State of Illinois
Illinois Department of Healthcare and Family Services

LONG TERM CARE FACILITY NOTIFICATION

To: ______________________ From: ______________________

Client Name ______________ Recipient Number: ______________ Case Number: ______________

SSN: ______________ Social Security Claim Number ______________ Birth Date: ______________

Place of Birth: State: ______________ City: ______________ County: ______________

☐ **1. ADMISSION**

Admission Date: ______________ From: ☐ Hospital ☐ Community ☐ SLF ☐ Other LTC Facility

Previous Address: ______________________________

Client receives or will receive hospice services ☐ Yes ☐ No

Admitting Diagnosis (ICD-9 Code): ______________________________

Attending Physician Name: ______________ Attending Physician Number: ______________

Level of Care (Check One): ☐ SNF ☐ ICF ☐ ICF/MR ☐ SLF ☐ SLF Dementia Unit

☐ **2. DISCHARGE**

Discharge Date: ______________

To: ☐ Community ☐ Other LTC Facility ☐ SLF ☐ General Hospital ☐ State Operated Facility

☐ Left State/County ☐ Unknown ☐ CILA ☐ Other ______________

New Address: ______________________________

☐ **3. DEATH**

Date of Death: ______________ Body Released To: ______________

☐ **4. COMPLETE THIS SECTION ONLY WHEN REPORTING A DISCHARGE OR DEATH**

☐ Personal Funds Balance on the Day of Discharge or Death: $ ______________

☐ Amount of Other Funds on the Day of Discharge or Death: $ ______________

☐ Room & Board Balance on the Day of Discharge or Death: $ ______________

Funds were Given to: ☐ Client ☐ Relative ☐ Administrator of Estate ☐ Other

Name/Relationship/Address: ______________________________ Amount: $ ______________

☐ **5. MEDICARE (Check as appropriate)**

☐ Full Medicare Covered SNF Services: Begin Date: ______________ End Date: ______________

☐ Medicare Coinsurance: Begin Date: ______________ End Date: ______________

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☐ **6. INSURANCE COVERAGE (TPL)**

(e.g. name of company, change in coverage, change in premium):

☐ **7. RECEIPT OF LONG TERM CARE INSURANCE (TPL) PAYMENT**

Date Received: ______________ Amount: $ ______________ Dates Covered by Payment: ______________

Date and Amount of TPL Funds, if any, Returned to Client: Date: ______________ Amount: $ ______________

Date and Amount of Group Care Credit Funds, if any, Returned to Client: Date: ______________ Amount: $ ______________

☐ **8. INCOME (Check as appropriate)**

☐ Change in Income: Previous Monthly Amount: $ ______________ Date Last Received: ______________
Current Monthly Amount: $ ______________ Date Last Received: ______________
Source: ______________

☐ Receipt of Income: Monthly Amount: $ ______________ Source: ______________
Date First Received: ______________

☐ Receipt of Sum: Amount: $ ______________ Source: ______________ Date Received: ______________

☐ **9. REMARKS**

HFS 26 Attached: ☐ Yes ☐ No HFS 2536 Attached: ☐ Yes ☐ No

Signature/Title: ______________ Date: ______________

INSTRUCTIONS FOR COMPLETION

PURPOSE: The HFS 1156 is used by the LTC or SLF facility to notify the Department of Human Services (DHS) Family Community Resource Center (FCRC) of admission, discharge, death or other changes in circumstances of a client which could have an effect on continuing eligibility. When changes in the client's circumstances occur, this notice must be forwarded to the DHS FCRC within five days of the change. Since reserve bed days do not affect eligibility, it is not necessary to complete this form to report absences for hospitalization or therapeutic home visits.

1. Check if reporting a new admission. Enter all information for this item.
2. Check if reporting a discharge. Enter all information for this item.
3. Check if reporting a death. Enter all information for this item.
4. Check as appropriate when reporting a discharge or death. Enter all information for this item. Do not delay submittal of this form because the client's funds have not been disbursed. Enter the balance of funds on the day of discharge or death. If none, enter "0". Enter name/relationship/address of persons to whom funds were given and the amount disbursed. Enter "0" if the funds have not been disbursed as of the date the form is completed.
5. Check if reporting a change to or from Medicare coverage. Enter all information for this item.
6. Check if reporting new insurance coverage or a change in existing coverage.
7. Check if reporting receipt of long term care insurance coverage.
8. Complete if reporting a change in the client's income. Complete upon receipt of information or as changes occur. Check as appropriate and enter necessary information.
9. This section is completed to convey additional information for which no other space is provided on the form (e.g., funds in excess of $2000). Complete as needed.

The form must be signed and dated by the person to whom the facility has assigned the responsibility for reporting changes in a client's circumstances.