Reset Form

MassHealth
Commonwealth of Massachusetts · EOHHS
www.mass.gov/masshealth

Status Change for Members in a Nursing Facility or Chronic Disease and Rehabilitation Inpatient Hospital

(Admission or Discharge of MassHealth Members)

SECTION 1 (Items 1 through 12 must be completed.)

1. Provider ID/Service Location	2. Provider Name	3. Provider Telephone Number
4. Provider Address		5. Reason for Submission ☐ New SC-1 ☐ Change to Existing SC-1
6. Member Last Name	7. Member First Name	8. Middle Initial
9. Member Home Address		
10. Member Date of Birth / /	11. Member Gender ☐ Female ☐ Male	12. Member ID or SSN (Provide SSN only if member ID is not available.)

SECTION 2 (Please read instructions on the back of this form for how to complete this section.)

13. Type of Status Change
- ☐ Admit
- ☐ Discharge
- ☐ Both admit and discharge

14. Type of Bed
- ☐ Nursing facility
- ☐ Chronic/Rehab

15. Admitted From
- ☐ Home/community
- ☐ Hospital
- ☐ Nursing facility
- ☐ Rest home

16. Admission Date
/ /

17. Discharge Date
/ /

18. Discharge Reason
- ☐ Discharged to Home/community
- ☐ Discharged to a hospital
- ☐ Discharged to a long-term-care facility
- ☐ Discharged to a rest home
- ☐ Left against medical advice
- ☐ Deceased. Date of death: ___/___/___
- ☐ Other (explain): _____

SECTION 3 (Please read instructions on the back of this form for how to complete this section.)

19. MassHealth Requested Payment Date / /	20. Reason for MassHealth Requested Payment Date

21. Length of Stay for Nursing Facility Services
- ☐ Short-term (six months or less)
- ☐ More than six months
- ☐ Short-term-care stay terminated

22. Clinical Eligibility for Nursing Facility Services
- ☐ Approved
- ☐ Approved – short term
- ☐ Denied

Effective date of decision: ___/___/___

Complete Items 23, 24, 25 only if member's expected stay is six months or less.

23. Certification of Short Term Stay. I certify that the above-named member's expected length of stay is _____ .	24. Physician's Signature	25. Date / /

26. Public Rate Amount $	27. Private Rate Amount $	28. Medicare Upon Admission? ☐ Yes ☐ No	29. Medicare End Date / /
30. Does member have managed care organization (MCO), Program for All-Inclusive Care for the Elderly (PACE), or Senior Care Options (SCO) coverage? ☐ Yes ☐ No			31. MCO End Date (N/A for SCO/PACE) / /
32. Is the nursing facility clinical eligibility determination form attached? ☐ Yes ☐ No		33. For new admission, is Level 1 OBRA/PASARR form attached? ☐ Yes ☐ No	
34. Signature of authorized representative completing the SC-1 form.		35. Date / /	

SC-1 (Rev. 05/09)

SEE REVERSE SIDE FOR INSTRUCTIONS.

INSTRUCTIONS FOR COMPLETING THE SC-1 FORM (PLEASE PRINT OR TYPE.)

Below are instructions for specific fields. All other fields are self-explanatory. For all items with check boxes, please make sure you check one box. As noted below, some fields are required to be completed.

SECTION 1

Items 1 through 12 are required to be completed on all SC-1 forms.

Item 1	Provider ID/Service Location	Enter the nine-digit provider ID followed by the one-character location code.
Item 12	Member ID or SSN	Enter the 12-digit MassHealth member ID number. Enter the social security number (SSN) *only* if member ID is not available.

SECTION 2

Item 13 is required to be completed.

- If Item 13 is "Admit," items 14-16 are required to be completed.
- If Item 13 is "Discharge," items 17-18 are required to be completed.
- If Item 13 is "Both admit and discharge," items 14-18 are required to be completed.

Item 18	Discharge Reason	Select the reason for discharge. If none of the reasons explains the situation clearly, use the other field to explain.

SECTION 3

- If Item 13 is "Admit" or "Both admit and discharge," items 19-22 and 26-33 are required to be completed.
- If Item 21 is "Short-term (six months or less)," items 23-25 are required to be completed.
- Items 34-35 are required to be completed on all SC-1 forms.

Item 19	MassHealth Requested Payment Date	Enter the start date for which MassHealth payment is requested.
Item 20	Reason for MassHealth Requested Payment Date	Describe the reason for the request date in Item 19 (e.g., Medicare days ended, private pay ended).
Item 21	Length of Stay for Nursing Facility Services	The nursing facility should enter the information as it appears on the clinical eligibility determination completed by MassHealth or its agent.
Item 22	Clinical Eligibility for Nursing Facility Services	The nursing facility should enter the information as it appears on the clinical eligibility determination completed by MassHealth or its agent. If clinical eligibility for MassHealth payment of nursing facility services has been denied, do not submit this form as the facility will not be paid.
Item 26	Public Rate Amount	Enter the public facility rate for this member.
Item 27	Private Rate Amount	Enter the private facility rate for this member.
Item 32	Is the nursing facility clinical eligibility determination form attached?	Check the "Yes" box if the nursing facility screening notification form is attached. Otherwise, check "No." If the form is not attached, the member will not be coded for long-term-care services.
Item 33	OBRA/PASARR form attached?	For new admissions only, check the "Yes" box if Level 1 OBRA/PASARR form is attached to the SC-1 form. Otherwise, select "No."