

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

| Request PAS |
|-----------------------|
| Notice of Admission |
| Notice of Termination |

| PATIENT INFORMATION | | | |
|---|---|--|---|
| I. Name: | | 2. Social Security | No.: |
| (East) | (Firesc) | | |
| HSP (Medicaid) Case No.: | | 4. Date of Birth: | ☐ Fernale ☐ Male |
| Confirmed By (CWA): | ☐ Medicald Only | SSI 5. Sex. | ☐ Fernale ☐ Male |
| I. PROVIDER INFORMATION | | | |
| Provider Number: | | 5. Provider Phon | e #: |
| 2. LTCF Name: | | 6. SONF: | |
| I. Address: | | | |
| City, State, Zip: | | | |
| II. REQUEST FOR PAS | | | |
| | Medicald Managed Ca | are Terminated | Date of Level I PASSR: |
| | ARC PAS | - Committee of the last | |
| | Out of State Approval | | Positive Negative |
| | Other | | |
| V. ADMISSION INFORMATION | | 2.00.2 | |
| Admission Date:// Date of PAS, if applicable:/ Admitted from://// Admitted from:///// | | | |
| Date of PAS, if applicable:/ | | nack 1 Track 2 | |
| | | | ☐ Psychiatric Hospital |
| Private to Medicaid - anticipated Med | licald effective date: | | |
| ☐Hospital ☐Other LTCF | Dither (specify): | | |
| . Name of Hospital/LTCF: | Sept. 200 300 3000 | Ad | mission Date: / / / |
| Address: | | | |
| If admitted from Hospital/LTCF, give the | name/address of previ | lous residence (Hospital N | iame and Address or Home Address): |
| | | | |
| | | | |
| | | | |
| , Discharge Date: / / / | _ | | |
| Discharge Date: / / / / / / / / / / / / / / / / / / / | | | |
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| Discharge Date: / / Discharged to: // / Discharged to: // / Pacility Name: | s borne)/ County of res | Cou | nty of NF: |
| Discharge Date: / / / Discharged to: Home-Community (including relative) Facility Name: Other (specify): | s borne)/ County of res | Cou | nty of NF : |
| Discharge Date: / / / Discharged to: Home-Community (including relative) Facility Name: Other (specify): | s homely County of res | County of r | nty of NF: |
| Discharge Date: / / / Discharged to: / / Discharged to: Home-Community (including relative) | s homely County of res | Cou | mity of NE: |
| ☐Facility Name: ☐Other (specify): | s homely County of res | County of r | ety of NF: esidence: |
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| Discharge Date: / / / Discharged to: Home-Community (including relative's Facility Name: Other (specify): Telephone Number of Discharge Site Death (Date): / / | bomel/ County of res | Country of r Count | esidence: chilied for participation in the New Jersey I Program. The facility also certifies tha ne covered by the New Jersey Medical person signing this form certifies that amber: |
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