COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

STATUS OF NURSING FACILITY CARE

Original Copy	☐
Corrected Copy	☐
County Transfer Copy	☐
Change Pt. Pmt. Copy	☐
Final Discharge Copy	☐

I. CLIENT INFORMATION:

Client: _____ _____ _____

Last Name First Name MI | County | State ID

_____/_____ _____ _____ _____ _____ _____

CBMS H.H. No. | Cat | Client D.O.B. | Gender | Date of Medicaid Application | Patient Level-of-care

_____ _____ _____ _____

Client's Own S.S. Number | S. S. Claim Number/Suffix | R. R. Claim Number | V. A. Claim Number

Name and Address of Responsible Party _____ Relationship _____

II: Facility Information:

Provider Number: _____

Nursing Facility: _____ Phone Number: _____

Address: _____ Medicaid Per Diem Rate $ _____

III: Financial Arrangement:

A. Patient Income

Soc. Sec.	_____
SSI	_____
RR	_____
VA	_____
Interest	_____
Other	_____
Total Income	_____

B. Monthly Income Adjustments

Personal Needs	_____
Trustee/Maintenance Fees	_____
Income Taxes	_____
Community Spouses Allowance	_____
Dependent Care Allowance	_____
Home Maintenance Allowance	_____
Other * (See Note Below)	_____
Total Deductions	_____

C. Patient Payment Calculations

Total Income $ _____

Total Deductions $ _____

LTC Insurance payment $ _____

Patient Payment $ _____

* If patient payment is -0-, give reasons:

_____

Admit Month $ _____

First Full Month $ _____

2nd Month $ _____

☐ Check If Client has Health Insurance

* Note: Medicare Part B Premium deductible for the 1st and 2nd month, Medicare Part D continuous, if applicable.

D. Change in Patient Payment

Month _____ $ _____

Month _____ $ _____

IV. We Request Medical Authorization for Medicaid Nursing Facility Care for the Above Patient:

☐ Original Admission Date to Nursing Facility _____ ☐ or original date hospitalized _____

Admitted to Medicaid _____ 20 _____ Discharged _____ 20 _____

From: Home ☐ Medicare ☐ To: home ☐ Address _____

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 _____

From _____ No. of Days _____

_____

Signature of Authorized NF Representative

V. County Transfer: (*This section is always completed by a county department staff*)

Date transferred out _____ 20_____ From _____

County

Date transferred in _____ 20 ____ To _____

County

VI. County Transfer: (*This section is always completed by a county department staff*)

Approved: _____ Comments:

Discontinued: _____ _____

Denied: _____ _____

Effective Date: _____ 20 _____ _____

_____ _____ _____

County Technician | Phone | Date

Transmission of this form through email requires encryption and password protection.