## Client with SSI income only

Original Copy

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

| Name and Address of Responsible Party  | l                       | Change Pt. Pmt. Copy                              |
|--|-------------------------|---|
| Name and Address of Responsible Party  | State ID                | Final Discharge Copy                              |
| II: Facility Information:  Nursing Facility:  Address:  III: Financial Arrangement:  A. Patient Income  Soc. Sec.  SSI  Trustee/Maintenance Fees Income Taxes  VA  Community Spouses Allowance Interest  Other  Total Income  Total Income  Check  If Client has Health Insurance  Health Insurance  Part D Continuous, if applicable.  IV. We Request Medical Authorization for Medicald Nursing Facility  Admitted to Medicaid  Part D Continuous, if applicable.  V. We Readmitted to Medicaid  From: Home  Hospital  Hosp Name  Readmitted to Medicaid  Part D Co County Transfer: (This section is always completed by a county depair  Date transferred out  Date transferred out  Date transferred in  Date transferred in  Date transferred in  Address:  B. Monthly Income Adj  B. Monthly Income Adj  B. Monthly Income Adj  Monthly Income Adj  Part Date Monthly Income Adj  Parsonal Needs  B. Monthly Income Adj   | of Medicaid Application | Patient Level-of-care                             |
| Nursing Facility:  Address:  II: Financial Arrangement: A. Patient Income  Soc. Sec. SSI RR Income Taxes VA Community Spouses Allowance Interest Other Total Income Total Income  Check If Client has Health Insurance Health Insurance Part D continuous, if applicable.  V. We Request Medical Authorization for Medicaid Nursing Facility Admitted to Medicaid Hospital Other Hospital Hospital Hospital Hospital Hospital Other Hospital Other Hospital Other Hospital Hospital Hospital Other Hospital Other Hospital Hospital Hospital Other Hospital Other Hospital Other Hospital Hospital Hospital Other Other Hospital Other Hospital Other Other Other Hospital Other Other Hospital Other Hospital Other Hospital Other Other Hospital Other Other Other Hospital Other Other Hospital Other Hospital Other Other Hospital Other Other Other Hospital Other Other Other Hospital Other Other Other From No. of Days Signature of Incompted by a county depail Date transferred out  Date transferred out  Date transferred in  | Number                  | V. A. Claim Number                                |
| Nursing Facility:  Address:  II: Financial Arrangement: A. Patient Income Soc. Sec. SSI RR   Personal Needs   Income Inco   |                         | Relationship                                      |
| Address:  III: Financial Arrangement: A. Patient Income  B. Monthly Income Adj Payment Calculations  Soc. Sec.   |                         | umber:  |
| III: Financial Arrangement: A. Patient Income  B. Monthly Income Adj Payment Calculations  Soc. Sec. SSI Trustee/Maintenance Fees RR Income Taxes VA Community Spouses Allowance Interest Dependent Care Allowance Other Home Maintenance Allowance Other Home Maintenance Allowance Total Income  Check If Client has Health Insurance Total Insurance  V. We Request Medical Authorization for Medicaid Nursing Facility Original Admission Date to Nursing Facility Admitted to Medicaid From: Home Hospital Hosp Name Other Hospital Name Other Other Other Hospital Name Other Other County Transfer: (This section is always completed by a county depail Date transferred out Date transferred in  20 County Cou   | Phone Nun               | mber:   |
| A. Patient Income  Soc. Sec. Soc. Sec. Soc. Sec. RR Income Taxes VA Community Spouses Allowance Interest Other Total Income Total Income  Check If Client has Health Insurance Health Insurance Hore Home Maintenance, if applicable.  V. We Request Medical Authorization for Medicaid Nursing Facility Original Admission Date to Nursing Facility Admitted to Medicaid From: Home Medicare Other Hospital Hosp Name Other Hospital Hosp Name Other Other Hospital Name Other Other Hospital Name Other Other Hospital Name Other Other Hospital Name Other Other From: Home Medicare From: Home Medicare From: Home Medicare Other Hospital Name Other Other From: No. of Days Signature of County Date transferred out Date transferred out Date transferred in Date transferred in  Oresonal Needs  Trustee/Maintenance Rees Income Adj Trustee/Maintenance Fees Income Adj Trustee/Maintenance Fees Income Adj Trustee/Maintenance Fees Income Adj Trustee/Maintenance Fees Income Adj Touthout Allowance Other Adj Touthout Allowance Other Income Taxes  V. We Request Allowance Income Taxes Income Ta   | Medicaid P              | Per Diem Rate \$                                  |
| A. Patient Income Payment Calculations Soc. Sec. Personal Needs SSI Trustee/Maintenance Fees RR Income Taxes VA Community Spouses Allowance Interest Dependent Care Allowance Dependent Care Allowance Other Home Maintenance Allowance Total Income Other '(See Note Below) Total Deductions  Check *Note: Medicare Part B Premium deductible for the 1st and 2nd month, Medile Fart D continuous, if applicable.  V. We Request Medical Authorization for Medicaid Nursing Facility Original Admission Date to Nursing Facility From: Home Medicare To: how Hospital Hosp Name Medicare From: Home Medicare NF LOA TO Cher Hospital Name Other Specify Admitted to Medicare NF LOA TO Tot Other Hospital Name Other Specify Admitted to Medicare Zo From No. of Days Signature of Incompt.  V. County Transfer: (This section is always completed by a county depair Date transferred out Zo From County Date transferred in Zo To   | <b>_</b>                | · · · · · · · · · · · · · · · · · · ·             |
