DPHHS-SLTC-052 (Rev. 08/16)

STATE OF MONTANA Department of Public Health and Human Services Senior & Long-Term Care Division P.O. Box 4210

Helena, MT 59604-4210 Phone (406) 444-4077 Fax (406) 444-7743

REQUEST FOR NURSING HOME BED RESERVATION DURING RESIDENT'S TEMPORARY HOSPITALIZATION

(NAME OF FACILITY)			(ADDRESS OF FACILITY)				
I certify that a bed was reserved for hospitalization, the facility was full at ARM 37.40.338(5).	or the following reand a waiting list was	sidents w s maintair	hile they ned. Plea	were tem se authori	porarily hospitalized. At ze reimbursement in acco	the tin	ne of with
NAME OF RESIDENT	SOCIAL SECURITY NUMBER	HOSPIT	To	TOTAL DAYS	NAME OF HOSPITAL	APPROVED	DENIED
	I	I				1	
(SIGNATURE OF ADMINISTRATOR / DESIGNEE & DATE)			(AUTHORIZING SIGNATURE & DATE)				

INSTRUCTIONS

Please submit original and both copies of this request to the Senior & Long-Term Care Division for review and authorization. The original, with authorization signature of approval or denial, will be returned for your records. The copies will be retained for the Department's records. Please fill in the date the resident was admitted to the hospital <u>and</u> the date of return to the facility, date of death or the date the facility releases the bed reservation. Also, please include a copy of your current waiting list.