



Nursing Facility Monthly Patient-Day Assessment Report

Name of Facility _____
 Month _____
 Year _____

Current Month Patient Days Not Subject to Patient-Day Assessment

Medicare _____
 Medicare HMO _____
 Total Current Month Patient Days Not Subject to Patient Day Assessment

Current Month Patient Days Subject to Patient-Day Assessment

Medicaid - Utah _____
 Medicaid - Non Utah _____
 Veterans _____
 Private _____
 Long Term Care - Managed Care (Medicaid Only) _____
 Hospice - Medicaid _____
 Hospice - Non Medicaid _____
 Other _____

Total Current Month Patient Days Subject to Patient Day Assessment

Patient Day Assessment Rate Per Day \$ 15.40

Total Patient Day Assessment Due (Patient Days subject to assessment X Patient Day Assessment Rate Per Day amount) \$

Effective 7/1/2014

FILING REQUIREMENT

THIS REPORT AND PAYMENT MUST BE RECEIVED BY DHCF ON OR BEFORE THE LAST DAY OF THE NEXT MONTH. Postmarked envelopes by the last day of the month are acceptable. Reports should be mailed to:

LynAnn Williams
 Department of Health
 Division of Medicaid and Health Finance
 Bureau of Financial Services
 Attn: Nursing Home Assessment
 P.O. Box 143104
 Salt Lake City, UT 84114-3104

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED IN THIS REPORT IS TRUE AND COMPLETE AS PREPARED FROM THE BOOKS AND RECORDS OF THE ABOVE NURSING FACILITY. RECORDS NECESSARY TO VERIFY THE ABOVE INFORMATION SHALL BE MADE AVAILABLE TO AGENTS OF THE STATE OR FEDERAL GOVERNMENT ON DEMAND. I UNDERSTAND THAT PAYMENTS OWING TO THE FACILITY NAMED ABOVE MAY BE WITHHELD IF THE INFORMATION REQUESTED ABOVE HAS NOT BEEN TIMELY PROVIDED.

Preparer: Signature and Title _____ Date _____ Phone Number _____