QMB Eligible Client

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

Soc. Sec.	854.00
SSI	
RR	
VA	
Interest	
Other	
Total Income	854.00

B. Monthly Income Adjustments

Personal Needs	50.00
Trustee/Maintenance Fees	
Income Taxes	
Community Spouses Allowance	
Dependent Care Allowance	
Home Maintenance Allowance	
Other * (See Note Below)	
Total Deductions	50.00

C. Patient Payment **Calculations**

Total Income $ 854.00
Total Deductions $ 50.00
LTC Insurance payment $ _____
Patient Payment $ 804.00
* 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 5/12 $ 804.00
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 5/6 20 12 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: _____
Discontinued: _____
Denied: _____
Effective Date: 5/6 20 12

Comments:
Patient payment is due beginning 5/6/12 when client changed to custodial care.

_____ _____ _____
County Technician | Phone | Date

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

EXAMPLE