



**INSTRUCTIONS**  
**CARE LEVEL CHANGE NOTICE (F-62281)**

Complete this form for nursing facilities and facilities for the developmentally disabled.

The assigned RN is responsible for the accurate completion of this form.

**SECTION A**

- Document only those residents whose care level has changed as a result of the survey process but whose care needs will continue to be met by this facility.
- List the name of the resident, MA number, previous care level (nursing/DD/MI), and current care level (Nursing/DD/MI)
- Sign with a complete signature (not initials).

**NOTE:** The effective date is the date served.

**SECTION B**

Document only those residents who no longer are eligible for coverage under the Wisconsin Medical Assistance Program because their needs no longer qualify them for care at this facility.

**NOTE:** Section B residents receive notice of non coverage via certified mail. The effective date of non coverage is always the 1<sup>st</sup> working day of the month following a ten calendar day notice plus 5 calendar days for mail delivery.

**Example 1 - Letter mailed to resident on March 10**

5 calendar days for mail delivery + 10 calendar days for notice of non coverage = March 25

Effective date would be the first working day in April.

**Example 2 - Letter mailed to resident on March 20**

5 calendar days for mail delivery + 10 calendar days for notice of non coverage = April 4

Effective date would be the first working day in May.

**SIGNATURE**

Provider signs and dates this form to indicate that the facility has received notice of the care level changes and the facility administrative review rights for those residents listed in Section A of this form.