MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-317 - EXCHANGE OF INFORMATION BETWEEN NURSING HOME OR HOSPITAL AND MEDICAID REGIONAL OFFICE

PURPOSE & USE

This form is used by the Nursing Home or Hospital and Regional Medicaid Office as an exchange of information form regarding applicants for and recipients of Medicaid. The purpose of this form is:

1. It is initiated by the Nursing Home/Hospital at the time a Medicaid applicant/recipient enters, transfers in or out, is discharged, or expires in the facility.

2. It is completed by the Regional Medicaid Office at the time an applicant has been approved for Medicaid and will notify the facility of the effective date of Medicaid eligibility and the amount of the client's Medicaid Income. It will also be used to notify the Nursing Home/Hospital of any change in Medicaid Income which occurs or if Medicaid is terminated or denied.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

The Nursing Home/Hospital originating the form will prepare an original and 2 copies. The original and 1 copy will be mailed to the appropriate Regional Medicaid Office while the second copy is retained by the facility.

The Regional Office will respond on the same forms originated by the Nursing Home or Hospital. The original is returned to the Nursing Home or Hospital and the copy is retained in the client's case record.

If the Regional Office originates the DOM-317 Form, follow the same procedure outlined above for the distribution of the original and copies of the completed form.

The top portion of the form contains identifying information about the Medicaid applicant or recipient and is completed by the office originating the form. The initial DOM-317 is completed by the nursing home or hospital.

NOTICE OF ACTION TAKEN - This portion of the form is completed by the Nursing Home or Hospital at the time the following situations occur:

1. At the time a Medicaid applicant or recipient enters the facility, the Nursing Home/Hospital will check the appropriate block and enter the month, day, and year of entry.

   Check the appropriate block to indicate whether the client or his/her family has been given DOM-300, Application Form, to complete.

2. At the time a client is discharged to another medical facility, check the appropriate block and enter the month, day and year of discharge. Include the name and address of the new facility, if known, in the space provided.

3. If a client is transferred to another medical facility, check the appropriate block and enter the month, day and year of the transfer. Include the name and address of the new facility in the space provided.

4. When a client is discharged to a private living arrangement, check the appropriate block and enter the month, day and year of discharge. Include the client's new address, if known, in the space provided.

5. At the time of the client's death, check the appropriate block and enter the month, day and year of death in the space provided.

6. When a client is discharged from the facility but remains physically in the facility in the Hospice program, enter the date of Hospice enrollment.

The Nursing Home Administrator will sign the form and enter the date the form is completed in the space provided prior to sending the form to the appropriate Medicaid Regional Office.

Page 2 of DOM-317 - To be completed by the Medicaid Regional Office.

MEDICAID ELIGIBILITY STATUS - This portion of the form is completed by the Medicaid Regional Office as follows:

1. Approvals - Check the 1st block when an applicant is approved for long-term care. In the space provided, enter the beginning Medicaid eligibility date.

   In the spaces provided enter the effective date (month, year) and the amount of applicant's Medicaid Income as reflected on the Institutional Budget. The form is designed to show fluctuating income amounts or income protection for first month and the amount of income to be effective in second month, third month, and fourth month, if different.

2. Changes in Medicaid Income - Check the 2nd block to report a change in the client's Medicaid Income as a result of a special or regular review of the client's case. In the space provided enter the effective date (month, year) and the new amount of client's Medicaid Income.

3. Regular Review - No Change in Medicaid Income - Check the 3rd block if at the time of the regular review there is no change in the client's Medicaid Income. Also enter the amount previously reported.

4. Denials - Check the 4th block if an applicant has been denied eligibility.

5. Terminations - Check the 5th block if a client's case is closed. In the space provided enter the month, day and year the closure is effective.

REMARKS: Enter in the space provided any remarks regarding applicant's or recipient's case.

Signature of Medicaid Worker/Date: The Medicaid Specialist or Supervisor will sign and date the form in the space provided.

DOM-317
Revised 01-01-03

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