

**Restricted Medicaid Coverage Period Determination**

Case Number	Date
Case Name	County
Street Address	Average Private Pay Rate (monthly)
City, State, Zip Code	Beginning Date of Medicaid Eligibility

**Improper Transfer(s)\***

Date of Transfer	Owner (at time of transfer)	Item Transferred	Amount of Transfer

\*Use back of form for additional improper transfers Total Amount Transferred \$ \_\_\_\_\_  
(Include Transfers from Back of Form)

**Transfers on or after February 8, 2006**

**Step 1**

(a) Total amount transferred \$ \_\_\_\_\_  
 (b) Divide by average private pay rate ÷ \$ \_\_\_\_\_  
 (c) Number of months in penalty period = \$ \_\_\_\_\_

**Step 2**

(a) Average private pay rate \$ \_\_\_\_\_  
 (b) Multiply by number of whole months from Step 1(c) x \$ \_\_\_\_\_  
 (c) Penalty amount for whole months = \$ \_\_\_\_\_

**Step 3**

(a) Total amount transferred from Step 1(a) \$ \_\_\_\_\_  
 (b) Subtract the amount in Step 2(c) - \$ \_\_\_\_\_  
 (c) Remaining partial month penalty amount = \$ \_\_\_\_\_

**Step 4**

Add the amount in Step 3(c) to the patient liability budget for the final month of restricted coverage.

Restricted Coverage Period

\_\_\_\_\_ thru \_\_\_\_\_  
 First Full Month/Year Last Full Month/Year Final (Partial) Month/Year

Eligibility Worker	District/ID	Telephone Number
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