



### Facility Face Sheet

Worker # \_\_\_\_\_

Client Name _____	POA/Representative _____
Case # _____	_____
SID # _____	POV LVL _____
App Date _____	CAR Request _____
	CAR Rcvd _____
	ISIS _____
	LOC _____

Institutionalized Spouse INCOME				Community Spouse INCOME			Name
Source	Amount	E/UE	DOB	Source	Amount	E/UE	DOB
SS			SS	SS			SS
							SID
TOTAL				TOTAL			

Life Insurance Co/Policy #/Owner	Face	Cash	Burial Contracts/Plots/Funds/Burial Ins.
			Type _____
			Irrevocable _____
			Where _____
			Amount _____

Vehicles	Year/Model	Exempt	Value	Additional Information
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

SS Claim # _____ Supplemental Policy _____ Medicare Part D _____	Medicare Premium _____ Monthly Premium _____ Monthly Premium _____
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Previous Living Arrangement _____	HMA? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Facility _____	Vendor Number _____
	Date of Entry _____
	LOC _____

Resources/Type/Acct #	Months				

Homestead (address) _____	Statement of intent? _____
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Effective Date of Approval	Retro
Denial	

Comments

Review Received Date	RFI Sent
Review Completed Date	RFI Due
Next Review	

Rights and responsibilities, 10 day report; \$2,000 resource limit reminder

UME			
		UME	CP
UME Balance	\$ <input type="text"/>	Begin Mo. <input type="text"/>	\$ 0.00
UME Contract Amt.	\$ <input type="text"/>	Partial Mo. <input type="text"/>	\$
Months to Repay	<input type="text"/>	End Mo. <input type="text"/>	\$ 0.00
Current Available CP	\$ <input type="text"/>	UME Reviewed	