Client with SSI income only

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	_____

☐ Check
If Client has
Health Insurance

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	_____

* Note: Medicare Part B Premium
deductible for the 1st and 2nd month, Medicare
Part D continuous, if applicable.

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	$ _____

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.

EXAMPLE