FACILITY NOTIFICATION INFORMATION SHEET

Save Print Reset

FROM (FACILITY NAME):	TO:
FACILITY CONTACT PERSON:	ATTN: NURSING HOME UNIT
FACILITY PHONE:	FSD FAX:
FACILITY FAX:	FACILITY ADDRESS:

Resident's Name: Date of Birth:

Spouse's Name: Date of Marriage

Social Security Number: DCN (if known):

NOTIFICATION AND DATE OF: (Please write date of event in appropriate space below.)

Date of Admission Date of Discharge Date of Death

NEW ADMISSION: (Please complete 1-4 for all admissions, and 5 or 6 if applicable.)

1. Admitted from? Home: Hospital: Other Facility:

2. Date DA-124 sent to COMRU: **3**. Date entered a Medicaid-certified bed:

4. Placement (please check one): SNF ICF RCF I ALF/RCF II DMH

5. If RCF or ALF monthly base rate for resident:

6. Guardian or Responsible Party and relationship:

Address:

Phone:

DISCHARGE: (Please complete 1 or 2.)

1. New facility – facility name and city:

2. Other living arrangement – individual's current address and telephone number:

If requesting a review or adjustment to surplus, please explain below:

IM 72 FNIS (08/20)

For FSD Use
Assigned to: _____ Date Assigned: _____ Due Date: _____