**Nursing Facility Notice of Action**

To be completed by nursing facility or DDA institution.

TO: Classic Medicaid cases FAX to DSHS: 1-855-635-8305
MAGI Medicaid cases FAX to: 1-866-841-2267
Health Care Authority (HCA) claims processing NF unit. Codes for classic and MAGI programs are in the 15-031 instructions.

### Section I: Type of Action

- 1. Discharged/transferred
- 2. Deceased
- 3. Social/therapeutic leave exceeds 18 days in calendar year
- 4. Change in payment status (includes Medicare to Medicaid, Managed Care admission and end dates, Hospice, etc.)
- 5. Readmit to Title XIX certified facility from hospitalization
- 6. Admit

#### IF DISCHARGED OR DECEASED CHECKED, COMPLETE THE FOLLOWING INFORMATION:

<table>
<thead>
<tr>
<th>AMOUNT OF REFUND</th>
<th>NAME ON REFUND</th>
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### Section II: Transfer / Discharge Information

- 1. Home
- 2. Hospital
- 3. Nursing Facility
- 4. Assisted Living
- 5. Institution - DDA ICF – IID, DDA state facility (RHC)
- 6. Away without leave
- 7. Adult Family Home
- 8. DDA ICF – IID Group Home
- 9. Hospice / Hospice Care Center
- 10. Other (specify):

#### NAME OF NEW FACILITY

<table>
<thead>
<tr>
<th>TELEPHONE NUMBER (INCLUDE AREA CODE)</th>
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<table>
<thead>
<tr>
<th>STREET ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
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<tr>
<th>MAILING ADDRESS, IF DIFFERENT FROM ABOVE</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
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### Section III: Reason for Action; Indicate Date:

- 1. Apple Health Managed Care rehabilitation / skilled nursing - admission / start date
- 2. Apple Health Managed Care rehabilitation / skilled nursing - coverage ends or prior authorization ends
- 3. Hospice admission / election (indicate hospice agency information in comments)
- 4. Hospice revocation
- 5. Private pay to Medicaid
- 6. Medicare to Medicaid
- 7. Medicaid to private pay
- 8. Medicaid to Medicare
- 9. Not in need of Nursing Facility Care

### Section IV: Comments

<table>
<thead>
<tr>
<th>NURSING FACILITY REPRESENTATIVE</th>
<th>DATE</th>
<th>TELEPHONE NUMBER (INCLUDE AREA CODE)</th>
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<table>
<thead>
<tr>
<th>NAME OF FACILITY REPORTING THE CHANGE</th>
<th>TELEPHONE NUMBER (INCLUDE AREA CODE)</th>
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Nursing Facility Notice of Action
DSHS 15-031

Instructions

This form is used by Nursing Facilities (NF) or Developmental Disabilities Administration (DDA) institutions to report changes to the DSHS financial worker on active Medicaid clients. Reporting changes promptly will enable correct eligibility and award letters and alert the DSHS financial worker of discharges and change in status. This form is also used by the HCA NF billing unit on active modified adjusted gross income (MAGI) clients. Do not submit this form without indicating an ACES client ID. All active Medicaid clients will have an ACES client ID and the medical coverage group in the provider inquiry function in Provider One. Forms submitted without an ACES client ID will not be processed. It is important to indicate the facility name and address as facilities have the same or similar names. Indicate the effective date of the change. For additional instructions and medical coverage group desk tool, consult the NF provider billing guide.

The NF is required to get pre-approval from the Managed Care Organization (MCO) if the Medicaid client is active with a MCO or was in an MCO at the time of hospital/facility admission.

DSHS staff determines eligibility for “Classic” Medicaid programs. FAX this form to DSHS at 1-855-635-8305 when a client is active on one of the following medical coverage groups: A01, A05, D01, D02, D26, G03, G95, G99, L01, L02, L04, L21, L22, L24, L31, L32, L41, L42, L51, L52, L95, L99, S01, S02, S08, S95, S99 And T02. HCA maintains eligibility for MAGI Medicaid authorized through the Health Benefit Exchange (HBE). FAX this form to the HCA claims processing NF unit 1-866-841-2267 when the client is active under the following medical coverage groups: N01, N02, N03, N05, N10, N11, N13, N23, N31, or N33. HCA also maintains the K01, K95, and K99.

Do not use this form to request a social service assessment from Home and Community Services (HCS). This form is used to report changes to the financial worker that may affect Medicaid eligibility. The DSHS 10-570 Intake and Referral request form is used to request a social service assessment.

https://www.dshs.wa.gov/sites/default/files/FSA/forms/word/10-570.docx. Contact the HCS social service intake line to request an assessment for discharge services in the community. (See below.)

• REGION 1 – Pend Oreille, Stevens, Ferry, Okanogan, Chelan, Douglas, Grant, Lincoln, Spokane, Adams, Whitman, Klickitat, Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield and Asotin: 509-568-3767 or 1-866-323-9409; FAX 509-568-3772
• Region 2 South HCS - King County 206-341-7750 or FAX 206-373-6855.
• Region 3 HCS - Pierce, Kitsap, Thurston, Mason, Lewis, Grays Harbor, Pacific, Cowlitz, Clark, Clallam, Jefferson, Skamania, and Wahkiakum, counties 1-800-786-3799 or FAX 1-855-635-8305.

Section I: Type of Action
• Select the appropriate box
• For boxes 2 through 6 enter the effective date the action took place

Section II: Transfer / Discharge Information
• If you selected box 1 in section one then:
  o Select appropriate box
  o Enter the effective date the action took place

Section III: Reason for Action
• Enter the effective date the action happened
• Select appropriate box

Section IV: Comments
Enter any comments to clarify the actions marked in section one through three.

NURSING FACILITY NOTICE OF ACTION
DSHS 15-031 (REV. 01/2018)