



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

B. Monthly Income Adjustments

C. Patient

Payment Calculations

Soc. Sec.	_____	Personal Needs	_____	Total Income	\$ _____
SSI	_____	Trustee/Maintenance Fees	_____	Total Deductions	\$ _____
RR	_____	Income Taxes	_____	LTC Insurance payment	\$ _____
VA	_____	Community Spouses Allowance	_____	Patient Payment	\$ _____
Interest	_____	Dependent Care Allowance	_____	* If patient payment is -0-, give reasons:	
Other	_____	Home Maintenance Allowance	_____		
Total Income	_____	Other * (See Note Below)	_____	Admit Month	\$ _____
		Total Deductions	_____	First Full Month	\$ _____
				2 nd 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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Coloradans money on health care and driving value for Colorado.

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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.

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