**Status Change for a Member 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.) PLEASE PRINT OR TYPE**

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 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 rest home Discharged to a hospital

Left against medical advice Discharged to a long-term-care facility   
Deceased. Date of death: ………………………………. Other (explain):

**SECTION 3 (Please read instructions on the back of this form 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 if member is expected to stay 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. Does member currently have the MassHealth Family Assistance 100-day coverage? Yes No

33. MassHealth Family Assistance 100-day coverage end date for this admission ………………………………

34. Is the nursing facility clinical eligibility determination form attached? Yes No

35. For new admission, is Level 1 OBRA/PASARR form attached? Yes No

35. Signature of authorized representative completing the SC-1 form. ………………………………………………………………

36. Date ………………………………

**Instructions for Completing the SC-1 Form**

Please see instructions below for the fields that are not 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. Family Assistance 100-day Coverage

Check the “Yes” box if member has MassHealth Family Assistance, and is eligible for 100-day coverage for this admission.

Item 33. MassHealth Family Assistance 100-Day Coverage End Date for this Admission

Enter end date for MassHealth Family Assistance 100-day coverage for this admission.

Item 34. 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 35. 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.”

SC-1 (Rev. 01/21)