# PHYSICIAN STATEMENT FOR MEDICAID TEMPORARY STAY REVIEW FOR INDIVIDUALS ENTERING A LONG-TERM CARE FACILITY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID POLICY UNIT
SFN 132 (3-2025)

Clear Fields

* In compliance with the Federal Privacy Act of 1974, disclose of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

## This form must be signed by a Medical Provider

| Name of Patient | Patient Social Security Number * | Patient Date of Birth |
|---|---|---|
| Name of Facility | Date Patient Admitted to Long-Term Care Facility | |

Is it a reasonable expectation that the patient will be able to return to their own home/lessor care within 6 months from date of entry into Long-Term Care?

☐ Yes ☐ No

| Briefly explain reasons for the stay/placement into Long-Term Care Facility |
|---|
| |

| Printed Name of Physician | |
|---|---|
| Signature of Physician | Date |

**Note: Expectation that patient may pass away within 6 months is not considered a temporary stay.**

**Submit the completed form to:**
HHS Medicaid Long Term Care Unit
701-328-5020 (fax)
Email: dhsmedicaidltc@nd.gov