



Return to: DHS/Med-QUEST Division
 Medical Standards Branch
 P. O. Box 339
 Honolulu, HI 96809-0339

CENSUS REPORT

Medicaid Resident Movement

FACILITY NAME

PERIOD COVERED
 From: ____ / ____ / ____ To: ____ / ____ / ____
mm/dd/yy mm/dd/yy

TYPE OF REPORT (Check only one) MONTHLY QUARTERLY

GENERAL INSTRUCTIONS:

- Please PRINT/TYPE all information.
- Submit a Monthly report each month.
- Reports due by 15 of following month.
- Submit Monthly and Quarterly (an alphabetical list) of all Medicaid residents in-house on March 31, June 30, September 30, and December 31.

MEDICAID RESIDENT <small>(List Last Name, First Name)</small>	MEDICAID (HMSA) ID No.	FOR MONTHLY						REMARKS **
		Admission Date		L O A	D	E	Date of Action *	
		To Facility	To Medicaid					
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
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19.								
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21.								
22.								
23.								
24.								
25.								

THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE FOR THE REPORTING PERIOD.

* DATE OF ACTION for Level of Acuity (LOA) Change, Discharge(D) or Expiration (E).

** REMARKS, i.e., Admit from, Discharged to, LOA change
 (A = ICF, B = ICF/MR, C = SNF)

 Signature/Title Date

DHS 1137 (Rev. 11/96)

Original-MQD/MSB Copy

Copy # 2 - Fiscal Intermediary

Copy # 3 - Facility Copy