NOTIFICATION OF FACILITY ADMISSION/DISCHARGE

Facilities are required to complete this form within 5 days of the residents admit or discharge. Send completed form to the KanCare Clearinghouse (FAX 1-844-264-6285). This form is not used for persons in an Assisted Living Facility.

A. Resident Information

First Name: _____ Last Name: _____ Gender: _____

SSN: _____ Date of Birth: _____ Client ID #: _____

Responsible Person Name: _____ Relationship: _____

Responsible Person Address: _____ Phone: _____

B. Facility Information (Assisted Living – Do Not Complete)

Facility Name: _____ Phone: _____

Facility Address: _____ Fax: _____

Name of Agency/Person Placing Resident: _____

Facility NPI: _____

Administrator/Designee: _____

C. CARE/Pre-Admission Screening (Responses to all Questions Required)

1. Is a CARE/Pre-Admission Screening Required? ☐ No ☒ Yes

If No, provide reason: _____

2. Is a CARE/Pre-Admission Screening Delayed? ☐ No ☐ Yes (if yes complete the following section)

☐ Emergency Admission Date to KDADS: _____

☐ 30 Day Provisional (resident expected to stay past 30 days) Date to KDADS: _____

☐ 30 Day Provisional (short-term stay) Date to KDADS: _____

☐ Out of State Admission Date to KDADS: _____

☐ Terminal Illness Date to KDADS: _____

3. Was the CARE/Pre-Admissions Screening Completed? ☐ No ☐ Yes ☐ Not Applicable

CARE Date: _____ CARE/Level 2, Date: _____ Other, Date: _____

If the CARE/Pre-Admission Screening is required, but was not completed, list reason below:

_____

D. Facility Admission

1. Date admitted to your facility: _____

2. Anticipated Length of Stay:

☐ Less than 30 days ☐ Temporary - Anticipated length: _____ ☐ Permanent

3. Current Level of Care in Your Facility:

☐ Skilled Nursing Facility (IC/NF/SN) ☐ NF - Mental Health (IC/NF/ MH)

☐ ICF/MR (IC/NF/DD) ☐ State Hospital - MR (IC/SH/SD)

☐ Swing Bed (IC/NF/SB) ☐ PRTF (IC/BF/MH)

☐ State Hospital – Mental Health (IC/SH/SM) ☐ Head Injury/Rehab. (IC/NF/HI)

Residents Previous Living Arrangement

4. Was the resident admitted directly from another facility? ☐ No ☐ Yes

If yes, Name of Facility: _____ Date Admitted to this Facility: _____

Type of Facility:

☐ Hospital ☐ Nursing Facility ☐ Nursing Facility-Mental Health

☐ Swing Bed ☐ ICF/MR ☐ State Hospital

If the resident was not admitted directly from a Facility, list previous living arrangement:

☐ Own Home ☐ Assisted Living ☐ Other _____

5. Please provide any other information that may be relevant to the individuals Medicaid determination.

_____

E. Temporary Absence

Complete this section only if the resident is absent from the facility more than 30 days and intends to return.

Name & Address of Facility: _____

Type of Facility: ☐ Acute Hospital ☐Swing Bed ☐ Other _____

Date Left: _____ Date Returned: _____ Or, Anticipated Return Date: _____

F. Discharge or Deceased

Complete this section if resident does not intend to return to the facility.

Discharge Date: _____

Date Deceased: _____

Discharged to: ☐ Private Home ☐ Facility ☐ Swing Bed

☐ Hospital ☐ Other _____

If discharged to a facility or hospital, name of facility: _____

Level of Care at new facility: _____

MS-2126 Instructions

1. This form can only be submitted by a facility.

2. The facility initiates the MS-2126 under the conditions specified in KEESM 8184.1 within 5 days of the event/request. Specific conditions prompting an MS-2126 include:
    - A Medicaid recipient is admitted or discharged from the facility
    - A resident files an application for medical assistance
    - A resident has been absent from the facility for 30 days or longer
    - A resident changes level of care

3. Sections A and B are always completed.

4. Sections C through F are completed as necessary.
    - Section C: Care Pre-Admission Screening – This section is required for new admissions and new Medicaid requests. Responses to questions 1, 2 and 3 are required regardless of the type of facility.

      Important: It is the responsibility of the admitting facility to ensure these requirements are met. A CARE Assessment is not required for Swing Bed placements.

    - Section D: Facility Admission – Required for new admissions, new Medicaid requests and any Level of Care change in the facility.

    - Section E: Temporary Absence - A form is only necessary if the resident will be temporarily absent more than 30 days from your facility. If the absence is for 30 days or less, a form is not required.
      Note regarding a resident temporarily residing in a Swing Bed - the original facility will not be paid for the absence. See the KMAP Provider Manual for information

    - Section F: Discharged or Deceased- Complete this section if the resident will not return to your facility,

5. If the resident is in State (DCF or KDOC) custody, note this in Section A under Responsible Person or Agency. Contact the designated individual in the DCF Regional Service Center if additional information is needed.

6. For PRTF, follow processing guidelines outlined in the appropriate KMAP provider manual regarding prior authorization and prescreening.

7. The facility retains the original MS-2126 and submits a copy to the Kancare Clearinghouse. The form may be faxed (1-844-264-6285) or mailed:

   The KanCare Clearinghouse
   P.O. Box 3599
   Topeka, KS 66601-9738

8. The Kancare Clearinghouse will notify the facility when the case is approved or denied.

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NOTE: Incomplete forms may not be processed timely and may be returned to the facility.