

**REQUEST FOR AUTHORIZATION OF PRIVATE ROOM
SUPPLEMENTAL PAYMENT FOR NURSING FACILITY**

Michigan Department of Health and Human Services

This is my written request for authorization of supplemental payment for a single room for:

Name of Beneficiary/Resident	Medicaid ID Number
Facility Contact	Facility Telephone Number - -
Facility Name	Facility Fax Number - -
Facility Address	

The basis for this request is:

<input type="checkbox"/> I believe a single room is medically necessary. (If medically necessary, the Medicaid daily rate already pays for a single room.)
<input type="checkbox"/> I believe a single room is not medically necessary, but is needed for the following reason(s): _____ _____

I understand that I must accept responsibility for paying the difference between the facility's two-person room and single room rates that are listed below. I will pay any difference in the rates that may change over time, as long as a single room is needed.

Two-person room rate: \$ _____ per day

Single room rate: \$ _____ per day

Printed Name of Requestor	Telephone Number - -
Address	Relationship to Beneficiary/Resident

Signature of Requester	Date
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MAIL TO: Long Term Care Policy Section
Michigan Department of Health and Human Services
PO Box 30479
Lansing, MI 48909-7979

FAX TO: 517-241-0066

Note: If no response is received within 10 working days, contact 517-241-4079.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.