

FACILITY ADMISSION NOTICE (MSA-2565-C)

INSTRUCTIONS

GENERAL INSTRUCTIONS/DISTRIBUTION:

- The MSA-2565-C serves as notice of admission of a beneficiary (or potential beneficiary). It must be completed for potentially eligible Medicaid beneficiaries of all ages.
- The facility must retain **THE ORIGINAL** of the Facility Admission Notice in the beneficiary's file. A copy **MUST** be sent to the Local DHS Office.
- A copy of the MSA-2565-C will be returned to the facility, noting the eligibility status and patient pay amount of the resident.

Authority: P.A. 280 of 1939 and Federal 42 CFR of 435
Title XIX of the Social Security Act

Completion: Is Voluntary

Penalty: None, but a medical eligibility determination would be delayed

The Michigan Department of Community Health is an equality opportunity employer,
services and programs provider.

Michigan Department of Community Health
FACILITY ADMISSION NOTICE

1. Patient Name (Last, First, Middle)			2. Gender <input type="checkbox"/> M <input type="checkbox"/> F		3. Birth Date / /		4. Social Security No. - -			
5. Home Address (No. & Street including apartment number)				City			State	Zip Code		
6. Name of Person Responsible for Patient (Last, First, Middle)				7. Phone No. () -			8. Relationship to Patient			
9. Home Address (No. & Street including apartment number)				City			State	Zip Code		
10. Name of Provider				12. a National Provider ID Number.			12. b Provider I.D. Number			
11. Provider Address (No. & Street)				13. Attending Physician Name						
City		State	Zip Code	14. Hospital Case No. (If Applicable)						
15. Type of Facility (Check ONE)										
<input type="checkbox"/> Hospital			<input type="checkbox"/> Long Term Care (in Hospital)			<input type="checkbox"/> Nursing Facility		<input type="checkbox"/> ICF/MR Care (in AIS Facility)		
<input type="checkbox"/> Special MR Nursing Facility			<input type="checkbox"/> ICF/MR Care (in DCH Facility)			<input type="checkbox"/> Medical Care Facility		<input type="checkbox"/> Psychiatric Care (in DCH Facility)		
<input type="checkbox"/> Other (Explain) _____										
16. Date of Admission / /			17. If LTC Facility, Specify Private Rate \$ _____ per diem amount			18. Is this Admission Likely to be 30 days or Longer? <input type="checkbox"/> NO <input type="checkbox"/> YES (If YES, Estimate Total Length of Stay) _____				
19. Present Status of Patient (Check ONE)										
<input type="checkbox"/> Still a Patient			<input type="checkbox"/> Discharged (Date): / /			<input type="checkbox"/> Deceased (Date): / /				
20. Primary Diagnosis				21. Secondary Diagnosis						
22. Patient Admitted to Facility From: (Check ONE)										
<input type="checkbox"/> Home			<input type="checkbox"/> Long Term Care Facility/Unit			<input type="checkbox"/> AFC/ Home for the Aged		<input type="checkbox"/> Other (Specify) _____		
<input type="checkbox"/> Hospital (Enter applicable dates)			Admission Date / /			Discharge Date / /				
23. Indicate Medicare or Private Health Insurance coverage available to patient and complete the following as applicable										
<input type="checkbox"/> Medicare			<input type="checkbox"/> No Other Insurance Coverage Available							
<input type="checkbox"/> Private Health Insurance (Complete Items 24 thru 29 below)			<input type="checkbox"/> Private LTC Coverage (Complete Items 30 thru 35 below)							
24. Name of Policyholder (Private Health Ins.)			25. Policyholder's SS No. - -		30. Name of Policyholder (Private LTC Ins.)			31. Policyholder's SS No. - -		
26. Name of Insurance Company				32. Name of Insurance Company						
27. Location (City)		State	Zip Code	33. Location (City)			State	Zip Code		
28. Group / Policy Number			29. Cert. / Contract No.		34. Group / Policy Number			35. Cert. / Contract No.		
PATIENT CERTIFICATION										
I certify that the information furnished by me in applying for skilled nursing facility, other long term care, or hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in section 10 above, the name(s) and address (es) of all parties liable or who may be liable in whole or in part for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible in whole or in part for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.										
36. Signature of Patient or Patient's Representative				Date Signed / /		37. Signature of Person Completing This Form			Date Signed / /	

STATEMENT OF ELIGIBILITY (To be completed by MDCH / DHS for MA eligibility)

Eligibility is:									
<input type="checkbox"/> DENIED (Contact Patient or Patient's Representative for Explanation)					<input type="checkbox"/> APPROVED (See the Billing Information Below)				
Eligible Person's Name				Program		Grantee Name			
Recipient ID No.		MA Eligibility Effective Date			Grantee Client ID No.		FIA Case No.		
Patient Pay Amount \$		Patient Pay Amt. Effective Date			County	District	Section	Unit	Worker Name
Insurance, Medicare, Third Party Name					Signature of Worker				