QMB Eligible Client

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

I. CLIEN				G FACILITY (Corrected Copy	
A 11	T INFORMATI	ON:				0	County Transfer Copy	
Client:	Last Name	First Name		County	State ID		Thange Pt. Pmt. Copy "inal Discharge Copy	
	Last Name	First Name	IVII	County	State ID			
CB	MS H.H. No.	_/Cat	Client D.O.B.	Gender	Date of Medicaid App	lication	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	d Address of Re	snonsihle P	artv			F	Relationship	
	cility Inforn		<u> </u>		Provid	der Num	ber:	
i u								
Nursing	Facility:				Phon	e Numb	er:	
Address:					Medicaid Per Diem Rate \$			
III: Fina	ancial Arrang							
A. Pati	ent Income		B. Mo	nthly Incon	ne Adjustments		C. Patient	
Payment	t Calculations							
Soc. Se	C		Personal Needs	_			Income \$	
SSI RR			Trustee/Maintenanc Income Taxes	ce ⊦ees			Deductions \$ nce payment \$	
					L1	Patie	ent Payment \$	
Interest			Dependent Care All	lowance	*	f patient	payment is -0-, give reasons:	
Other			Home Maintenance					
Total Income			Other * (See Note I	Below)			it Month \$	
			Total Deductions				Full Month \$ Month \$	
	Check		* Note: Medicare F	Part B Premium	D		ange in Patient Payment	
						. 011	ange in ratient rayment	
If CI	iont hae		deductible for the	1 st and 2 nd mon	h Medicare	Mon	h ¢	
	lient has th Insurance		deductible for the Part D continuous,	1 st and 2 nd mon , if applicable.	th, Medicare	Mon Mon	th \$ th \$	
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Heal	th Insurance	cal Authoriz	Part D continuous,	, if applicable.	th, Medicare Facility Care for th			
Heal	th Insurance Request Media		Part D continuous, zation for Medic	, if applicable. aid Nursing	Facility Care for th	e Abov talized	e Patient:	
Heal	th Insurance Request Media	Date to Nurs	Part D continuous, zation for Medic ing Facility	, if applicable. aid Nursing	Facility Care for th	e Abov talized	e Patient:	
Heal	th Insurance Request Medic riginal Admission d to Medicaid	Date to Nurs	Part D continuous, zation for Medic ing Facility20	, if applicable. aid Nursing	Facility Care for th or original date hospi scharged	e Abov talized	e Patient:	
Heal	th Insurance Request Medic riginal Admission d to Medicaid n: Home	Date to Nurs	Part D continuous, zation for Medic ing Facility20 are	, if applicable. aid Nursing Discrete	Facility Care for the or original date hospischarged	talized	e Patient: 20	
Heal	th Insurance Request Medic riginal Admission d to Medicaid n: Home [Hospital]	Date to Nurs Medica Hosp N	Part D continuous, zation for Medic ing Facility20 are lame	, if applicable. aid Nursing Dis	Facility Care for th or original date hospi scharged To: home Addre # Days in hospital	he Abov talized ess	e Patient: 20 # Days in NF	
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EXAMPLE