

## Nursing Facility Residents Change in Status

Admission, Discharge, Transfer, Hospitalization or Change in Level of Care\*

<b>Resident Name:</b>	<b>Medicaid Number (or SSN):</b>	<b>DOB :</b>
<b>Facility/ Medicaid Provider #:</b> /	<b>Facility Contact Name:</b>	<b>Phone Number:</b>

**I. Type of Action: (please use one form per action)**

- |   |   |
|---|---|
| <input type="checkbox"/> Admission (Complete Section II.)                 | <input type="checkbox"/> Discharge (Complete Section IV.) |
| <input type="checkbox"/> Hospitalization: Transfer to Hospital            | <input type="checkbox"/> Deceased                         |
| <input type="checkbox"/> Hospitalization: Return from Hospital            | <input type="checkbox"/> Other: _____                     |
| <input type="checkbox"/> Leave of Absence: Transfer                       |   |
| <input type="checkbox"/> Leave of Absence: Return                         |   |
| <input type="checkbox"/> Change in Payment Status (Complete Section III.) |   |

**EFFECTIVE DATE OF ACTION:** \_\_\_\_\_

**II. Admission:** ( Prior Authorization/PAS for Medicaid-funded service,  PASRR Level I required)

<b>Primary Payor:</b>	<b>Admitted From:</b>	<b>Level of Care: (*note: please do not use this form for CMAO)</b>
<input type="checkbox"/> Medicare (Title XVIII)	<input type="checkbox"/> Hospital	<input type="checkbox"/> Basic
<input type="checkbox"/> Medicaid (Title XIX)	<input type="checkbox"/> Community Based Care	<input type="checkbox"/> PHEC (20 day max)
<input type="checkbox"/> Managed Care	<input type="checkbox"/> Home	<input type="checkbox"/> Medicare Skilled
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

**III. Change in Payment Status: (\*Please do not use this form for CMAO)**

<b>Current Payor Source:</b>	<b>New Payor Source:</b>
<input type="checkbox"/> Medicare (no copays)	<input type="checkbox"/> Medicare (no copays)
<input type="checkbox"/> Medicare (with copays)	<input type="checkbox"/> Medicare (with copays)
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicaid (please do not use this form for CMAO)
<input type="checkbox"/> Private	<input type="checkbox"/> Private
<input type="checkbox"/> Insurance	<input type="checkbox"/> Insurance
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

**IV. Transfer/Discharge:**

- |  |   |
|--|---|
| <input type="checkbox"/> Own Home                  | <input type="checkbox"/> Adult Foster Home      |
| <input type="checkbox"/> Relative's Home           | <input type="checkbox"/> Homeless Shelter       |
| <input type="checkbox"/> Nursing Facility          | <input type="checkbox"/> Alzheimer's Care Unit  |
| <input type="checkbox"/> Residential Care Facility | <input type="checkbox"/> Enhanced Care Facility |
| <input type="checkbox"/> Assisted Living Facility  | <input type="checkbox"/> Other: _____           |

\_\_\_\_\_  
Authorized Representative Signature

\_\_\_\_\_  
Date

Please fax this form to local Area Agency on Aging/Seniors & People with Disabilities office

Entered by \_\_\_\_\_ (worker) to Oregon Access on \_\_\_\_\_ (date)