



Inland Empire Health Plan

**INLAND EMPIRE HEALTH PLAN
LONG TERM CARE (LTC) DATA SHEET**

IPA Name: _____

Date Submitted: _____

Report for Month of: _____

Submitted by: _____

Member Name	Member ID	Facility Name	Attending Physician	Reason for Admit (deconditioning, IVABX, wd care, etc.)	Admission/ Enrollment Date	Last Cover Date (LCD)	Total SNF Days (Include past & present days)	Prior Residence *See Legend:	Is Member at risk for custodial care? Why?	Member Remains Skilled or Custodial

***Legend:**

- BC = Board & Care
- GH = Group Home
- LA = Live Alone
- AL = Assisted Living
- HL = Homeless
- SNF = Skilled Nursing Facility