LONG TERM CARE ACTIVITY REPORT

□ Community MA □ Waiver

For Agency Use Only
Date Received
Control No.
Due Date
Completed

TO: Receiving Agency______________________________________
Address ____
____

FROM: Name of Provider ______________________________________
Address____
____

Medicaid Provider ID_______________________ CARES Vendor ID________________________
Contact Name_________________________________ Telephone_________________________

PROVIDER TYPE □ Nursing Facility □ Chronic/Special Hospital □ Medical Day Care Center □ Other__________________

RECIPIENT INFORMATION

Name ____ Sex □ M □ F Date of Birth ______________

Medicare Claim No. ___________________________ MD Medicaid No. ____

Representative____ Phone________________________________

Address____

ACTION REQUESTED - COMPLETE EITHER BOX A OR B AS APPROPRIATE, AND PRINT AND SIGN NAME/DATE

* *

A. Begin Payment Admission Date_____________ Private pay rate__________

Check all that apply - both beginning and ending pay dates must be completed when requested. NOTE: Actions marked with "*" require Utilization Control Agent/DHMH certification

1. □ *Full MA coverage Begin pay date_______________ For MDC only □ Initial □ Continued
2. □ Medicare A co-payment Begin pay date ___________ End pay date _____________
3. □ Bed reservations for Medicare full coverage period Begin pay date_____________ End pay date______________
4. □ *Revocation of Hospice care and return to NF care Effective date_____________

* *

B. Cancel Payment

1. □ Discharged to □ Another Provider □ Community □ Hospice Date of Discharge ________________

   If discharged to another provider, name of provider ____

2. □ Death – Date of Death ____________________

* *

Administrator/Designee Signature____ Date_______________________

Print Name of Administrator/Designee____________________________________ Title___________________________

Level of Care Certification (For UCA/DHMH Use Only)

The above named recipient is certified for the following level of care (check one):

□ Chronic/Special Hospital □ Nursing Facility Effective Dates _______________ through_________________

___________________________________ ____ _____________________

Utilization Control Agent/DHMH Authorized Signature M/D/YYYY

DHMH 257 (Revised 4/2011)

AGENCY/UCA/PROVIDER COPY