MassHealth
Commonwealth of Massachusetts · EOHHS
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Status Change for Residents in a Rest Home

(Admission or Discharge of SSI Recipients)

SECTION 1

1. Rest Home ID/Service Location	2. Name of Rest Home	3. Telephone No. of Rest Home

4. Address of Rest Home

5. Resident Last Name	6. Resident First Name	7. Middle Initial

8. Resident Home Address

9. Resident Date of Birth	10. Resident Gender	11. Member ID or SSN (Provide SSN only if member ID is not available.)
/ /	☐ Female ☐ Male	

SECTION 2

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

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

14. Admission Date
/ /

15. Discharge Date
/ /

16. 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

17. Requested Payment Date
/ /

18. Signature of authorized representative completing the SC-1-RH form.	19. Date / /

INSTRUCTIONS FOR COMPLETING THE SC-1-RH 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.

SECTION 1		
Item 1	Rest Home ID/Service Location	Enter the nine-digit provider ID followed by the one-character location code.
Item 11	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 16	Discharge Reason	Includes home/community, hospital, long-term-care facility, rest home, or left against medical advice. If selecting deceased, enter the date of death. If reason is any other, explain the reason in the space provided.
SECTION 3		
Item 17	Requested Payment Date	Enter the start date for which payment is requested.