COLORADO
Department of Health Care Policy & Financing

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

Payment Calculations

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

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_____ $ _____

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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.

Revised February 2022