NM5

To: Pre Admission Screening
From: (name of submitter) ______________________________________
Facility___________________________Date of submission: __________
Phone number of facility: ____________________

PLEASE COMPLETE THE FOLLOWING:

Name of Resident: ____
Home Address: ____
DOB: __________________ SSN: ___-__-____
Medicare # _______________ Medicaid # ___________________
Male ____ Female ____ Date of admission to the NF: _________

Authorized Representative's name: _____________________________________
Relationship: ____
Mailing Address: ____
Phone Number: ________________________

- LTCC notification for expiration of a time limited stay/determination

  ________ Convalescent – has exceeded 29 day length of stay
  ________ Categorical – has exceeded 14 day respite stay
  ________ Categorical – has exceeded 7 day emergency stay

Please check the following if applicable:
______ Resident is Hospice enrolled
______ Resident is expected to be in the NF for less than 90 days
______ Resident is covered by Medicare, Medicaid HMO, or other private insurance
______ Resident will not deplete funds in the next 6 months
______ Resident does not have support in the community to return home

COA office completes:

Action Taken:
Date:

8/07