NURSING HOME REFORM ACT OMNIBUS BUDGET RECONCILIATION ACT (OBRA)
Target Resident (MI, ID, ORC) Reporting Form - MA 408 (revised March 1, 2014)

(Must fill in Sections I, II, and III)

SECTION I FACILITY INFORMATION

Facility Name and Complete Address (may affix Facility stamp)	Date	County Code	Service Provider ID
	Contact Person Name		Title
	Telephone Number		Fax Number

SECTION II TRACKING DATA - Check the appropriate box(es)

☐ **NEW ADMISSION** Date _____
A Target resident who is a new admission to a nursing facility and is not being accepted as a transfer from another nursing facility.

EXCEPTIONAL ADMISSION Date _____
(As described in the Exceptional Admission Section of the PA-PASRR-ID (MA 376) form)
Check one of the following:

☐ Resident is an Exempted Hospital Discharge (30 days or less)
(See Change in Condition if individual becomes a long-term placement)

☐ Resident requires Respite Care (14 days or less)
(See Change in Condition if individual becomes a long-term placement)

☐ Resident requires Emergency Placement (30 days or less)
(See Change in Condition if individual becomes a long-term placement)

☐ Resident is in a coma or functions at brain stem level
(See Change in Condition if individual no longer meets coma criteria)

☐ **CHANGE IN CONDITION** Date _____
Any change in individual's condition that affects target status, **OR** a Target individual admitted as an Exceptional Admission and now is in need of long-term nursing facility services, or is no longer in a coma.

☐ **TRANSFER** Date _____
A Target resident who is transferred from one nursing facility to another nursing facility.

Indicate in Section III under comments, the facility name and address the Target individual is transferred to/from. A hospital transfer should not be included here.

☐ **DISCHARGE** Date _____
Indicate below in Section III, comments, where Target individual is discharged to (i.e., home, PCH, etc.).

☐ **EXPIRED** Date _____

☐ **UNREPORTED TARGET** Date _____
A resident who was not identified as a Target at time of admission to nursing facility.

SECTION III RESIDENT INFORMATION

Name - Last, First, M.I.	Social Security Number	MA Recipient Number	Admission Date	Target Category			Date of Program Office Letter of Determination
				MI	ID	ORC	

Comments

NOTE: SEND OR FAX ORIGINAL WITHIN 48 HOURS TO: YOUR NURSING FACILITY FIELD OPERATIONS OFFICE

ENTER NAME AND ADDRESS OF NURSING FACILITY FIELD OPERATIONS OFFICE

FOR DPW USE ONLY

_____ _____
Signature - Nursing Facility Field Operations Representative DATE