**The purpose of this form is to:**

1. **Track MFP days**
2. **Provide statistics to CMS on reasons for readmission**

|  |  |
| --- | --- |
| **Participant’s Name:** | **Medicaid No.:** |

1. Start Date (day of move to community):

*This is the date of discharge from the NF to the community setting, day one (1) of the 365 days under the MFP program.*

1. Date of Nursing Facility Readmission:  OR Date of Hospital Admit Over 30 Days:

**The tracking form must be submitted within 48 hours of the date entered.**

*If applicable, if after a hospitalization participant requires a NF stay or if participant enters a NF for any reason (see below).*

1. Reason for Readmission:

Deterioration in physical or mental health

Events that led to a hospitalization (for example: acute medical events, falls or accidents)

The existence of a complex or chronic condition requiring more care than could be received at home

Inadequate community or family member support

Requests by either the family or the participant to return to an institutional setting

Loss of caregiver

Loss of housing

Lack of sufficient home care services in the area

Other

1. Date of MFP Termination:

Reason:

No longer meets NF Level of Care/withdrawn

Transferred into Assisted Living Residence

Re-institutionalization *\*for re-institutionalization within 90 days of discharge, complete page 2\**

Expired (reason): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If applicable, date of discharge back to community (after the above stay):

*This date will restart the clock for a total of 365 days (days in the NF are not counted as part of the 365)*

Care Manager Phone #:       Care Manager Email:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Care Manager’s Signature:       MCO:       Date:

**According to section 9.7.3 (G) of the MCO contract with the state, the MFP 76 must be submitted within 48 hours of a trigger event.** If the completion of this form exceeds 48 hours from the date of the trigger event entered in question 2, please explain why:

**Participant’s Name:**

**Re-institutional within 90 days**

**For participants re-institutionalized within 90 days of discharge to the community, provide the following information**

Date of first care manager visit: Date of last care manager contact:

|  |  |  |  |
| --- | --- | --- | --- |
| **Personal Care Support** | | | |
| Approved | **If Approved:** | Date PCA Service Began: | Click or tap here to enter text. |
| Not Approved | PCA Hours Approved: | Click or tap here to enter text. |
| Declined by Member | PCA Hours Filled: | Click or tap here to enter text. |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Durable Medical Equipment** | | |  | **Home Modifications** | | | |
| **Item** | Received | Not Received |  | **Modification Needed** | Completed | Estimates Completed | No Estimates Completed |
| Click or tap here to enter text. |  |  |  | Click or tap here to enter text. |  |  |  |
| Click or tap here to enter text. |  |  |  | Click or tap here to enter text. |  |  |  |
| Click or tap here to enter text. |  |  |  | Click or tap here to enter text. |  |  |  |
| Click or tap here to enter text. |  |  |  | Click or tap here to enter text. |  |  |  |
| Click or tap here to enter text. |  |  |  | Click or tap here to enter text. |  |  |  |

Provide detail about why the member returned to the nursing home. You may need to contact the member in their current setting if you do not have detailed information. If member was discharged to the community before PCA was in place, please describe steps taken to secure PCA services.