| Soc. Sec. Personal Needs Soc. Sec. Personal Needs SSI Trustee/Maintenance Fees RR Income Taxes VA Community Spouses Allowance Interest Dependent Care Allowance Other Home Maintenance Allowance Other Home Maintenance Allowance Other Glient has deductible for the 1st and 2nd month, Medi Health Insurance Part D continuous, if applicable.  V. We Request Medical Authorization for Medicaid Nursing Facility Original Admission Date to Nursing Facility From: Home Medicare To: hon Hospital Hosp Name Medicare From: Home Medicare NF LOA YTD Tot Other Hospital Name Other Specify Admitted to Medicare From Medicare 20 Signature of Insurance No. of Days Signature of Insurance County Date transferred out 20 To County Date transferred in 20 To Tounty Date transferred in 20 To County Transfer: (This section is always completed by a county depair County Date transferred in 20 To County   | ustments                | C. Patient  |
| Soc. Sec. Personal Needs SSI Trustee/Maintenance Fees RR Income Taxes VA Community Spouses Allowance Interest Dependent Care Allowance Other Home Maintenance Allowance Other See Note Below) Total Income  Check * Note: Medicare Part B Premium If Client has deductible for the 1st and 2nd month, Medi Health Insurance Part D continuous, if applicable.  V. We Request Medical Authorization for Medicaid Nursing Facility Original Admission Date to Nursing Facility Original Admission Date to Nursing Facility Hospital Hosp Name Hospital Hosp Name From: Home Medicare NF LOA YTD Tot Hospital Name Other Specify Admitted to Medicare From No. of Days  V. County Transfer: (This section is always completed by a county depair Date transferred out Date transferred in Date transferred in  Ocounty Date transferred in  Ocounty  Touthout Admission Dependent Care Allowance Income Taxes  V. Medicare Part B Premium Medicare Part B Premium Medicare Net Income Institute  Admitted to Medicaid Nursing Facility Income Institute Dependent Care Allowance Income Taxes  Note: Medicare Part B Premium Medicare Net Institute Dependent Care Allowance Income Taxes Income   |                         |   |
| SSI RR Income Taxes VA Community Spouses Allowance Interest Other Other Home Maintenance Allowance Total Income  Check If Client has Health Insurance  V. We Request Medical Authorization for Medicaid Nursing Facility Original Admission Date to Nursing Facility Admitted to Medicaid From: Home Hospital Hosp Name Other Hospital Name Other Hospital Name Other Specify Admitted to Medicare From No. of Days  V. County Transfer: (This section is always completed by a county depair Date transferred out Dependent Care Allowance Income Taxes I   | Tot                     | tal Income \$                                     |
| Income Taxes   | Tot                     | tal Deductions \$                                 |
| Interest Other   | LTC Inst                | urance payment \$                                 |
| Other Total Income    Home Maintenance Allowance Other * (See Note Below) Total Deductions   Other independent Deductions   Other * (See Note Below) Total Deductions   Other independent Deductions   Other * (See Note Below) Total Deductions   Other independent Deductions   Other * (See Note Below) Total Deductions   Other independent Deductions   Other * (See Note Below) Total Deductions   Other independent D   | <br>* If notice         | atient Payment \$nt payment is -0-, give reasons: |
| Total Income  Other * (See Note Below) Total Deductions  * Note: Medicare Part B Premium deductible for the 1 <sup>st</sup> and 2 <sup>nd</sup> month, Medi Health Insurance  * Note: Medicare Part B Premium deductible for the 1 <sup>st</sup> and 2 <sup>nd</sup> month, Medi Part D continuous, if applicable.  * We Request Medical Authorization for Medicaid Nursing Facility Original Admission Date to Nursing Facility Original Admission Date to Nursing Facility From: Home Hospital Hosp Name Hosp Name # Days Readmitted to Medicaid Pother Hospital Name Other Other Specify Admitted to Medicare From No. of Days Signature o  * County Transfer: (This section is always completed by a county depair Date transferred out Date transferred in  Other County Date transferred in  Other County Tothor Other County Tothor Other County Tothor Other O |                         | nt payment is -o-, give reasons.                  |
| Total Deductions  Total Deductions  * Note: Medicare Part B Premium deductible for the 1st and 2nd month, Medicare Part D continuous, if applicable.  * We Request Medical Authorization for Medicaid Nursing Facility   |                         | dmit Month \$                                     |
