Bureau of Elderly & Adult Services
Long Term Care
Nursing Facility Change of Status/Transfer/Discharge Form

Fax to: (603) 271-7985

Resident Name:	Last:	First:	MI:
Medicaid ID Number:		Facility:	
Phone Number:		Fax Number:	

Status of Change Notification – To be used only for current ICF Medicaid clients

Medicare Start Date: Medicare Stop Date:

Resume Medicaid status date: **Date of Death:**

Transfer from one New Hampshire nursing facility and/ or CFI to nursing facility

(New Notice of Medical Eligibility will be sent to new facility)

Name of nursing facility, or for CFI, date being transferred from:

Name of facility being transferred to:

Fax: Phone:

Date of transfer:

Change of date request: Original Medicaid start date approved:

Actual Medicaid start date:

Original discharge date from facility:

Actual discharge date from facility:

Discharge to Community (CFI program) –

Date entered Nursing Facility:

Anticipated or Actual Date Of Discharge to Community:

Community address:

Phone number (if known):

Facility Representative Signature _____ Date: _____

BEAS Representative Signature _____ Date: _____