1s	st and 2 nd mon			
We Request Medical Authorization for Medicaid Nursing Facility Care for the Above Patient: Original Admission Date to Nursing Facility	Health Insurance					Month \$	
Original Admission Date to Nursing Facility Or original date hospitalized							
Admitted to Medicaid	/. We Request Medi	cal Authoriz	ation for Medica	id Nursing	Facility Care for the Ab	oove Patient:	
Admitted to Medicaid	Original Admission	Date to Nursi	ing Facility		or original date hospitalize	d	
From: Home	Admitted to Medicaid		20	 Di	scharged	20	
Hospital Hosp Name # Days in hospital # Days in NF Readmitted to Medicaid 20 Medicare NF LOA YTD Total From: Home Medicare NF LOA YTD Tot Other Specify Hospital Name Died Other Specify Place of Death Admitted to Medicare 20 Signature of Authorized NF Representative County Transfer: (This section is always completed by a county department staff) Date transferred out 20 From Date transferred in 20 To County Transfer: (This section is always completed by a county department staff) Approved: County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer: (This section is always completed by a county department staff) County Transfer:			are 🗆		To: home Address		
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Hospital Name Died Other Specify Place of Death Admitted to Medicare 20 From No. of Days Signature of Authorized NF Representative County Transfer: (This section is always completed by a county department staff) Date transferred out 20 From County Date transferred in 20 To County County Transfer: (This section is always completed by a county department staff) Approved: County County department staff) Approved: Comments: Comments: Discontinued: Denied: 20 To County County department staff) Effective Date: 20 To County department staff)	Readmitted to Medicaid		20				
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Signature of Authorized NF Representative County Transfer: (This section is always completed by a county department staff) Date transferred out 20 To	From		No. of Day	/S			
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Date transferred out	County Transfer: (This section	is always complete	ed by a coun	ty department staff)		
Date transferred in 20 To							
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County Technician Phone Date	Ellective Date:		2	υ			
County Technician Phone Date							
Transmission of this form through email requires encryption and password protection.	County Technician					 Date	