

**Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services**

MEMORANDUM

TO: _____ County Office
(Department for Community Based Services)

FROM: _____
(Nursing Facility/Waiver Agency) _____ (Provider Number)

DATE: _____

SUBJECT: _____
(Recipient Name) _____ (Social Security Number)

(Previous Address)

(City) _____ (State) _____ (ZIP)

(Responsible Relatives Name)

(Street Address)

(City) _____ (State) _____ (ZIP)

This is to notify you that the above referenced recipient:

was admitted to this nursing facility/waiver agency on _____ is in Title _____
(Date) _____ (XVIII or XIX)

Placement Status, and was placed in a:

- | | |
|---|--|
| <input type="checkbox"/> Nursing Facility Bed | <input type="checkbox"/> Home and Community Based Waiver Services (HCBW) |
| <input type="checkbox"/> ICF/IK/DD Bed | <input type="checkbox"/> Michelle P. Waiver Services |
| <input type="checkbox"/> Mental Hospital Bed | <input type="checkbox"/> Psychiatric Residential Treatment Facilities (PRTF) bed |
| <input type="checkbox"/> EPSDT Bed | |

Was admitted discharged from this facility/waiver on _____ and went to _____
(Date) _____ (Name of Nursing Facility)

(Home Address or Name and Address of New Nursing Facility/Waiver Agency)

(City) _____ (State) _____ (ZIP)

and or expired on _____
(Date)

was returned to HCBW, Michelle P. waiver services within 60 days of the Nursing Facility admission _____
(Date re-instated)

For HCBW and Michelle P. waiver clients only – Last date service was provided _____
(Date)

(Signature)