| If Client has Health Insurance Part D continuous, if applicable.  V. We Request Medical Authorization for Medicaid Nursing Facility  Original Admission Date to Nursing Facility  Admitted to Medicaid  From: Home Hospital Hosp Name Hospital Hosp Name Hospital Name Other Hospital Name Other Other Hospital Name Other From  No. of Days  County Transfer: (This section is always completed by a county depair Date transferred out  Date transferred in  Oder Days  County  To County   |                         | irst Full Month \$                                |
| If Client has Health Insurance Part D continuous, if applicable.  V. We Request Medical Authorization for Medicaid Nursing Facility  Original Admission Date to Nursing Facility  Admitted to Medicaid  From: Home Hospital Hosp Name Hospital Hosp Name Hospital Name Other Hospital Name Other Other From Specify Admitted to Medicare From No. of Days  C. County Transfer: (This section is always completed by a county depair Date transferred out Date transferred in  Other  Date transferred in  Died County Coun   | 2 <sup>n</sup>          | Month \$  |
| If Client has Health Insurance Part D continuous, if applicable.  V. We Request Medical Authorization for Medicaid Nursing Facility  Original Admission Date to Nursing Facility Admitted to Medicaid From: Home Hospital Hosp Name Hospital Hosp Name Hospital Name Other Other Other From Specify Admitted to Medicare From From  Other From Specify Admitted to Medicare From No. of Days Date transferred out Date transferred in  Medicarion To: hor Medicare  # Days # Days # Days # Died # Died # Place of Insurance  County  County  To County   | D. (                    | Change in Patient Payment                         |
| We Request Medical Authorization for Medicaid Nursing Facility Original Admission Date to Nursing Facility Admitted to Medicaid From: Home Hospital Hosp Name Hospital Name Other Hospital Name Other Hospital Name Other Other From Specify Admitted to Medicare From No. of Days  To: hor # Days No. of Days  To: hor # Days  Medicare Place of I  To County Transfer: (This section is always completed by a county depair Date transferred out Date transferred in  Other Date transferred in  Other Date transferred in  Other Date transferred in  Other Double Date transferred in  Other Date transferred in   | icare M                 | onth \$   |
| V. We Request Medical Authorization for Medicaid Nursing Facility  Original Admission Date to Nursing Facility Admitted to Medicaid From: Home Medicare Hospital Hosp Name From: Home Medicare From: Home Medicare From: Home Medicare NF LOA TD Tot Other Hospital Name Other Specify Admitted to Medicare From No. of Days  Ocunty Transfer: (This section is always completed by a county depair Date transferred out Date transferred in  Ocunty Date transferred in  Original Authorization for Medicaid Nursing Facility Discharge To: hor # Days Medicare # Days  Medicare # Days  Medicare # Days  Medicare # Dother # Dother Other Died Place of In County Transfer: (This section is always completed by a county depair County Date transferred in  Ocunty To County To County County Date transferred in  Original Admistacle Nursing Facility  Date transferred Nedicare  20 From County County County To County To County  | M                       | onth \$   |
| Original Admission Date to Nursing Facility Or original Admitted to Medicaid 20 Discharged From: Home  |                         |   |
| From: Home   |                         |   |
| From: Home   | nal date hospitalized   | 20  |
| From: Home   | d .                     | 20  |
| Readmitted to Medicaid   | me 🗖 Address            |   |
| Readmitted to Medicaid   | s in hospital           | # Days in NF                                      |
| From: Home   |                         | OA U YTD Total                                    |
| Hospital Name Died Other Specify Place of I Admitted to Medicare 20 From No. of Days Signature of I County Transfer: (This section is always completed by a county depair Date transferred out 20 From County Date transferred in 20 To County   | Specify                 | .6/( - 115 16tal                                  |
| Other Specify Specify Place of I Admitted to Medicare 20 No. of Days Signature or Signatur   |                         |   |
| Admitted to Medicare 20  |                         |   |
| From No. of Days Signature or  | Death                   |   |
| Signature of County Transfer: (This section is always completed by a county depair Date transferred out  |                         |   |
| Date transferred in 20 To County 20 To County County 20 To County  | f Authorized NF Repres  | sentative   |
| Date transferred out 20 From   |                         | - Chicatro  |
| Date transferred in 20 To County   |                         |   |
| Date transferred in 20 ToCounty  |                         |   |
| County   |                         |   |
| County Transfor (This section is above a security of the security of   |                         |   |
| I. County Transfer: (This section is always completed by a county depar  |                         |   |
| Approved: Commer   | nts:                    |   |
| Discontinued:  |                         |   |
| Denied: 20 20  |                         |   |
| Effective Date:20  |                         |   |
|  |                         |   |
| County Technician Phone Transmission of this form through email requires encryption  |                         | Date  |

**EXAMPLE**