Utah Department of
Health & Human Services
Integrated Healthcare

ICF/ID Nursing Facility Monthly Patient-Day Assessment Report

Name of Facility _____ Month _____ Year _____

*Current Month Patient Days **Not Subject to Patient-Day Assessment**

Medicare	
Medicare HMO	
Total Current Month Patient Days Not Subject to Patient Day Assessment	0

*Current Month Patient Days Subject to Patient-Day Assessment

Medicaid - Utah	
Medicaid – Non-Utah	
Veterans	
Private	
Long Term Care - Managed Care (Medicaid Only)	
Hospice - Medicaid	
Hospice – Non-Medicaid	
Other	
Total Current Month Patient Days Subject to Patient Day Assessment	0
Patient Day Assessment Rate Per Day	9.51
Total Patient Day Assessment Due (Patient Days subject to Assessment X Patient Day Assessment Rate Per Day amount)	$ 0.00

***All fields are required to have an entry. Use zero where applicable.**

Effective for all non-Medicare bed days & admissions beginning 7/1/2020
(Begins with July 2020 numbers reported in August 2020)

FILING REQUIREMENT

THIS REPORT AND PAYMENT MUST BE RECEIVED BY DMHF ON OR BEFORE THE LAST DAY OF THE NEXT MONTH AS REQUIRED IN UAC R414-401.

Reports and payment may be mailed to:

DHHS - Division of Integrated Healthcare
Attn: Nursing Home Assessment
P.O. Box 143104
Salt Lake City, UT 84114-3104

If submitting electronic payment, email a copy of the wire transfer and this report to:
medicaidinvoicing@utah.gov

I HEREBY CERTIFY THE INFORMATION PROVIDED IN THIS REPORT IS TRUE AND COMPLETE AS PREPARED FROM THE BOOKS AND RECORDS OF THE ABOVE NURSING FACILITY. RECORDS NECESSARY TO VERIFY THE ABOVE INFORMATION SHALL BE MADE AVAILABLE TO AGENTS OF THE STATE OR FEDERAL GOVERNMENT ON DEMAND. I UNDERSTAND PAYMENTS OWING TO THE FACILITY NAMED ABOVE MAY BE WITHHELD IF THE INFORMATION REQUESTED ABOVE HAS NOT BEEN PROVIDED IN A TIMELY MANNER.

Preparer: _____ Signature _____ Title _____ Date

_____ Email Address _____ Phone Number