

Ohio Department of Medicaid
INSTRUCTIONS FOR FACILITY COMPLETION OF ODM 09401, FACILITY COMMUNICATION

GENERAL INSTRUCTIONS

The ODM 09401 is to be used only for nursing facility (NF) Fee-For-Service (FFS) stays greater than 90 days, for new Medicaid applicants requesting Medicaid payment for their facility stay, for discharges and deaths of residents, and for NFs, Intermediate Care Facilities for Individuals with Disabilities or Developmental Centers to communicate change in income information to the county department of job and family services (CDJFS).

Section I. RESIDENT INFORMATION - Communicate basic information about the individual residing in the NF. This section must be completed when any other section of the form is completed.

- Enter the resident’s **First Name, Last Name and Middle Initial** in the appropriate boxes.
- Enter individual’s **Medicaid Number** (twelve digits). **If the individual does not have a Medicaid number, indicate whether a Medicaid application has been submitted** and the **Application Date** (if known) using mm/dd/yyyy format.
- Enter individual’s **Social Security Number** (XXX-XX-XXXX) if known.
- Indicate if the individual has an **Authorized Representative** and enter what the **Relationship to the Resident** is for the authorized representative. Enter the contact information for the authorized representative including **Address, Apartment/Unit Number, City, State, Zip Code and Telephone Number**.

Section II. FACILITY INFORMATION – ADMISSION - Communicate NF admission data to the PASSPORT Administrative Agency (PAA) when the individual’s NF stay has exceeded 90 days, when the individual is transferring from another NF, or when the individual has applied for Medicaid in order for Medicaid to pay for the NF stay. When an individual has applied for Medicaid or is transferring from another NF, the admitting NF should submit the admission section of this form to the PAA regardless of the expected length of stay.

- Enter **Admission Date** using mm/dd/yyyy format.
- Indicate if the ODM 9401 is being submitted to indicate a **Level of Care (LOC) Exemption**. This should be checked “yes” when the individual is being admitted to the NF for hospice, a Medicare Part A stay, or any other exemption listed on the *Most Common Scenarios Chart* here: <http://medicaid.ohio.gov/Portals/Providers/ProviderTypes/LongTermCare/MostCommonScenarios.pdf>
- Indicate if the NF is requesting a **Level of Care Validation**. If yes, select the **Type of Validation Request**.
- Enter information about the NF the individual is residing including, **Facility name, Street Address, Building or Unit Number, City, State, Zip Code and Facility Telephone Number**.

Section III. FACILITY INFORMATION – UPDATE - Communicate discharge information to the Ohio Department of Medicaid (ODM) including date of discharge and reason for discharge.

- Enter **Date of Discharge** using mm/dd/yyyy format.
- Select the **Reason for Discharge** from the options listed on the form.

Section IV. RESIDENT INFORMATION – UPDATE – Communicate date of death and/or change of income information to the CDJFS in order to calculate or recalculate the individual’s patient liability amount.

- If applicable, enter individual’s **Date of Death** using mm/dd/yyyy format.
- Indicate if the individual has had a **Change of Income** (either increase or decrease) and attach verification of the new income amount. Enter the **Amount** of the change in income and the **Effective Date of Change**.
- Enter the **Type of Lump Sum** received and the **Date Lump Sum Received**.
- Enter the change in amount the **Resident’s Personal Needs Account (PNA)** balance (if applicable) and enter the **Effective Date of PNA** change. *Report changes to the PNA when it is within \$200 of the Medicaid resource limit.*

Section V. SUBMITTER INFORMATION – Communicate information about the individual submitting the form. This section must be completed when any other section of the form is completed.

- Enter information about the submitter of the form including **Submitter Name** (first and last), **Facility Name, Medicaid Provider Number** (7-9 digits), **Email Address, Telephone Number and Date**.

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 9401 right away to the CDJFS.