

CalPERS Long-Term Care Program
CONTINUED MONTHLY RESIDENCE FORM

Instructions:

- The Continued Monthly Residence (CMR) form is a required part of the monthly claim submission and must be completed thoroughly by facility staff.
- Ensure copies of current BLANK CMR forms are maintained by the facility.
- Complete a form for each month, on or after the last day of the month, after the services have been provided. (Example: Facility charges from June 1st-June 30th should not be submitted prior to July 1st).
- Submit with a copy of the facility's invoice reflecting room and board charges for the service period.
- Incomplete forms and photocopies of a prior month's completed CMR form will be considered ineligible and may delay the reimbursement process.

Please complete the form and return monthly via fax to 1-866-294-6967 (preferred), or mail to: CalPERS Long-Term Care Program, P.O. Box 64902, St. Paul, MN 55164.

Facility Name: _____	Resident Name: _____
Facility Address: _____	Resident Policy #: _____
Facility City/State: _____	Resident Room #: _____
Facility Phone #: _____	Resident Move-In Date: _____
Facility Fax #: _____	Month of Service: From _____ Through _____

1. **Has the resident remained in the same room/apartment for the entire month?** Yes No
If no, provide prior room/apartment #: _____

2. **Select the level of care that describes the resident's current room, unit or apartment:**

<input type="checkbox"/> Alzheimer's/Dementia unit (secured)	<input type="checkbox"/> Independent living apartment or unit
<input type="checkbox"/> Alzheimer's/Dementia unit (non-secured)	<input type="checkbox"/> Skilled Nursing Facility
<input type="checkbox"/> Assisted living unit (secured)	<input type="checkbox"/> Intermediate Care Facility
<input type="checkbox"/> Assisted living unit (non-secured)	

3. **At any time during this service period, was the resident away from the facility overnight for any reason?** Yes No
If yes, provide dates: Departure Date: _____ Return Date: _____
Provide reason for absence: _____
If absence was a hospital stay, provide dates: Admission Date: _____ Discharge Date: _____

4. **Is Medicare, Medicaid/MediCal or any other insurance providing benefits for expenses incurred during this service period?**
 No
 Yes, **Medicare**, provide a copy of the Explanation of Medicare Benefits (EOMB); or other proof of remittance by Medicare or Medicare intermediary; or provide dates of 100% coverage/coinsurance coverage:

 Yes, **Medicaid/MediCal**, provide the contact information for Medicaid/MediCal Case Worker:
Case Worker Name: _____
Phone Number: _____ Fax Number: _____
Medicaid/MediCal office: _____
 Yes, **other insurance coverage** information:
Insurer Name: _____ Policy Number: _____
Insurer Address: _____ Phone Number: _____

I verify, to the best of my knowledge, the above information is correct.

Print Name Title Phone Number

Signature Date