 Date: **Enter Date**

**TennCare Long Term Services and Supports**

**Notification for NF (ICF) Admission**

**Member Information:**

|  |  |
| --- | --- |
| **Member’s Name: Type Name.**  |  **SSN: Enter SSN here.**  |
| **Age: Enter Age here.**  |  **Date of Birth: Enter DOB here.**  |
| **Member’s Contact Phone #: Enter Phone # here.** | **Member’s Alternative Phone #: Enter Phone # here.** |
| **Designee/Conservator Name: Type Name.** | **Designee/Conservator Phone #: Enter Phone # here.** |
|  **Is member in LTSS program? Select LTSS Program**. | **Is member in DIDD waiver?**  **DIDD Waiver?** |
|  |  |

**Submitter:**

|  |
| --- |
| **Member’s MCO: Choose Submitter.** **Contact Name: Type Name.** |
| **Contact Phone Number:** **Type Phone #**. | **Contact Fax Number:****Type Fax #**. | **Contact Email Address:** **Type Email**. |

**Nursing Facility Short Term Stay:**

|  |  |
| --- | --- |
| **Name of facility** | **Type Name of facility.** |
| **Date of admission (should be future date)** | **Click here to enter a date.** |
| **Anticipated length of stay** | **Type Anticipated length of stay.** |
| **Clinical summary** | **Type current clinical summary and include any barriers and the transition plan, if known.** |
| **Services offered/ attempted to be provided in the community** | **List summary of services.** |

**Nursing Facility Long Term (with Transition to CHOICES Group 1):**

|  |  |
| --- | --- |
| **Name of facility** | **Type Name of facility.** |
| **Date of admission (should be future date)** | **Click here to enter a date.** |
| **CHOICES PAE CN** | **Type PAE Control #.** |
| **Services offered/ attempted to be provided in the community** | **List summary of services.** |

**ICF/ IID:**

|  |  |
| --- | --- |
| **Name of facility** | **Type Name of facility.** |
| **Date of admission (should be future date)** | **Click here to enter a date.** |
| **Anticipated length of stay** | **Type Anticipated length of stay.** |
| **Clinical summary** | **Type current clinical summary and include any barriers and the transition plan, if known.** |
| **Services offered/ attempted to be provided in the community** | **List summary of services.** |

|  |  |  |
| --- | --- | --- |
| **Attach electronic signature of person completing this form** | **Title of person completing this form****Type Title Here.** | **Date****Enter date.** |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For TennCare use only:**

[ ]  **Reviewed**

[ ]  **Additional Information Needed: List the additional information requested**.