



AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)
DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Nursing Facility Notice of Action

To be completed by nursing facility or DDA institution.

CLIENT NAME LAST	FIRST	MIDDLE INITIAL (MI)
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH
PROVIDER NUMBER, IF A NURSING FACILITY (NF)		
DSHS ACES CLIENT ID (REQUIRED FOR SUBMISSION)		
EFFECTIVE DATE OF ACTION		

TO: Classic Medicaid cases FAX to DSHS: 1-855-635-8305

MAGI Medicaid cases FAX to: 1-866-841-2267

Health Care Authority (HCA) claims processing NF unit. Codes for classic and MAGI programs are in the 15-031 instructions.

Section I: Type of Action

IF DISCHARGED OR DECEASED CHECKED, COMPLETE THE FOLLOWING INFORMATION:		
<input type="checkbox"/> 1. Discharged/transferred	AMOUNT OF REFUND	NAME ON REFUND
<input type="checkbox"/> 2. Deceased		
<input type="checkbox"/> 3. Social/therapeutic leave exceeds 18 days in calendar year		
<input type="checkbox"/> 4. Change in payment status (includes Medicare to Medicaid, Managed Care admission and end dates, Hospice, etc.)		
<input type="checkbox"/> 5. Readmit to Title XIX certified facility from hospitalization		
<input type="checkbox"/> 6. Admit		

Section II: Transfer / Discharge Information

IF BOX 1 ABOVE WAS CHECKED, COMPLETE THE FOLLOWING:			
<input type="checkbox"/> 1. Home	<input type="checkbox"/> 7. Adult Family Home		
<input type="checkbox"/> 2. Hospital	<input type="checkbox"/> 8. DDA ICF – IID Group Home		
<input type="checkbox"/> 3. Nursing Facility	<input type="checkbox"/> 9. Hospice / Hospice Care Center (The Medicare / Medicaid Hospice provider must also submit HCA 13-756 to report changes per the Hospice billing guide.)		
<input type="checkbox"/> 4. Assisted Living	<input type="checkbox"/> 10. Other (specify):		
<input type="checkbox"/> 5. Institution - DDA ICF – IID, DDA state facility (RHC)			
<input type="checkbox"/> 6. Away without leave			
NAME OF NEW FACILITY		TELEPHONE NUMBER (INCLUDE AREA CODE)	
STREET ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS, IF DIFFERENT FROM ABOVE	CITY	STATE	ZIP CODE

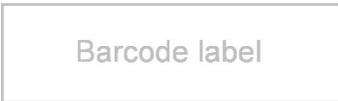
Section III: Reason for Action; Indicate Date:

<input type="checkbox"/> 1. Apple Health Managed Care rehabilitation / skilled nursing - admission / start date	<input type="checkbox"/> 4. Hospice revocation
<input type="checkbox"/> 2. Apple Health Managed Care rehabilitation / skilled nursing - coverage ends or prior authorization ends	<input type="checkbox"/> 5. Private pay to Medicaid
<input type="checkbox"/> 3. Hospice admission / election (indicate hospice agency information in comments)	<input type="checkbox"/> 6. Medicare to Medicaid
	<input type="checkbox"/> 7. Medicaid to private pay
	<input type="checkbox"/> 8. Medicaid to Medicare
	<input type="checkbox"/> 9. Not in need of Nursing Facility Care

Section IV: Comments

NURSING FACILITY REPRESENTATIVE		DATE	TELEPHONE NUMBER (INCLUDE AREA CODE)
NAME OF FACILITY REPORTING THE CHANGE			TELEPHONE NUMBER (INCLUDE AREA CODE)
STREET ADDRESS	CITY	STATE	ZIP CODE

NURSING FACILITY NOTICE OF ACTION
DSHS 15-031 (REV. 01/2019)



15031

Nursing Facility Notice of Action
DSHS 15-031

Instructions

This form is used by Nursing Facilities (NF) or Developmental Disabilities Administration (DDA) institutions to report changes to the DSHS financial worker on active Medicaid clients. Reporting changes promptly will enable correct eligibility and award letters and alert the DSHS financial worker of discharges and change in status. This form is also used by the HCA NF billing unit on active modified adjusted gross income (MAGI) clients. Don't submit this form without indicating an ACES client ID. All active Medicaid clients will have an ACES client ID and the medical coverage group in the provider inquiry function in Provider One. Forms submitted without an ACES client ID won't be processed. It is important to indicate the facility name and address as facilities have the same or similar names. Indicate the effective date of the change. For additional instructions and medical coverage group desk tool, consult the NF provider billing guide.

The NF is required to get pre-approval from the Managed Care Organization (MCO) if the Medicaid client is active with a MCO or was in an MCO at the time of hospital/facility admission.

DSHS staff determines eligibility for "Classic" Medicaid programs. FAX this form to DSHS at 1-855-635-8305 when a client is active on one of the following medical coverage groups: A01, A05, D01, D02, D26, G03, G95, G99, L01, L02, L04, L21, L22, L24, L31, L32, L41, L42, L51, L52, L95, L99, S01, S02, S08, S95, S99 And T02. HCA maintains eligibility for MAGI Medicaid authorized through the Health Benefit Exchange (HBE). FAX this form to the HCA claims processing NF unit 1-866-841-2267 when the client is active under the following medical coverage groups: N01, N02, N03, N05, N10, N11, N13, N23, N31, N33, K01, K95, or K99.

Do not use this form to request a social service assessment from Home and Community Services (HCS). This form is used to report changes to the financial worker that may affect Medicaid eligibility. The DSHS 10-570 Intake and Referral request form is used to request a social service assessment.

<https://www.dshs.wa.gov/sites/default/files/FSA/forms/word/10-570.docx>. Contact the HCS social service intake line to request an assessment for discharge services in the community. (See below.)

- **REGION 1** – Pend Oreille, Stevens, Ferry, Okanagan, Chelan, Douglas, Grant, Lincoln, Spokane, Adams, Whitman, Klickitat, Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield and Asotin: 509-568-3767 or 1-866-323-9409; FAX 509-568-3772
- **Region 2 North HCS** - Snohomish, Whatcom, Skagit, Island, and San Juan Counties 1-800-780-7094 or FAX 425-977-6579. Nursing Facility Intake: FAX 425-977-6579.
- **Region 2 South HCS** - King County 206-341-7750 or FAX 206-373-6855.
- **Region 3 HCS** - Pierce, Kitsap, Thurston, Mason, Lewis, Grays Harbor, Pacific, Cowlitz, Clark, Clallam, Jefferson, Skamania, and Wahkiakum, counties 1-800-786-3799 or FAX 360-586-0499.

Section I: Type of Action

- Select the appropriate box
- For boxes 2 through 6 enter the effective date the action took place

Section II: Transfer / Discharge Information

- If you selected box 1 in section one then:
 - Select appropriate box
 - Enter the effective date the action took place

Section III: Reason for Action

- Enter the effective date the action happened
- Select appropriate box

Section IV: Comments

Enter any comments to clarify the actions marked in section one through three.