NURSING HOME FAX COVER SHEET

Date:

TO:

PREADMISSION REVIEW PHONE:_____

TOLL FREE:_____

INTAKE/SCREENING PHONE:_____

PAR FAX NUMBER:_____

FROM:

Facility Name:_____
Contact Person:_____
Phone Number:_____
Fax Number:_____
Client Name:_____

(PLEASE PRINT CLIENT'S NAME ON EACH PAGE)

REQUESTING: **For Non-Medicaid Individuals**
(Please check one)

_____ Expired respite stay, needs assessment
_____ Expired convalescent stay, needs assessment
_____ New admission from community
_____ Transfer or readmission with substantial improvement, needs assessment
_____ Other
(explain)_____
_____

For Medicaid Individuals

_____ New admission from community
_____ Change of vendor payment
_____ LOC for NF-to-NF transfer
_____ Other
(explain)_____
_____

REFAXING

ADDITIONAL INFO. Requested by:_____