ADMISSION AND EVALUATION DATA

Medicare Admission Date_____ Medicaid Admission Date_____

Date of Death_____ Medicaid Discharge Date_____

If no Medicare Days are used provide reason(s): _____

_____ NPI Number _____
Name of Facility

_____ Telephone Number _____
Address of Facility

_____ _____ _____ Female____ Male____
Patient's First Name M.I. Patient's Last Name

Birth Date ____ /____ /_____ Medicaid Number# _____- _____- _____- _____ -___

_____**New Admission** ____**Re-Admission** ____**Transfer Admission From** _____

_____ Spend Down From Date ____ /____ /_____ To Date ____ /____ /_____

Diagnosis and Pertinent Medical Information (include medical documentation)

Medications including: route, dosage, time, treatment, diet, etc. (include medication list for the month of Medicaid admit)

Please indicate the criteria, (a. through k 1-9) the recipient meets for nursing facility care as per the Administrative Code Chapter 10, Rule Number 560-X-10-10. The criteria are listed on the Admission Criteria sheet. The nursing facility record must validate the criteria listed for the effective MEDICAID admission date appearing on this form.

Medical Criteria Met: _____

CERTIFICATION:
I certify this resident requires nursing facility care effective on the admission date appearing on this form.

_____ _____
Authorized Printed Name & Credentials Authorized Signature & Credentials

NOTE: The nurse practitioner or physician assistant cannot be employed by the facility. See number 16 in Instructions for Completion of Revised Form 161 sheet.

_____
Facility Registered Nurse Reviewer Signature & Date