Government of the District of Columbia
Department of Health Care Finance
Office of Chronic & Long-Term Care

Proof of Contact of In-State Nursing Facilities

Please print clearly and be sure to complete all sections.

_____ / _____ / _____
Date of Request

Name of Beneficiary for Whom Out-of State Nursing Facility Placement Request is Made:

_____
Last First Middle Initial

DC nursing facilities must be contacted within 48 hours of out-of-state request.

1. Facility Name _____

   Person Contacted _____ Date Contacted _____

   Reason Admission Denied _____

2. Facility Name _____

   Person Contacted _____ Date Contacted _____

   Reason Admission Denied _____