Reset

EXCHANGE OF INFORMATION BETWEEN LONG TERM CARE FACILITY AND REGIONAL MEDICAID OFFICE

MISSISSIPPI DIVISION OF MEDICAID

Name of Facility _____

Provider # _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Medicaid applicant or recipient information:

Name _____

Medicaid ID # _____ Social Security # _____

County of Residence before entering facility _____

Does individual receive SSI? ❑ Yes ❑ No If yes, amount $_____

Name of Responsible Person _____Phone # _____

Address of Responsible Person _____

Facility Reported Information:

❑ Individual entered facility (Mo/Day/Yr) _____ Medicaid application provided? ❑ Yes ❑ No

Entered facility from: ❑ Home ❑ Hospital ❑ Other Facility: Give name of hospital or other facility & dates of admission: _____

❑ Individual is deceased. Date of death (Mo/Day/Yr): _____ ❑ Died in this facility ❑ Place of death _____

❑ Individual was discharged to another facility on (date) _____

Name/address of new facility: _____

❑ Individual has been discharged to a private living arrangement on (date) _____

Address _____Phone # _____

_____ _____

Signature of Facility Official Date

Name of Medicaid Applicant or Recipient: _____

Medicaid ID# _____ Provider # _____

Regional Office Reported Information – Medicaid Eligibility Status:

❑ Individual is eligible for Medicaid effective (date) _____

Effective _____, Medicaid Income is $_____

Effective _____, Medicaid Income is $_____

Effective _____, Medicaid Income is $_____

Effective _____, Medicaid Income is $_____

❑ Individual has been denied Medicaid benefits.

❑ Individual is eligible for all Medicaid services except payment to the facility due to a transfer of assets penalty. Penalty is from _____ to _____

Comments: _____

❑ Individual has had a change in Medicaid Income.

Effective _____, Medicaid Income is $_____

Effective _____, Medicaid Income is $_____

Effective _____, Medicaid Income is $_____

Effective _____, Medicaid Income is $_____

❑ Annual review has been completed, no change in Medicaid Income.

❑ Individual's Medicaid benefits terminate effective _____

The Medicaid Income amount(s) shown represent a total monthly amount. When collecting Medicaid income from the individual for a partial month stay, the above amount must be prorated according to the number of days of the stay.

Remarks: _____

Medicaid Specialist _____ Date _____