Georgia Department of Community Health
Non-Institutional Reimbursement Unit
2 Martin Luther King Jr Dr. SE, East Tower 17th Floor,
Atlanta, GA 30334

APPENDIX B
HOSPICE CAP RATE DATA REQUEST FORM

HOSPICE FACILITY: **FREESTANDING** _____ **HOSPITAL BASED** _____

Medicaid Provider Name: _____

Medicaid Provider ID: _____
Street address: _____

City: _____ State: _____ Zip Code: _____

COUNTY: _____

COST REPORTING FY: FROM: _____ TO: _____

CAP RATE REPORTING PERIOD: _____ TO: _____

Enter information from agency's records for CAP reporting period November through October

	Medicaid XIX Beneficiaries	Medicaid XIX Days	Medicaid XIX Medicaid Payments
CONTINUOUS HOME CARE **(Unduplicated Days, Beneficiaries & Medicaid Payments)**			
ROUTINE HOME CARE **(Unduplicated Days, Beneficiaries & Medicaid Payments)**			
INPATIENT RESPITE CARE **(Unduplicated Days, Beneficiaries & Medicaid Payments)**			
GENERAL INPATIENT CARE **(Unduplicated Days, Beneficiaries & Medicaid Payments)**			
ENROLLED AIDS PATIENTS **(Unduplicated Days, Beneficiaries & Medicaid Payments)**			
TOTALS			

How many Medicaid members transferred in from another hospice facility? _____

How many Medicaid members transferred out to another hospice facility? _____

Officer or Administrator of Agency: (Print) _____

Title: _____

Signature: _____

Contact Phone Number: _____

For assistance, please send an email to DCH_NIR@dch.ga.gov
Information is requested pursuant to Part II Policies and Procedures for Hospice Services Sections 1005 and 1007