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.: _____ - ___
4. Date of Birth: ___ / ___ / ___
5. Sex: ☐ Female ☐ Male

Confirmed By (CWA): _____ ☐ Medicaid Only ☐ SSI

II. PROVIDER INFORMATION

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

III. REQUEST FOR PAS

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

Date of Level I PASSR: _____
☐ 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 NF: _____
   ☐ 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: ___ / ___ / ___

COUNTY WELFARE OFFICE: _____
Street Address: _____
City and Zip: _____
Remarks: _____
Name of Case Worker: _____ Date: _____

LTC-2
SEP 10

Original-CWA Copy-LTCFO Copy-Provider

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