Department of HUMAN SERVICES

# PathTracker Case Activity Report

This form is generated electronically with information received through PathTracker.

## 1. Member Data

| Name | Date Entered Facility | PASRR Date |
|---|---|---|
| Social Security Number | State ID | Medicaid Case Number |

## 2. Facility Data

| Medicaid Provider Number | Facility Type<br>☐ Nursing Facility (NF/ICF)<br>☐ Skilled Nursing Facility (SNF)<br>☐ Nursing Facility for Persons with Mental Illness (NF/MI) | | |
|---|---|---|---|
| NPI Number | | | |
| Facility Name | | | |
| Street Address | City | State | ZIP |
| Person Completing Form | | Date Completed | |
| Contact Phone Number | | Contact Email | |

## 3. Level of Care

| Level of Care | Level of Care Process | Effective Date |
|---|---|---|
| ☐ NF/ICF ☐ NF/MI<br>☐ Skilled ☐ Other | ☐ IME Medical Services ☐ Managed Care<br>☐ Medicare ☐ Non-Medicaid | |

## 4. Medicare Information for Skilled Patients in Facilities

**Note:** Dates in this section are populated when Medicare is marked in Section 3.

| Expected Dates of Medicare Coverage<br>through |
|---|

## 5. Discharge Data

| Reason for Discharge:<br>☐ Died<br>☐ Hospital (Less than 10 days, form is not required)<br>☐ Transferred to another facility<br>☐ Moved home<br>☐ Moved to other living arrangement | Date of Discharge | Per Diem at Discharge | |
|---|---|---|---|
| | Address Discharged to: | | |
| | Facility Name (if applicable) | | |
| | Street | | |
| | City | State | ZIP |

## 6. Hospice or PACE Provider Information

**Note:** Only complete this section if individual residing in your facility has elected hospice or is enrolled with PACE.

| Elected/Enrolled Program Information | Medicaid Provider Number | NPI Number |
|---|---|---|
| ☐ Hospice ☐ PACE | Hospice PACE | Hospice PACE |
| Name of Hospice or PACE Provider | Date of Election/Enrollment | Date of Revocation/Disenrollment |
| Contact Name for Hospice or PACE | Contact Phone Number | Contact Email |

## Instructions for Preparing the PathTracker Case Activity Report

- When a current resident applies for Medicaid, complete sections 1, 2, and 3 and if applicable, sections 4 and 6. If the individual is already in PathTracker, their name will populate when the SSN is entered. If not in PathTracker, enter the resident's first name, middle initial, and last name as they appear on the *Medical Assistance Eligibility Card*. The state ID number is assigned by the Iowa Department of Human Services and consists of seven digits plus one letter, e.g., 1100234G.
- When a Medicaid applicant or member enters the facility, complete sections 1, 2, and 3 and if applicable, sections 4 and 6.
- When a Medicaid applicant or member changes level of care, complete sections 1, 2, and 3 and if applicable, sections 4 and 6.
- When there is Medicare coverage and the Medicaid rate is higher than the Medicare rate, complete sections 1, 2, and 4 and if applicable, section 6.
- When a Medicaid applicant or member dies or is discharged or transferred, complete sections 1, 2, and 5 and if applicable, section 6.
- The administrator or designee responsible for the accuracy of this information should complete section 2.
- If the Medicaid member is receiving benefits through a hospice or PACE provider, please refer to bullets 1 through 5 above and also complete section 6.

## Distribution Instructions for Hospice, NFs, NF/MIs, and SNFs

All NFs, NF/MIs, and SNFs in Iowa are required to enter admission, discharge, and transfer information into Ascend Database PathTracker Plus (PathTracker). This form is generated electronically with information received through PathTracker.

Hospices can submit this form via paper. The facility should keep a copy for their records and also mail, email or fax a copy to:

Centralized Facility Eligibility Unit
Imaging Center 1
Iowa Department of Human Services
417 E. Kanesville Blvd.
Council Bluffs, IA 51503-4470
Fax: 515-564-4040 Email: facilities@dhs.state.ia.us

## Distribution Instructions for PACE

PACE Organizations (PO) can submit this form via paper if the member is enrolled with a PACE program. The PO should keep a copy for their records and also email or fax a copy to the appropriate Imaging Center with an attention to your DHS IM:

Western Service Area
Fax: 515-564-4014
Email: Imagingcenter1@dhs.state.ia.us

Northern Service Area
Fax: 515-564-4015
Email: Imagingcenter2@dhs.state.ia.us

Des Moines Service Area
Fax: 515-564-4018
Email: Imagingcenter5@dhs.state.ia.us

Cedar Rapids Service Area
Fax: 515-564-4017
Email: Imagingcenter4@dhs.state.ia.us