New Jersey Department of Human Services
Division of Aging Services

NOTIFICATION FROM LONG-TERM CARE FACILITY
ADMISSION OR TERMINATION OF A MEDICAID BENEFICIARY

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

I. PATIENT INFORMATION

1. Name: ______________________ *(Last)* *(First)*
2. Social Security No.: ________ - ______ - ________
3. Sex: ☐ Female ☐ Male
4. Date of Birth __ / __ / ____
5. HSP# (Medicaid) Case No. if applicable: ____________

Confirmed By (CWA): __________ ☐ NJ Family Care ☐ MLTSS ☐MCO: ____________

II. PROVIDER INFORMATION

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

III. PASRR STATUS (COMPLETE FOR ALL NEW ADMISSIONS)

1. Date of PASRR Level I ____ / ____ / ____
2. Outcome of PASRR Level I Screen – For Positive Screens Check all that Apply
   - ☐ Negative ____________________
   - ☐ Positive: ☐ MI ☐ ID/DDD ☐ MI and ID/DDD ☐ 30-Day Exempted Hospital Discharge ☐ Categorical
3. If Positive, Date of PASRR Level II Evaluation: ____ / ____ / ____

   Outcome of PASRR Level II Evaluation - Client Needs Specialized Services: ☐ Yes ☐ No

IV. REQUEST FOR PAS

☐ Private to Medicaid
☐ PAS Exempt >20 Days
☐ Medicare to Medicaid
☐ SCNF to NF
☐ NF to SCNF
☐ Out of State Approval Admission
☐ Transfer
☐ E-ARC PAS
☐ Other: ____________________

V. ADMISSION INFORMATION

1. Admission Date: ____ / ____ / ____
2. Date of PAS, if applicable: ____ / ____ / ____
3. Admitted from: ☐ Community/Boarding Home ☐ Psychiatric Hospital
   - ☐ Private to Medicaid - Anticipated Medicaid Effective Date: ____ / ____ / ____
   - ☐ Hospital ☐ Other LTCF ☐ Other ____________________
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):

   ____

VI. 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

VII. 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: ____________

VIII. CWA USE ONLY

Medicaid Effective Date: ____ / ____ / ____
☐ Medicaid ONLY (PR-1 Attached)
☐ SSI Only (PR-1 Required, Contact DHS)
☐ Not Eligible
☐ Transcript Requested - Date: ____ / ____ / ____

COUNTY WELFARE OFFICE ____________
Street Address: ____________
City and Zip: ____________

Remarks: ____________
Name of Case Worker: ____________ Date: ____________