pennsylvania
DEPARTMENT OF HUMAN SERVICES

LONG TERM CARE ADMISSION AND DISCHARGE TRANSMITTAL

The Medical Assistance (MA) Admission & Discharge Transmittal (MA 103) is a one sided, two-part snapset (Original and one copy) designed to be completed in the following manner:

Tear off the top instruction sheet. It will guide you through the proper completion of the MA 103.

INSTRUCTIONS FOR COMPLETING THE MA 103 FORM: (Failure to complete the appropriate sections of the MA 103-1/15 in their entirety may result in the return of the MA 103 to you.)

NOTE: The MA 103 MUST be completed by the facility or the resident's attending physician when an MA applicant is admitted to the facility or converts to MA or when it is determined that a resident no longer needs the services provided by your facility or when the resident expires. The copy of the form labeled "County Assistance Office (CAO)" must be sent to your CAO within three days of completion. The original of the form labeled "Resident's Clinical Record" must be retained in the resident's clinical record.

I. RESIDENT DATA:

1. Name of Resident - Print the resident's name (last, first, middle initial).
2. Access Number - Refer to the resident's MA ACCESS card and print the ten-digit number in the designated space.
3. Social Security Number - Print the resident's Social Security number.
4. Birthdate - Print the month, day and year of the resident's birth in six-digit format. Zero fill to the left all single-digit numbers.
5. Sex - Print M for male and F for female.
6. County - Print the name of the county in which the facility is located.

7a - 7e. Type of Service for which payment is presently authorized by the department on the PA 162 Notice - Mark (x) the box in front of the type of care for which payment is presently authorized by the department. If your choice is not represented, mark (x) the box for Other and describe.

8. Admission Date to Facility - Print the date the resident was admitted to the facility. This date might not be the same as the resident's Medical Assistance eligibility date. Print the date in six-digit format. Zero fill to the left all single-digit numbers.
9. Short Term Stay - If the department determined that the resident should be admitted only for a limited time period, in addition to marking the Type of Service authorized by the department in 7a through 7e, mark the Short Term Stay box and print the length of time recommended in the space provided.

II. PROVIDER DATA:

10. Facility Name - Print the facility name as it appears on your MA Provider Notice. (If the Facility name is in error, immediately notify the Bureau of Provider Support at 1-800-932-0939.)
11. Service Provider ID-Service Location - Record the facility's nine-digit Service Provider ID number and the four-digit Service Location Code.
12. Attending Physician - Print the complete name of the attending physician with degree.
13. Physician Number - Print the attending physician's Medical Assistance identification number if enrolled in the MA Program or the physician's license number if **not** enrolled.

III. DISCHARGE PLANNING DATA:

There must be an individual discharge plan which is current with the resident's condition and includes, at a minimum, the items in Section III. This information should be provided by the person responsible for discharge planning in your facility.

14. Date of Current Discharge Plan - Record the date the current discharge plan was most recently reviewed or updated.
15. Does the current discharge plan include items (a-f)? (Mark (x) yes or no, as appropriate.)
    Comment Section - Explain why any items marked "NO" in Section III are not included in the resident's discharge plan. Also, include time frames for immediate corrective action of the "NO" response items.

IV. CHANGE OF CARE RECOMMENDATIONS:

16a -16e. When a resident no longer needs the services being provided by your facility, mark (x) the box representing the type of care for which the resident is recommended and explain the resident's condition that warrants the recommendation.
NOTE REGARDING SHORT TERM STAY: If the resident was originally recommended for Short Term Stay and now is determined to need continued placement in the facility, mark (x) the appropriate box and explain the resident's condition that warrants the recommendation.

V. TRANSFER / DISCHARGE SECTION:

Definitions:
Discharge - The resident has no intent to return.
Transfer - The resident intends to return.

17. Discharge Codes - When a resident is transferred/ discharged or expires, mark (x) the appropriate code. If you record a code from numbers 05 through 08, circle either transfer or discharge, whichever applies. If you mark code 05-12, record in the Explanation of Codes section below: the name, address of the place and the county code (if the resident is discharged to a different county). For number 12 (Other), record the type, name and address of the place to which the resident was discharged. NOTE: Code 01-Routine Discharge refers to discharge to home.
18. 30 Day Notice of Discharge - When a resident no longer needs nursing facility services and is recommended for discharge, a 30 Day Notice of Discharge must be sent to the resident. Mark (x) the box to indicate that a Notice was sent.
19. Record the date the 30 Day Notice was sent. NOTE: Attach copy of the 30 Day Notice to this Transmittal. The original of this transmittal and a copy of the notice should be kept in the resident's clinical record.

