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 BENEFICIARY

pe	
Request PAS	
☐ Notice of Admission	
☐ Notice of Termination	

I.	PATIENT INFORMATION				
1		2 S	ocial Security	No · -	
٠.	Name:(Last) (First)	2.0	oolal occarity		
3.	HSP (Medicaid) Case No.:		Date of Birth:	1 1	
	Confirmed By (CWA): Medicaid Only	☐ SSI	5. Sex:	Female	e
Ш	PROVIDER INFORMATION				
		5 I	Provider Phon	- #·	
1. 2	Provider Number:	ე. r გ [<i>=</i> #	
	LTCF Name:	0. [SCINE		
J. ₄	Address:				
4.	City, State, Zip:				
III.	. REQUEST FOR PAS				
	☐ Private to Medicaid ☐ Medicaid Managed Ca	are Termina	ted	Date of Level I F	PASSR:
	☐ PASRR Exempt >30 Days ☐ ARC PAS	A duninging			
	☐ PAS Exempt >20 Days ☐ Out of State Approval			☐ Positive ☐] Negative
	☐ Hospice Revoked ☐ Other:		<u>.</u>		
IV.	. ADMISSION INFORMATION				
	Admission Date: / /				
2.	Date of PAS, if applicable: / / T	rack 1	☐ Track 2	☐ E-ARC PA	S
3.	Admitted from:			☐ Psych	niatric Hospital
	☐ Private to Medicaid - anticipated Medicaid effective date:	/	1		
	☐ Hospital ☐ Other LTCF ☐ Other (specify):				
4.	Name of Hospital/LTCF:		Adr	nission Date:	1 1
	Address:		<u></u>		<u> </u>
5.	If admitted from Hospital/LTCF, give the name/address of previ	ous residen	ce (Hospital N	ame and Address	or Home Address):
٧.	TERMINATION INFORMATION				
1.	Discharge Date: / /				
1.	Discharge Date: / /	sidence:			
1.	Discharge Date: / / Discharged to: Home-Community (including relative's home)/ County of res			nty of NF:	
1.	Discharge Date: / /		Cour	nty of NF:	
1.	Discharge Date: / / Discharged to: / / Home-Community (including relative's home)/ County of reschild in the coun		Cour	nty of NF:esidence:	
1. 2.	Discharge Date: / / Discharged to: / / Home-Community (including relative's home)/ County of restable in the property of the property of Discharge Site		Courty of re	nty of NF:esidence:	
1. 2. 3.	Discharge Date: / /		Courty of re	nty of NF:esidence:	
1. 2. 3.	Discharge Date: / / Discharged to: / / Home-Community (including relative's home)/ County of rescaling the proof of th	☐ In Hos	Cour County of re spital	esidence:	
1. 2. 3.	Discharge Date: / / Discharged to: / / Home-Community (including relative's home)/ County of rescapility Name: Other (specify): / / / In LTCF Death (Date): / / / In LTCF CERTIFICATION The facility certifies that the patient will reside only in those areas	☐ In Hos	Courty of respital	esidence:	ion in the New Jersey
1. 2. 3.	Discharge Date: / / Discharged to: / /	☐ In Hos	Courty of respital y which are cerersey Medicaid	esidence:tified for participat Program. The far	ion in the New Jersey cility also certifies that
1. 2. 3.	Discharge Date: / / Discharged to: / /	of the facility the New Juyed for the f	County of respital y which are cerersey Medicaidull period of tim	tified for participat Program. The fare covered by the	ion in the New Jersey cility also certifies that New Jersey Medicaid
1. 2. 3.	Discharge Date: / / Discharged to: / / Home-Community (including relative's home)/ County of rescapility Name: Other (specify): / / In LTCF Death (Date): / / In LTCF CERTIFICATION The facility certifies that the patient will reside only in those areas Medicaid Program at the level of care authorized for this patient be upon discharge to a hospital, the patient's room/bed will be reserved Reserve Policy. If nursing facility bills Medicaid for long the facility has a valid PAS on file.	of the facility the New Juyed for the f	County of respital y which are cerersey Medicaidull period of tim	tified for participat Program. The fare covered by the	ion in the New Jersey cility also certifies that New Jersey Medicaid
1. 2. 3.	Discharge Date: /	of the facility the New Juyed for the face s	Courty of respital y which are cerersey Medicaid ull period of timeservices, the period court in the court i	tified for participat Program. The factor the covered by the erson signing the	ion in the New Jersey cility also certifies that New Jersey Medicaid is form certifies that
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1. 2. 3. VI.	Discharge Date: / / Discharged to: Home-Community (including relative's home)/ County of restable Facility Name: Other (specify): Telephone Number of Discharge Site Death (Date): / / In LTCF CERTIFICATION The facility certifies that the patient will reside only in those areas Medicaid Program at the level of care authorized for this patient bupon discharge to a hospital, the patient's room/bed will be reser Bed Reserve Policy. If nursing facility bills Medicaid for long the facility has a valid PAS on file. This form completed by: Name: Title:	of the facility the New Jived for the ferm care s	Courty of respital y which are cerersey Medicaid ull period of timeservices, the period Nurservices of the period	tified for participat Program. The far he covered by the erson signing th	ion in the New Jersey cility also certifies that New Jersey Medicaid is form certifies that
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1. 2. 3. VI.	Discharge Date: / /	of the facility the New Joved for the face services. TY WELFAL Address:y and Zip:	Courty of respital y which are cerersey Medicaid ull period of time services, the period of the per	tified for participat Program. The factor of the covered by the erson signing the mber: Date:	ion in the New Jersey cility also certifies that New Jersey Medicaid is form certifies that
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