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

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAID POLICY UNIT
SFN 132 (1-2019)

Clear Fields

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

* 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.

Printed Name of Physician	
Signature of Physician	Date

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