State of Illinois
Department of Healthcare and Family Services

Screening Verification Form

This form is used for prospective residents who are being admitted from another nursing facility where a copy of the original screening assessment completed for admission to the transferring nursing facility cannot be found. Pursuant to 89 Ill. Adm. Code 140.642, Screening Assessment for Nursing Facility and Alternate Residential Settings and Services, the transferring facility is responsible for ensuring that copies of the resident's most recent screening assessment accompany the transferring resident. Admitting facilities must make every effort to obtain a copy of the screening assessment from the discharging facility prior to completing this form.

To: CCU Name _____ Date: _____

From: Facility Name _____ Address _____

Phone Number _____ Fax Number _____

Resident Name _____ Birth Date _____

Social Security Number _____ Medicaid Eligible: Yes ☐ No ☐

If yes, Medicaid Recipient Identification Number _____

Anticipated Date of Admission: _____

(Following to be completed by CCU)

Agency records show that the above named resident was screened on _____

The screening ☐ indicate nursing facility services are appropriate.

Signature of Individual Verifying Screening Results	Title	Agency/Office	Date