

**EXCHANGE OF INFORMATION BETWEEN NURSING FACILITY OR HOSPITAL
AND REGIONAL MEDICAID OFFICE**

Name of Nursing Facility/Hospital _____

Provider No. _____

Address _____

City _____ State _____ Zip _____

Client's Name _____

Medicaid ID _____ Social Security No. _____

Name of Responsible Relative _____

Address of Relative _____

Client's County of Residence Before Entering Facility _____

Does this client receive SSI? () Yes () No Amount _____

NOTICE OF ACTION TAKEN

() Client entered facility (Month, Day, Year) _____

Family or client has been given an application form? () Yes () No

() Client has been discharged to another medical facility as of _____ (date).

Name/address of new facility: _____

() Client has been transferred to another facility as of _____ (date).

Name/address of new facility: _____

() Client has been discharged to hospice care within same facility effective _____ (date).

() Client has been discharged to a private living arrangement: _____ (date).

() Client is deceased. Date of death: _____

SIGNATURE

DATE

Client's Name _____

Medicaid ID # _____ Provider # _____

MEDICAID ELIGIBILITY STATUS

- () Client is eligible for Medicaid effective _____
Effective _____, Medicaid Income \$ _____
Effective _____, Medicaid Income \$ _____
Effective _____, Medicaid Income \$ _____
Effective _____, Medicaid Income \$ _____
- () Client has had a change in Medicaid Income.
Effective _____, Medicaid Income \$ _____
Effective _____, Medicaid Income \$ _____
Effective _____, Medicaid Income \$ _____
Effective _____, Medicaid Income \$ _____
- () Yearly review has been completed, no change in Medicaid Income.
- () Client has been denied Medicaid benefits.
- () Client's Medicaid benefits terminate effective _____

The Medicaid Income figures shown represent a total monthly amount. When collecting medicaid Income from a patient for a partial month stay in your facility, the above figure must be prorated according to the number of days of the stay.

REMARKS: _____

Signature

Date