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

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	$ ________
				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________ $ __________

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