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: