State of California—Health and Human Services Agency

Department of Health Care Services

MEDI-CAL LONG-TERM CARE FACILITY ADMISSION AND DISCHARGE NOTIFICATION

(Instructions and distribution on reverse.)

I. COMPLETE THIS PORTION FOR ALL ACTIONS

Patient's name (last) (first) (MI)	Name of facility
Social security number	Address (number and street)
Note: Level of care is SNF/ICF unless checked here as board and care. ☐	City State ZIP code

II. COMPLETE THIS PORTION ONLY FOR ADMISSIONS

Medi-Cal ID number (taken from the Medi-Cal card)	Admission date (month/day/year)

A. Do you have Medicare Part A, Hospital Coverage?

☐ Yes ☐ No

B. Expected length of stay:

☐ At least one full month after the month of admission

☐ Less than one full month after the month of admission

C. Medi-Cal is expected to pay over 50% of facility cost of care.

☐ Yes, beginning with month of _____, 20__

☐ No, other insurance, private pay, etc.

D. Current income (check all applicable boxes):

☐ Supplemental Security Gold Checks

☐ Social Security Green Checks

☐ Other Income (i.e., railroad, military retirement, etc.)

☐ None

E. Admission from:

☐ Home ☐ Board and Care

☐ Household of another

☐ Acute Hospital—Home, B&C, other household immediately prior to acute

☐ Acute Hospital—SNF/ICF immediately prior to acute

☐ Acute Hospital extended stay—over 30 days

☐ Another SNF/ICF

F. If known, enter your address prior to facility admission. If admitted from an acute hospital, enter your address prior to the acute hospital admission. (Do not give the acute hospital's address.)

Address (number and street)

City State ZIP code

G. Signature of recipient or representative payee or family member/other:

Signature of recipient	Signature of Representative Payee	Phone number

If recipient's signature cannot be obtained, please indicate reason in this space.

Signature of family member/other (Indicate your relationship to the recipient.)	Phone number

III. COMPLETE THIS PORTION ONLY FOR DISCHARGES

A. Reason for discharge:

☐ Discharged to Acute Hospital

☐ Discharged to another SNF/ICF

☐ Discharged to residence/home of another

☐ Discharged to Board and Care

☐ Discharged to other

☐ Discharge due to death

B. Date of discharge (month/day/year)

C. Medi-Cal ID number (taken from the Medi-Cal card)

D. Complete the forwarding address for discharges other than death:

Name of facility (if not discharged home)

Address (number and street)

City State ZIP code

Facility representative signature	Date

I. General Instructions

This form is to be used for each admission and discharge. Please do not use this form for Medi-Cal reauthorizations.

II. Admission Instructions

A. Preparation

Prepare an original and two copies of this form for each SSI/SSP and/or Medi-Cal admission.

B. Distribution

Original: Send to your local social security office for recipients with aid codes 10, 20, and 60. Send to the county welfare department (see attached list) for all other aid codes.

Copy 1: Attach to the Treatment Authorization Request (TAR) and send to the Department of Care Health Services, Medi-Cal field office in your area. It will be forwarded by the Medi-Cal field office to the county welfare department.

Copy 2: Retain for your file.

III. Discharge Instructions

A. Preparation

Prepare an original and two copies of this form for each SSI/SSP and/or Medi-Cal discharge. Instead of completing a new form, use copy two of the form retained in your file as part of the admissions process. Complete Part III of the form (which becomes the original for the discharge process), and make two copies.

B. Distribution

Original: Send to the Medi-Cal field office.

Copy 1: Send to the county welfare department (see attached list).

Copy 2: Retain for your file.

IV. Explanation of over 50% of cost of care mentioned in item II.C. of this form.

Cost of care is the daily charge per patient excluding any additional services rendered to the patient which are billed separately by other providers (i.e., ambulance, physician, pharmacy, etc.).

For example, if the daily rate is $30 per day, the monthly charge for a 30-day month would be $900. If a patient enters the facility during the month of January, and is expected to stay at least one full calendar month after the month of admission (through February), a “YES” response would be indicated for item II.C. if Medi-Cal is expected to pay over $450 of the $900 charge for February.