



Request for Title XIX Nursing Assessment

Form 02AG001E is completed by the intermediate care facility (ICF) to notify OKDHS of a Medicaid client's admission into the ICF and request a nursing assessment by the long-term care (LTC) nurse.

Resident information:

Last name		M.I.	First
Client identification (ID) number		Social Security number	
Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Case number	Primary language

Is the resident able to participate in the assessment process? Yes No

Facility information:

Date of ICF admission		Date of discharge
Private pay requesting Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date	
Facility name	Phone	
Address	Facility number	

ADvantage respite: Yes No
 Facility certified for ADvantage respite? Yes No

Physician <input type="checkbox"/> M.D. <input type="checkbox"/> D.O.	Phone
Address	

Person to contact for information:

Name		Relationship to resident
Address		
Phone	Legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	Power of attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No

Name	Relationship to resident
Address	Phone

Comments:

OKDHS use only:		
Information received by		Date
Referral forwarded to	RN date	Date received by LTC nurse

Nursing facility: Mail, fax, or hand carry to the OKDHS county office