

		STATU	ENT OF HEALTH JS OF NURSING			ANCING	Original C Corrected	
Client:	t Information	on:					County Tr Change P	ansfer Copy t. Pmt. Copy harge Copy
	Last Name	First Name	MI	County	Sta	te ID		
CBM	IS H.H. No.	_/ Cat	Client D.O.B.	Gender	Date of Medic	aid Applicatio	n Patient L	evel-of-care
Client's C	Own S.S. Number		laim Number/Suffix		. Claim Number		V. A. Cla	im Number
Name and	Address of Re	esponsible Pa	rty				_Relationshi	p
II: Fac	ility Inforn	nation:				Provider N	umber:	
Nursina F	Facility:					Phone Nur	mber:	
i turonig i								
Address:	·					Medicaid F	Per Diem Rate	e \$
Address:	ancial Arrai							
Address: III: Fina A. Patie	ancial Arrai				ne Adjustme			∍ \$ Patient
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Address: III: Fina A. Patie Payment Soc. Sec. SSI RR VA Interest Other	encial Arrai ent Income Calculations	ngement: P II II D D	B. Mon Personal Needs Trustee/Maintenance ncome Taxes Community Spouses Dependent Care Allo Nome Maintenance A	e Fees Allowance Allowance	ne Adjustme	ents _ To _ TC _ LTC Ins _ F _ * If patie _ A	C. Intal Income Detal Deductions Surance payme Patient Payment Patient payment is	Patient \$ \$ nt \$ t \$0-, give reasons: \$
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Address: III: Fina A. Patie Payment Soc. Sec. SSI RR VA Interest Other Total Inco	ancial Arran ent Income Calculations	ngement: P T II C D D	B. Mon Personal Needs Trustee/Maintenance ncome Taxes Community Spouses Dependent Care Allo Home Maintenance / Other * (See Note Br otal Deductions	Thly Incom Fees Allowance Allowance elow)	ne Adjustme	ents - To - To - LTC Ins - F - A - A - A - A - A - A - A - A	C. Interpretent of the second secon	Patient





IV. We Request Medical Authorization for Medicaid Nursing Facility Care

for the Above Patient:

Original Admission Da	te to Nursing Facility	or original date hospitalized	u
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	INF LOA YTD Tot	Other 📮 Specify	
Hospital 🖵 Name			
Other 🖵 Specify		Place of Death	
Admitted to Medicare	20		
From	No. of Days		
County Transfer:	This section is always completed	Signature of Authorized NF Repre	esentative
Date transferred out	This section is always completed2020	by a county department staff. From	
Date transferred out	20	by a county department staff. FromCountyToCounty	
Date transferred out Date transferred in	202020	by a county department staff. _ From County _ To County by a county department staff.	
Date transferred out Date transferred in . County Transfer: - Approved:	20202020	by a county department staff. _ From	
Date transferred out Date transferred in . County Transfer: • Approved: Discontinued:	20202020	by a county department staff. _ From	

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

Revised February 2022

