BED-HOLD NOTICE

______________________ is receiving this notice because you are admitting/recently were admitted
Resident Name
to the hospital or will be out of this facility temporarily on therapeutic leave or vacation. It is the policy of

____________________________ to remind you of the bed-hold policy for such absences
Facility Name
and to provide you/your representative with information about holding your bed while you are out.

If your stay in this facility is paid by Medicaid, your bed will be held at no cost to you (your room/bed will be reserved upon your request) for a maximum of ____ days in a calendar month while you are hospitalized. If you are hospitalized beyond that number of days, you/your representative may choose to request that this facility extend the bed-hold beyond those days, however you must use your own funds to pay for that extended bed-hold.

If you will be out of this facility on therapeutic leave or vacation for a maximum of ____ days in a calendar year and your stay in this facility is paid by Medicaid, your room/bed will be reserved upon your request for those days without cost to you. If you/your representative wish to hold your bed beyond that number of days, you must use your own funds to pay for that extended bed-hold.

If you do not hold your bed (in accordance with the bed-hold policy) and you wish to return to this facility, you will be allowed to return to your previous room, if it's available, or immediately upon the first availability of another bed in a semi-private room. This is conditioned upon requiring the services provided by this facility and your eligibility for Medicaid nursing facility services or Medicare skilled nursing facility services.

Medicare does not provide a bed-hold benefit. As a result, private pay residents as well as those residents utilizing Medicare coverage for his/her stay may choose to hold the bed at the current room and board rates until you return to this facility.

You/your representative must verify that you wish to have your bed held within 24 hours of being admitted to the hospital or your bed will be relinquished. Verification of bed-hold must be made prior to the start of your vacation or therapeutic leave from this facility. Bed-hold fees are payable prior to return to this facility.

Please contact ______________________ at ______________ with any questions you have.
Name | Phone Number

❍ AM
❍ PM

______________________________ ____________ ____________
Signature/Title of Administrative Officer | Date | Time

❍ I wish to reserve my room. ❍ I do not wish to reserve my room.

Signature:______________________________ Date:____________

Title (if not the Resident):______________________________ Time:________ ❍ AM ❍ PM

Private Pay Rates as of __________: Daily Semi-Private $________ Daily Private $________

PART 1 – Resident **PART 2 – Facility**

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

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