

**Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services**

MEMORANDUM

TO: _____ County Office
(Department for Community Based Services)

FROM: _____ (Facility/Waiver Agency) _____ (Provider Number)

DATE: _____

SUBJECT: _____ (Recipient Name) _____ (Social Security Number)

_____ (Previous Address)

_____ (City) _____ (State) _____ (ZIP)

_____ (Responsible Relatives Name)

_____ (Street Address)

_____ (City) _____ (State) _____ (ZIP)

This is to notify you that the above referenced recipient:

was admitted to this facility/waiver agency on _____ is in Title _____
(Date) (XVIII or XIX)

Placement Status, and was placed in a:

- NF Bed
- ICF/MR/DD Bed
- MH Bed
- ESPDT Bed
- Home and Community Based Services (HCBS)
- Michelle P. Waiver Services

was discharged from this facility/waiver on _____ and went to _____
(Date) (Name of Facility)

_____ (Home Address or Name and Address of New Facility/Waiver Agency)

_____ (City) _____ (State) _____ (ZIP)

and or expired on _____
(Date)

was returned to HCBS, Michelle P. waiver services within 60 days of the Nursing Facility admission _____
(Date re-instated)

For HCB and Michelle P. waiver clients only – Last date service was provided _____
(Date)

(Signature)