

REQUEST FOR EXTRAORDINARY CIRCUMSTANCES

PLEASE FAX COMPLETED FORM TO: (207) 287-9231 OES, Attn: Linda Cayer

Date of Request: _____

Resident's Name: _____ MaineCare # _____

Facility: _____ Phone # _____

Address: _____ Fax # _____

Does the resident have a legal guardian or some other family member who should also be notified of the Extraordinary Circumstances determination?

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name of person completing form: _____

Date of Admission: _____

Payment source at time of admission was: MaineCare Medicare Private Pay

Most recent payment source : MaineCare Medicare Private Pay

Date of MaineCare denial (Goold denial) : _____

Has MaineCare paid for resident's care for more than 120 consecutive days, *EXCLUDING APPEAL DAYS*?

Yes No Dates: _____ to _____

Has there been any interruption of the nursing facility providing services: Yes No

If yes, please explain, giving dates: _____

For what dates is the facility requesting payment? Start date: _____ End date: _____ (You may indicate " until placement" if there is no end date .)

Has the resident filed an appeal: Yes No If yes, on what date was the appeal filed? _____ Date of hearing: _____

(continued on page 2) Request for Extraordinary Circumstances June 1, 1996 (revised 6/25/02)

Commissioner's final decision:

EVIDENCE OF DISCHARGE PLANNING

What home care options have been identified for this resident? What steps have been taken?

PLEASE LIST THE RESIDENTIAL CARE OR CONGREGATE HOUSING FACILITIES WITHIN A 30 MILE RADIUS CONTACTED BY FACILITY STAFF.

Facility name: _____	Phone # _____
Address: _____	Contact person: _____

Date (s) facility was contacted: _____	
What type of resident do they serve? _____ Do they have any vacancies? _____	
Is your resident on their waiting list? <input type="checkbox"/> yes <input type="checkbox"/> no Est. time to reach the top of the list: _____	

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Address: _____	Contact person: _____

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Is your resident on their waiting list? <input type="checkbox"/> yes <input type="checkbox"/> no Est. time to reach the top of the list: _____	

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Facility name: _____ Phone # _____
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Date (s) facility was contacted: _____
What type of resident do they serve? _____ Do they have any vacancies? _____
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