

Ohio Department of Medicaid
FACILITY COMMUNICATION

Required fields are marked with an asterisk (*). Only the required fields within the section that is being completed by the submitter must be answered.

I. RESIDENT INFORMATION			
First Name*	Last Name*		Middle Initial
Medicaid Number <i>(12 digits)</i>		Social Security Number*	
If individual does not have a Medicaid Number, has a Medicaid application been submitted? <input type="checkbox"/> Yes <i>(provide application date)</i> <input type="checkbox"/> No <input type="checkbox"/> Unknown		Application Date <i>(mm/dd/yyyy)</i>	
Authorized Representative or Contact Person		Relationship to Resident	
Address			Apartment/Unit Number
City	State	Zip Code	Telephone Number
II. FACILITY INFORMATION - ADMISSION			
Admission Date <i>(mm/dd/yyyy)*</i>		Level of Care (LOC) Exemption?* <i>(e.g. hospice enrollment or Medicare Part A stay)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Level of Care (LOC) Validation Request?* <input type="checkbox"/> Yes <i>(if yes, select the type)</i> <input type="checkbox"/> No		Type of LOC Validation Request* <input type="checkbox"/> Waiver <input type="checkbox"/> Readmission <i>(same NF) after hospitalization (bed-hold days not exhausted)</i>	
Facility Name*			
Street Address			Building Number
City	State	Zip Code	Facility Telephone Number
III. FACILITY INFORMATION - UPDATE			
Date of Discharge* <i>(mm/dd/yyyy)</i>			
Reason for Discharge* <input type="checkbox"/> Waiver Enrollment <input type="checkbox"/> NF to NF Transfer <input type="checkbox"/> Hospital <i>(out of bed-hold days)</i> <input type="checkbox"/> Other: <input type="checkbox"/> Assisted Living Waiver Enrollment <input type="checkbox"/> Home/Community <input type="checkbox"/> Death			
IV. RESIDENT INFORMATION - UPDATE			
Date of Death* <i>(mm/dd/yyyy)</i>	Change of Income <i>(attach verification)</i> <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	Amount \$	Effective Date of Change <i>(mm/dd/yyyy)</i>
Type of Lump Sum <i>(i.e. Social Security, Railroad Retirement, Sale of Property, Insurance Payment)</i>		Date Lump Sum Received <i>(mm/dd/yyyy)</i>	
Resident's Personal Needs Account (PNA) \$		Effective date of PNA <i>(mm/dd/yyyy)</i>	
Other Comments or Requests for CDJFS:			
V. SUBMITTER INFORMATION			
Submitter Name* <i>(First and Last)</i>	Facility Name*		Medicaid Provider Number* <i>(7-9 digits)</i>
Email Address*	Telephone Number*		Date* <i>(mm/dd/yyyy)</i>

The following information should be completed by the county department of job and family services and returned to the submitter.

VI. COUNTY INFORMATION		
County Name		County Email Address
Resident Name*		Medicaid Number*
Medicaid Status <input type="checkbox"/> Approved <input type="checkbox"/> Changed <input type="checkbox"/> Denied <input type="checkbox"/> Discontinued		Status Begin Date (mm/dd/yyyy)
		Status End Date (mm/dd/yyyy)
Medicaid Type <input type="checkbox"/> Medicaid <input type="checkbox"/> Restricted Medicaid Coverage Period <input type="checkbox"/> Managed Care		Type Begin Date (mm/dd/yyyy)
		Type End Date (mm/dd/yyyy)
Pro-rated Patient Liability Amount \$		Begin Date (mm/dd/yyyy) End Date (mm/dd/yyyy)
Patient Liability Amount \$		Begin Date (mm/dd/yyyy) End Date (mm/dd/yyyy)
Lump Sum Amount \$	Qualified Medicare Beneficiary (QMB) Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No	QMB Effective Date (mm/dd/yyyy)
State Hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of State Hearing (mm/dd/yyyy)	Appeal Number
Comments		
CDJFS Worker Signature		Telephone Number Date (mm/dd/yyyy)

Instructions for submitting the form:

SECTION COMPLETED	CIRCUMSTANCE	WHERE TO SUBMIT
Section II: Facility Information – Admission	New Medicaid Applicant	NF shall submit the form right away to the PAA within their region
	Admission of a resident from another facility (NF-to-NF transfer)	
	Request LOC validation on form (waiver enrollee or readmission to same NF)	
Section II: Facility Information – Admission	Medicaid Fee-For-Service (FFS) resident whose NF stay has exceeded 90 days	NF shall submit the form to the PAA in their region on day 90
Section III: Facility Information – Update	Any time Section III is completed	NF shall submit the form right away to ODM via secure email (NFStay@medicaid.ohio.gov) or FAX to 614-466-6945 or 614-387-7661
Section IV: Resident Information – Update	Any time Section IV is completed	NF shall submit the ODM 09401 right away to the CDJFS (Nursing Home Section)