NOTIFICATION OF NURSING FACILITY ADMISSION
Arkansas Department of Human Services
Division of Medical Services
Office of Long Term Care

NOTICE OF ADMISSION

FACILITY	
	Name of Facility
	City

RESIDENT		
	Name of Resident	**Date of Birth**
	Contact Person and Title	**Contact Person's Telephone Number**
	Contact Person's Home Address	
	Resident's County of Residence	**Resident's SSN**
	Referral Date	**Medicaid ID # (or NA)**
	Type of Placement ☐ Long Term NF(Permanent) ☐ Short Term NF (Convalescent not to exceed 6 months) ☐ NF Rehab (Also considered Short Term, but admission specifically related to Rehab) ☐ Hospice ☐ Other (Specify)	
	Date of Admission	
	Payment Source ☐ Medicaid ☐ Medicare ☐ Private Pay/Third Party	

DECLINATION FOR LONG TERM CARE OPTIONS COUNSELING

are eligible to receive counseling on various options regarding long term care services. Your facility may be the most appropriate place to reside and to receive care. In other instances, you may find other programs that provide care in the home and in the community to be an alternative to nursing facility care. If you do not wish to receive counseling regarding these programs please check the following box:

☐ **I DO NOT WISH TO RECEIVE LONG TERM CARE OPTIONS COUNSELING**

LTC Options Counseling Form: ☐ Read to Resident/Representative ☐ Not Read to Resident/Representative because the resident lacks decisional capacity and does not have a representative.

_____

Signature of Resident and/or Representative _____Date

Distribution: Complete and submit a COPY of this form to the Office of Long Term Care no later than 5:00 p.m. of the next business day following the contact. Maintain the original of this form in the individual's file at the Long Term Care facility.

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