IV. CHANGE OF CARE RECOMMENDATIONS:

20. Signature of Administrator or Designee - This line should be signed by the administrator or a designee in the administrator's absence.
21. Record the date the administrator or designee signs the form.

pennsylvania
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LONG TERM CARE ADMISSION AND DISCHARGE TRANSMITTAL

I. RESIDENT DATA

1. Name of Resident	2. Access Number	3. Social Security No.	4. Birthdate	5. Sex

6. County	7. Type of service for which payment is presently authorized by the Department
	a. ☐ Nursing facility services b. ☐ ICF/ORC c. ☐ Inpatient psychiatric d. ☐ ICF/MR e. ☐ Other_____

8. Admission date to facility (mm,dd,yy)	9. Short term stay
	☐ Yes - Length of stay _____

II. PROVIDER DATA

10. Facility Name	11. Service Provider ID-Service Location	12. Attending Physician	13. Physician Number

III. DISCHARGE PLANNING DATA (to be completed by "Discharge Coordinator" or other appropriate person)

14. Data of Current Discharge Plan (mm,dd,yy)	

15. Does the Current Discharge Plan include items a-f? (If "no" to any of the items, explain under comments)

a. ☐ Yes ☐ No	Information relative to current diagnoses	d. ☐ Yes ☐ No	Physician's advice concerning resident's immediate care needs
b. ☐ Yes ☐ No	Description of prior treatments	e. ☐ Yes ☐ No	Pertinent social information
c. ☐ Yes ☐ No	Description of rehabilitation potential	f. ☐ Yes ☐ No	Information on alternative available community resources to which the resident may be referred

Comments:

IV. CHANGE OF CARE RECOMMENDATION

16. The resident's condition warrants a change to: (Check one)

a. ☐ Nursing facility services b. ☐ ICF/ORC c. ☐ Inpatient psychiatric d. ☐ ICF/MR e. ☐ Other _____

Summarize condition that warrants the care recommended:

V. TRANSFER/DISCHARGE SECTION

17. Discharge codes:
Discharge - The resident has no intent to return
Transfer - The resident intends to return

☐ (01) Routine Discharge	☐ (04) Expired, Autopsy	☐ (07) Transfer / Disch. to rehab. facility	☐ (11) Discharge to hosp. home care
☐ (02) Discharge against medical advice	☐ (05) Transfer / Disch. to hospital	☐ (08) Transfer / Disch. to psych. facility	☐ (12) Other (specify) _____
☐ (03) Expired, no autopsy	☐ (06) Transfer / Disch. to nursing facility	☐ (09) Disch. to boarding home	_____

Explanation of Codes:

THIS SECTION FOR DISCHARGE ONLY

18. ☐ 30-day notice of discharge was sent to this resident on 19. _____ (mm,dd,yy)

(a copy of this 30-day notice should be kept in the resident's clinical record)

VI. TO BE COMPLETED BY FACILITY ADMINISTRATOR OR DESIGNEE

The above information and attachments provide an accurate description of the resident's condition and needs at the time of this review. I recognize that the information referred to in the "Discharge Planning Data" section must be kept current with the resident's condition and must be provided to those responsible for the resident's post-discharge care.

20. _____ 21. _____

Signature of administrator or designee — Date (mm,dd,yy)

RESIDENT'S CLINICAL RECORD

pennsylvania
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LONG TERM CARE ADMISSION AND DISCHARGE TRANSMITTAL

I. RESIDENT DATA

1. Name of Resident	2. Access Number	3. Social Security No.	4. Birthdate	5. Sex

6. County	7. Type of service for which payment is presently authorized by the Department
	a. ☐ Nursing facility services b. ☐ ICF/ORC c. ☐ Inpatient psychiatric d. ☐ ICF/MR e. ☐ Other_____

8. Admission date to facility (mm,dd,yy)	9. Short term stay
	☐ Yes - Length of stay _____

II. PROVIDER DATA

10. Facility Name	11. Service Provider ID-Service Location	12. Attending Physician	13. Physician Number

III. DISCHARGE PLANNING DATA (to be completed by "Discharge Coordinator" or other appropriate person)

14. Data of Current Discharge Plan (mm,dd,yy)	

15. Does the Current Discharge Plan include items a-f? (If "no" to any of the items, explain under comments)

a. ☐ Yes ☐ No	Information relative to current diagnoses	d. ☐ Yes ☐ No	Physician's advice concerning resident's immediate care needs
b. ☐ Yes ☐ No	Description of prior treatments	e. ☐ Yes ☐ No	Pertinent social information
c. ☐ Yes ☐ No	Description of rehabilitation potential	f. ☐ Yes ☐ No	Information on alternative available community resources to which the resident may be referred

Comments:

IV. CHANGE OF CARE RECOMMENDATION

16. The resident's condition warrants a change to: (Check one)

a. ☐ Nursing facility services b. ☐ ICF/ORC c. ☐ Inpatient psychiatric d. ☐ ICF/MR e. ☐ Other _____

Summarize condition that warrants the care recommended:

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☐ (02) Discharge against medical advice	☐ (05) Transfer / Disch. to hospital	☐ (08) Transfer / Disch. to psych. facility	☐ (12) Other (specify) _____
☐ (03) Expired, no autopsy	☐ (06) Transfer / Disch. to nursing facility	☐ (09) Disch. to boarding home	_____

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20. _____ 21. _____

Signature of administrator or designee — Date (mm,dd,yy)

COUNTY ASSISTANCE OFFICE