



|                                   |
|-----------------------------------|
| Date: _____                       |
| Case name: _____                  |
| Case number: _____                |
| County number: _____              |
| Supervisor/worker number: __ / __ |

**Notification Regarding Patient in a Nursing Facility (NF), Intermediate Care Facility for the Mentally Retarded (ICF/MR), or Hospice**

|       |  |                                   |       |                 |
|-------|--|-----------------------------------|-------|-----------------|
| TO:   | Oklahoma Department of Human Services (OKDHS) local office |                                   |       |                 |
|       | Street address   | City                              | State | Zip             |
| FROM: | Facility   |                                   |       | Provider number |
|       | Street address   | City                              | State | Zip             |
| RE:   | Name of patient  | Client identification (ID) number |       | Case number     |
|       | Former street address                                      | City                              | State | Zip             |
|       | Social Security or health insurance benefit (HIB) number   |                                   |       |                 |
|       | Date of birth  | Sex                               | Race  |                 |

- Patient is in a Title XVIII certified **skilled** bed
  - Will patient remain in facility when skilled care days end?
    - Yes
    - No
    - Unknown

**Section I. Admission.**

Patient was admitted to this facility on (date): \_\_\_\_\_ from (previous location): \_\_\_\_\_

SoonerCare (Medicaid) financial eligibility approved?  Yes  No  
 SoonerCare (Medicaid) medical eligibility approved?  Yes  No

When did patient transfer from skilled care to ICF care? \_\_\_\_\_

- New patient:
  - NF admission.**  
 Oklahoma Health Care Authority (OHCA) Form LTC-300A, PASRR Level 1 Screen, signed physician's order for nursing care, and a plan of care are on file in the facility (not applicable on ICF/MR admissions).

**ICF/MR admission.**

A report of psychological testing performed within the last 12 months and a plan of care for this patient, signed by a physician, are on file in the facility (not applicable on NF admissions).

**Hospice admission.**

Eligible recipient's election statement and plan of care are on file in the facility.

Returned from hospital:

|                            |      |       |     |
|----------------------------|------|-------|-----|
| Name of hospital           |      |       |     |
| Patient's physician        |      |       |     |
| Physician's street address | City | State | Zip |

**Section II. Discharge.**

This is to notify you that the above named individual was discharged from this facility on (date): \_\_\_\_\_

- Discharged to (place): \_\_\_\_\_
- Entered hospital (name of hospital): \_\_\_\_\_
- Date deceased: \_\_\_\_\_

\_\_\_\_\_  
Signature of operator

\_\_\_\_\_  
Date

**OKDHS USE ONLY:** Patient's initial continued stay review date: \_\_\_\_\_  
Date Form 08MA083E (ABCDM-83) returned to facility: \_\_\_\_\_

**Purpose of form**

Form 08MA083E (ABCDM-83) is a multi-purpose form provided by OKDHS to operators of nursing facilities, ICF/MR facilities, and hospices for their convenience to:

- notify OKDHS of an admission or discharge of a patient on whose behalf OHCA is making a payment for care;
- notify OKDHS of the admission of a patient who wishes to make an application for help with his or her expenses for care;
- notify the Social Security Administration when a recipient of Supplemental Security Income (SSI) is admitted; and
- assign an initial continued stay review date.

Early notification of a change in a patient's status aids in processing claims accurately and in providing assistance to patients who wish to make application.

## Instructions

**To:** Enter the address of the local OKDHS office.

**From:** Enter the name, address, and provider number of the facility or hospice submitting the form.

**Re:** Enter the patient's name and former address; client ID number; SoonerCare (Medicaid) case number, if any; Social Security or HIB number; date of birth; sex; and race. Indicate if patient is in a Title XVIII certified bed. If the patient is in a skilled bed, please indicate if he or she will remain in the facility after the skilled days have ended.

**Section I. Admission.** If the notification is for the patient's admission, enter the date admitted as well as immediate previous location and check to indicate whether the patient is new at this facility or is returning from a hospital stay. **If known, check whether the patient's SoonerCare (Medicaid) financial and medical eligibility is approved.** If the patient was previously in a skilled bed, please indicate when he or she transferred from skilled care to ICF care.

**NF admission:** If the patient is new and being admitted to a nursing facility, check NF admission to indicate if OHCA Form LTC-300A, PASRR Level I Screen, allows admittance and whether a plan of care for the patient, signed by a physician, is on file in the facility.

**ICF/MR admission:** If the patient is new and being admitted to an ICF/MR facility, check ICF/MR admission to indicate if a report of psychological testing performed within the last 12 months, and a plan of care for the patient, signed by a physician, is on file in the facility.

**Hospice admission:** Check hospice admission if eligible client elects hospice care. The nursing facility retains a copy of the client's hospice election statement and current plan of care.

If the patient is returning from the hospital, enter the name of the hospital. Enter the name of the physician and the physician's address.

**Section II. Discharge.** If the notification is for a patient leaving the facility, enter the date discharged. Check the appropriate block to show that the patient was discharged to some other living arrangement, entered a hospital and indicate which hospital, or that the patient died and the date of death.

**Signature:** The operator or representative must sign and date the form.

## Routing

The original form must be sent to the local OKDHS office no later than five days after a patient is admitted or discharged. If the recipient receives SSI, mail a copy to the local Social Security Administration Office. The remaining copy is retained by the facility.