Georgia Department of Human Services
Department of Family and Children Services
Nursing Facility Information Request

Applicant/Recipient Information – To Be Completed by DFCS Case Worker

A/R Name ______________________ Case Number ______________
Facility Name ______________________ Client ID ______________

Facility Information – Facility to Complete Each Line Marked

_____ **Responsible Party Information**
- Name ______________________
- Phone Number ______________________
- Address ______________________

_____ **Patient Fund Account Information**
- Does your facility have a patient fund account for this patient? _______ Yes _______ No

If A/R has a patient fund account, what is the balance as of the FIRST DAY of the month(s) listed below?

Month	Balance	Interest Paid

Were any deposits made to the patient fund account in the following months?

Month	Amount	Source

_____ **Pre-payment and Deposit Information**
- Is your facility holding a pre-payment or deposit for this month? _______ Yes _______ No
- If yes, what is the amount? ______________
- If yes, to whom will it be returned? ______________________

_____ **Funeral Home Information**
- Do facility records list a funeral home? _______ Yes _______ No
- If yes, name of funeral home? ______________________
- Address ______________________

_____ **Contribution Above Medicaid Billing Rate**
- Is any contribution made to the facility above the Medicaid billing rate? Yes No

_____ **Bank Account Information**
- Has your facility opened a bank account for this patient? _______ Yes _______ No
- If yes: Bank Name ______________ Account Number ______________

______________________________ Nursing Home Representative Signature

______________ Date

______________________________ Printed Name

______________ Title