Notification Regarding a Patient in a Long Term Care (LTC) Facility

Instructions

Skilled, nursing, and intermediate care for the intellectually disabled facility operators use this form to notify the Oklahoma Department of Human Services (DHS) each time a patient approved for SoonerCare (Medicaid) LTC benefits is admitted to or discharged from the facility, and when a patient wants to make a LTC application. This form is submitted within five-calendar days of admission or discharge.

DHS Information

Enter information regarding the DHS county office where you are sending this form:

DHS county office

Street address | City | State | ZIP code

Facility Information

Enter information regarding your facility:

Facility name | Phone number | Provider number

Street address | City | State | ZIP code

Patient Information

Enter patient information:

Patient name | Marital status | Gender | Date of birth

DHS case number | Client identification number | Social Security number

Race - check all that apply:

☐ American Indian or Alaska Native; when checked, tribe: _____

☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Patient's former street address | City | State | ZIP code

Admission Information

Enter admission information:

What date was the patient admitted to your facility? _____

Does the patient want to apply for SoonerCare (Medicaid)? ☐ Yes ☐ No ☐ Has applied

Is SoonerCare (Medicaid) financial eligibility approved for this patient? ☐ Yes ☐ No ☐ Unknown

Admission Type

Check the type of admission:

☐ Skilled facility When checked, answer questions below:

What date did the patient enter skilled care? _____

Is the patient in a Title XVIII certified skilled bed? ☐ Yes ☐ No

Will the patient remain in the facility when his or her skilled care days end? ☐ Yes ☐ No ☐ Unknown

☐ Nursing home care/Intermediate care admission

☐ Intermediate care for the intellectually disabled admission

☐ Returned from hospital When checked, enter hospital information:

_____
Hospital name

_____
Patient's physician

_____ _____ _____ _____
Physician's street address City State ZIP code

Patient's Immediate Previous Location

Check the appropriate box and answer questions, when indicated, regarding the patient's location immediately prior to this admission.

☐ a hospital

_____ _____
Hospital name Hospital admission date

☐ another nursing facility

☐ a skilled nursing facility

_____ _____
Skilled care admission date Date patient transferred to intermediate care

☐ his or her home

☐ other Explain: _____

Person to Contact for Information

Enter contact information for the patient's representative, such as a spouse, relative, or power of attorney, who can assist with the SoonerCare (Medicaid) application or renewal.

Name _____ Relationship to patient _____

Street address _____ City _____ State _____ ZIP code _____

Phone number _____ Legal guardian? ☐Yes ☐No Power of attorney? ☐Yes ☐No

Name _____ Relationship to patient _____

Street address _____ City _____ State _____ ZIP code _____

Phone number _____ Legal guardian? ☐Yes ☐No Power of attorney? ☐Yes ☐No

Discharge Information

Patient's name _____ Discharge date _____

☐ Discharged to: _____
Place name

☐ Entered hospital: _____
Hospital name

☐ Deceased: _____ _____
Date deceased When known, name of funeral home

Signature

Signature and title of person completing this form _____ Date _____

Routing Instructions

After completion, the facility retains a copy and sends another copy of the form to the local DHS county office no later than five-calendar days after a patient is admitted or discharged. When the recipient receives Supplemental Security Income, the facility also mails a copy of this form to the Social Security Administration Office.