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 the following residents while they were temporarily hospitalized. At the time of hospitalization, the facility was full and a waiting list was maintained. Please authorize reimbursement in accordance with ARM 37.40.338(5).

NAME OF RESIDENT	SOCIAL SECURITY NUMBER	HOSPITALIZED		TOTAL DAYS	NAME OF HOSPITAL	APPROVED	DENIED
		FROM	TO			☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

_____ _____

(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 ***and*** 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.