RESIDENTIAL HEALTH CARE FACILITY REPORT OF MEDICAID RECIPIENT ADMISSION/DISCHARGE/READMISSION/CHANGE IN STATUS

TO: (PATIENT'S/RESIDENT'S LOCAL DEPARTMENT OF SOCIAL SERVICES OFFICE)	FROM: (REPORTING FACILITY)	
PATIENT/RESIDENT NAME (*Last, First, M.I.*)	PROVIDER NUMBER	TYPE OF PLACEMENT ☐ SNF ☐ ICF
MEDICAID CLIENT IDENTIFICATION NUMBER	DATE OF ADMISSION/READMISSION:	
SOCIAL SECURITY NUMBER	DATE OF DISCHARGE/TRANSFER:	
FROM: (FACILITY OR HOME ADDRESS) Bed was reserved ☐ Yes ☐ No ☐ Not applicable	TO: (FACILITY OR HOME ADDRESS; or INDICATE IF DECEASED) Bed was reserved ☐ Yes ☐ No ☐ Not applicable	
PATIENT IS ENROLLED IN MEDICAID MANAGED CARE: ☐ Yes ☐ No NAME OF MEDICAID MANAGED CARE PLAN:	MEDICAID MANAGED CARE PLAN WAS NOTIFIED OF ADMISSION, DISCHARGE, OR CHANGE IN STATUS: ☐ Yes ☐ No DATE NOTIFIED:	

LDSS-3559 is required from the facility for each individual upon initial admission, and for every change in placement status, including upgrade to permanent placement, readmission, transfer, discharge or death of the patient after admission. Prompt submission of this completed form to the Local Department of Social Services (LDSS) responsible for the client will ensure timely payment by Computer Sciences Corporation/Medicaid Managed Care plan to the billing provider.

Indicate placement situation for this patient:

☐ Placement is for short term rehabilitation, which is expected to be less than 29 consecutive days (for Medicaid eligibility determination purposes only).

☐ Placement is considered to be permanent. The individual is not expected to return home to a community setting.

☐ Placement is considered to be non-permanent. The individual is expected to return home to a community setting.
NOTE: A physician must complete and sign the attached statement indicating the diagnosis, prognosis, expected time frame and the anticipated discharge plan for a non-permanent admission.

NOTE: The facility is responsible for obtaining prior approval and billing Medicaid Managed Care plans for medically necessary non-permanent stays. If the placement is determined to be permanent, the facility must include a medical determination to facilitate disenrollment from the Medicaid Managed Care plan.

Health Insurance Information:

☐ The individual is in receipt of Medicare coverage for nursing facility services and/or has other health insurance coverage at the time of admission.

☐ Medicare or other third party health insurance coverage was terminated on_________________(date).

NAME OF INDIVIDUAL COMPLETING THIS FORM (*Please print*)	TITLE	TELEPHONE NO. ( )

FACILITY MUST SUBMIT COMPLETED FORM WITHIN 48 HOURS OF ADMISSION/DISCHARGE OR ANY CHANGE IN PATIENT STATUS

Physicians Statement of Temporary Nursing Home Placement

STATEMENT OF PURPOSE

The information provided will help determine the appropriate budgeting methodology to use for Medicaid eligibility purposes for the Medicaid applicant/recipient and to ensure appropriate Medicaid payments to the nursing facility. Establishing the intent and purpose of admission to the nursing facility will also aid in the determination of payment liability from Medicaid or the recipient's Medicaid Managed Care plan.

PATIENT NAME	Date of Birth	Social Security Number	SEX

HOME ADDRESS: APT/STREET	City	State	Zip Code

Facility Name/ Address	**Anticipated timeframe for discharge**

Reason for nursing home admission including diagnosis, prognosis, discharge plan and reason for non-permanent placement.

Physician's Certification

I, the undersigned physician, do certify that all the medical information contained within this form is both true and complete to the best of my knowledge and that I may be contacted, if necessary, for further clarification.

______________________________ ______________________________
(Print) Physician's Name Physician's Signature

______________________________ ______________________________
Date Contact Phone Number

Information for LDSS

When the physician statement verifies that the above individual's placement in a residential health care facility is non-permanent and the recipient is enrolled in Medicaid Managed Care, s/he is not disenrolled from the plan. The facility is responsible for billing the Medicaid Managed Care plan for medically necessary non-permanent (rehabilitation) stays. If a RHCF stay is subsequently classified as a permanent placement, the individual should be disenrolled from the Medicaid Managed Care plan effective the first day of the month in which the stay is classified as permanent. This will allow the facility to bill fee-for-service from the date the member was determined permanent.