island health care island hospice THAGroup independent life at home ideal aging

INDIGENT / UNINSURED PATIENT CONTINUATION OF SERVICES

Service Line: Date: _____

☐ Island Health Care ☐ Island Hospice

Community Office:

☐ Beaufort ☐ Bluffton/HHI ☐ Skidaway/RH ☐ Statesboro ☐ W Savannah (Pooler)

Part I:

Patient Name	MRN
Referring Physician	
Diagnosis	
Additional Services Requested (Frequency and Duration)	
Circumstances of Requested Admission to Include Alternate/Follow-Up Plan	

_____ _____

Director of Patient Centered Care Date

_____ _____

VP Authorizing Approval Date

_____ _____

CEO or Designee Date

Part II: To be completed by Community Office

MSW Assigned to Follow Up on Medicaid Application (Name and Date)	Date Application Completed and Forwarded to Medicaid	
Medicaid Eligible? ☐ Yes ☐ No	Application Status ☐ Pending ☐ Not Applied ☐ MSW	
Estimated Cost	Finance Notified ☐ Yes ☐ No	
Date Faxed to The Center	Date Scanned in Chart	Date Forwarded to Finance