#Jenny

Finally I get this ebook, thanks for all these I can get now!

#Rio

Cool! I'am really happy

#Markus Jensen

I did not think that this would work, my best friend showed me this website, and it does! I get my most wanted eBook

#Hun Tsu

wtf this great ebook for free?!

#Che Salsa

My friends are so mad that they do not know how I have all the high quality ebook which they do not!

#Diego Butler

so many fake sites. this is the first one which worked! Many thanks

New Jersey Department of Health and Senior Services
Division of Aging and Community Services

NOTIFICATION FROM LONG-TERM CARE FACILITY
OF ADMISSION OR TERMINATION OF A MEDICAID PATIENT

Type
☐ Request PAS
☐ Notice of Admission
☐ Notice of Termination

I. PATIENT INFORMATION
1. Name: _____ (Last) _____ (First)
2. Social Security No.: ___ - ___ - ___
3. HSP (Medicaid) Case No.: _____ Confirmed By (CWA): _____ ☐ Medicaid Only ☐ SSI
4. Date of Birth: ___ / ___ / ___
5. Sex: ☐ Female ☐ Male

II. PROVIDER INFORMATION
1. Provider Number: _____
2. LTCF Name: _____
3. Address: _____
4. City, State, Zip: _____
5. Provider Phone #: _____
6. ☐ SCNF: _____

III. REQUEST FOR PAS
☐ Private to Medicaid
☐ PASRR Exempt >30 Days
☐ PAS Exempt >20 Days
☐ Hospice Revoked
☐ Medicaid Managed Care Terminated
☐ ARC PAS
☐ Out of State Approval Admission
☐ Other _____
Date of Level I PASSR: _____
☐ Positive ☐ Negative

IV. ADMISSION INFORMATION
1. Admission Date: ___ / ___ / ___
2. Date of PAS, if applicable: ___ / ___ / ___ ☐ Track 1 ☐ Track 2
3. Admitted from: ☐ Community/Boarding Home ☐ Medicare to Medicaid ☐ Psychiatric Hospital ☐ Private to Medicaid - anticipated Medicaid effective date: ___ / ___ / ___ ☐ Hospital ☐ Other LTCF ☐ Other (specify): _____
4. Name of Hospital/LTCF: _____ Admission Date: ___ / ___ / ___
Address: _____
5. If admitted from Hospital/LTCF, give the name/address of previous residence (Hospital Name and Address or Home Address): _____

V. TERMINATION INFORMATION
1. Discharge Date: ___ / ___ / ___
2. Discharged to:
☐ Home-Community (including relative's home)/ County of residence: _____
☐ Facility Name: _____ County of NF: _____
☐ Other (specify): _____ County of residence: _____
Telephone Number of Discharge Site _____
3. Death (Date): ___ / ___ / ___ ☐ In LTCF ☐ In Hospital

VI. CERTIFICATION
The facility certifies that the patient will reside only in those areas of the facility which are certified for participation in the New Jersey Medicaid Program at the level of care authorized for this patient by the New Jersey Medicaid Program. The facility also certifies that upon discharge to a hospital, the patient's room/bed will be reserved for the full period of time covered by the New Jersey Medicaid Bed Reserve Policy. **If nursing facility bills Medicaid for long term care services, the person signing this form certifies that the facility has a valid PAS on file.**
This form completed by:
Name: _____ Phone Number: _____
Title: _____ Date: _____

VII. CWA USE ONLY
Medicaid Effective Date: ___ / ___ / ___
☐ Medicaid ONLY (PA-3L Attached)
☐ SSI Only (PA-3L Required, Contact DHSS)
☐ Not Eligible
☐ Transcript Requested - Date: ___ / ___ / ___
Remarks: _____
Name of Case Worker: _____ Date: _____
COUNTY WELFARE OFFICE _____
Street Address: _____
City and Zip: _____

LTC-2
SEP 10
Original-CWA Copy-LTCFO Copy-Provider

Download PDF version of :

Hospital Discharge Form Template