



Printable Hospital Discharge Forms

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 PATIENT**

Type:
☐ Request PAS
☐ Notice of Admission
☐ Notice of Termination

I. PATIENT INFORMATION

1. Name: _____ (Last) _____ (First) _____
2. Social Security No.: _____ - _____ - _____
3. HSP (Medicaid) Case No.: _____
Confirmed By (CWA): ☐ Medicaid Only ☐ SSI 4. Date of Birth: ____/____/____
5. Sex: ☐ Female ☐ Male

II. PROVIDER INFORMATION

1. Provider Number: _____ 5. Provider Phone #: _____
2. LTCF Name: _____ 6. ☐ SCNF: _____
3. Address: _____
4. City, State, Zip: _____

III. REQUEST FOR PAS

☐ Private to Medicaid ☐ Medicaid Managed Care Terminated
☐ PASRR Exempt >30 Days ☐ ARC PAS
☐ PAS Exempt >20 Days ☐ Out of State Approval Admission
☐ Hospice Revoked ☐ Other _____

Date of Level I PASRR: _____

☐ Positive ☐ Negative

IV. ADMISSION INFORMATION

1. Admission Date: ____/____/____
2. Date of PAS, if applicable: ____/____/____ ☐ Track 1 ☐ Track 2
3. Admitted from: ☐ Community/Boarding Home ☐ Medicare to Medicaid ☐ Psychiatric Hospital
☐ Private to Medicaid - anticipated Medicaid effective date: ____/____/____
☐ Hospital ☐ Other LTCF ☐ Other (specify): _____
4. Name of Hospital/LTCF: _____ Admission Date: ____/____/____
Address: _____
5. If admitted from Hospital/LTCF, give the name/address of previous residence (Hospital Name and Address or Home Address): _____

V. TERMINATION INFORMATION

1. Discharge Date: ____/____/____
2. Discharged to:
☐ Home-Community (including relative's home)/ County of residence: _____
☐ Facility Name: _____ County of NJ: _____
☐ Other (specify): _____ County of residence: _____
Telephone Number of Discharge Site: _____
3. Death (Date): ____/____/____ ☐ In LTCF ☐ In Hospital

VI. CERTIFICATION

The facility certifies that the patient will reside only in those areas of the facility which are certified for participation in the New Jersey Medicaid Program at the level of care authorized for this patient by the New Jersey Medicaid Program. The facility also certifies that upon discharge to a hospital, the patient's room/bed will be reserved for the full period of time covered by the New Jersey Medicaid Bed Reserve Policy. If nursing facility bills Medicaid for long term care services, the person signing this form certifies that the facility has a valid PAS on file.

This form completed by:

Name: _____ Phone Number: _____
Title: _____ Date: _____

VII. CWA USE ONLY

Medicaid Effective Date: ____/____/____
☐ Medicaid ONLY (PA-3L Attached)
☐ SSI Only (PA-3L Required, Contact DHSS)
☐ Not Eligible
☐ Transcript Requested - Date: ____/____/____
Remarks: _____
Name of Case Worker: _____ Date: _____

COUNTY WELFARE OFFICE

Street Address: _____
City and Zip: _____

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J Elliott



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