



Department of
HUMAN SERVICES

PathTracker Case Activity Report

This form is generated electronically with information received through PathTracker.

1. Member Data

Name	Date Entered Facility	PASRR Date
Social Security Number	State ID	Medicaid Case Number

2. Facility Data

Medicaid Provider Number	Facility Type <input type="checkbox"/> Nursing Facility (NF/ICF) <input type="checkbox"/> Skilled Nursing Facility (SNF) <input type="checkbox"/> Nursing Facility for Persons with Mental Illness (NF/MI)		
NPI Number			
Facility Name			
Street Address	City	State	ZIP
Person Completing Form		Date Completed	
Contact Phone Number		Contact Email	

3. Level of Care

Level of Care <input type="checkbox"/> NF/ICF <input type="checkbox"/> NF/MI <input type="checkbox"/> Skilled <input type="checkbox"/> Other	Level of Care Process <input type="checkbox"/> IME Medical Services <input type="checkbox"/> Medicare <input type="checkbox"/> Managed Care <input type="checkbox"/> Non-Medicaid	Effective Date
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4. Medicare Information for Skilled Patients in Facilities

Note: Dates in this section are populated when Medicare is marked in Section 3.

Expected Dates of Medicare Coverage through
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5. Discharge Data

Reason for Discharge: <input type="checkbox"/> Died <input type="checkbox"/> Hospital (Less than 10 days, form is not required) <input type="checkbox"/> Transferred to another facility <input type="checkbox"/> Moved home <input type="checkbox"/> Moved to other living arrangement	Date of Discharge	Per Diem at Discharge	
	Address Discharged to:		
	Facility Name (if applicable)		
	Street		
	City	State	ZIP

6. Hospice or PACE Provider Information

Note: Only complete this section if individual residing in your facility has elected hospice or is enrolled with PACE.

Elected/Enrolled Program Information <input type="checkbox"/> Hospice <input type="checkbox"/> PACE	Medicaid Provider Number Hospice PACE	NPI Number Hospice PACE
Name of Hospice or PACE Provider	Date of Election/Enrollment	Date of Revocation/Disenrollment
Contact Name for Hospice or PACE	Contact Phone Number	Contact Email

Instructions for Preparing the PathTracker Case Activity Report

- ◆ When a current resident applies for Medicaid, complete sections 1, 2, and 3 and if applicable, sections 4 and 6. If the individual is already in PathTracker, their name will populate when the SSN is entered. If not in PathTracker, enter the resident's first name, middle initial, and last name as they appear on the *Medical Assistance Eligibility Card*. The state ID number is assigned by the Iowa Department of Human Services and consists of seven digits plus one letter, e.g., 1100234G.
- ◆ When a Medicaid applicant or member enters the facility, complete sections 1, 2, and 3 and if applicable, sections 4 and 6.
- ◆ When a Medicaid applicant or member changes level of care, complete sections 1, 2, and 3 and if applicable, sections 4 and 6.
- ◆ When there is Medicare coverage and the Medicaid rate is higher than the Medicare rate, complete sections 1, 2, and 4 and if applicable, section 6.
- ◆ When a Medicaid applicant or member dies or is discharged or transferred, complete sections 1, 2, and 5 and if applicable, section 6.
- ◆ The administrator or designee responsible for the accuracy of this information should complete section 2.
- ◆ If the Medicaid member is receiving benefits through a hospice or PACE provider, please refer to bullets 1 through 5 above and also complete section 6.

Distribution Instructions for Hospice, NFs, NF/MIs, and SNFs

All NFs, NF/MIs, and SNFs in Iowa are required to enter admission, discharge, and transfer information into Ascend Database PathTracker Plus (PathTracker). This form is generated electronically with information received through PathTracker.

Hospices can submit this form via paper. The facility should keep a copy for their records and also mail, email or fax a copy to:

Centralized Facility Eligibility Unit
Imaging Center 1
Iowa Department of Human Services
417 E. Kaneshville Blvd.
Council Bluffs, IA 51503-4470
Fax: 515-564-4040 Email: facilities@dhs.state.ia.us

Distribution Instructions for PACE

PACE Organizations (PO) can submit this form via paper if the member is enrolled with a PACE program. The PO should keep a copy for their records and also email or fax a copy to the appropriate Imaging Center with an attention to your DHS IM:

Western Service Area
Fax: 515-564-4014
Email: Imagingcenter1@dhs.state.ia.us

Des Moines Service Area
Fax: 515-564-4018
Email: Imagingcenter5@dhs.state.ia.us

Northern Service Area
Fax: 515-564-4015
Email: Imagingcenter2@dhs.state.ia.us

Cedar Rapids Service Area
Fax: 515-564-4017
Email: Imagingcenter4@dhs.state.ia.us