Referral Process Information

This packet includes the information necessary for making a referral to Bostick Nursing Center. The referring facility is only responsible for providing the requested medical records and completing the attached SSA-3288 form (Social Security Release Information). Please see instruction below.

1. Please use the attached Medical Record Request Checklist to ensure all necessary documents are submitted.
2. Completion of the SSA-3288, including all signatures, is required with every referral. The form is provided in this packet. Please fill in the applicant's name, date of birth and social security number on the top of the form and have the applicant sign the form.
3. Please fax the medical records and the SSA-3288 form to our fax number below.

Referral Coordinator: Erica Pettigrew – **erica.pettigrew@correctlife.com**

Director of Nursing: Mercy Aquino – **mercedes.aquino@correctlife.com**

Main Phone Number: 478-414-9600

Referral Fax Line: 866-242-3378

Medical Record Request Checklist

Review of the medical records information will help determine if the individual meets the level of care necessary to qualify for nursing placement.

- ☐ **Medical Record Face Sheet – if Available**
- ☐ **Consent for Release of Information**
- ☐ **Recent History and Physical**
- ☐ **Medical Diagnosis List**
- ☐ **Most Recent Medication Administration Record (MAR)**
- ☐ **Behavioral Health Progress Notes**
- ☐ **Immunization Records *TB, Influenza, Pneumo, CoVid-19**
- ☐ **Diet Order**
- ☐ **List of Allergies**
- ☐ **Lab Work (last 3-6 months)**
- ☐ **List of Past Surgical Procedures**
- ☐ **Recent Hospital Notes**

Notes: _____

_____

_____

Additional documentation may be requested after record review

Medical Record Request Checklist

Review of the medical records information will help determine if the individual meets the level of care necessary to qualify for nursing placement.

- ☐ List of adaptive equipment:
  - ☐ Wheelchair
  - ☐ Cane
  - ☐ Walker
  - ☐ Rollator
- ☐ Oxygen _____ Liter, What Device:
  - ☐ Nasal Cannula
  - ☐ Trach Mask
  - ☐ Face Mask
- ☐ CPAP ☐ BiPap
- ☐ Ambulatory ☐ Non-Ambulatory
- ☐ Assistance with:
  - ☐ Feeding
  - ☐ Bathing
  - ☐ Transfer
  - ☐ Toileting
- ☐ Dentures
- ☐ Tracheostomy
- ☐ Feeding tube
- ☐ Colostomy
- ☐ Wounds _____ Stages

Notes: _____

_____

Additional documentation may be requested after record review

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- You, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*signifies a required field).*

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**	***ADDRESS OF PERSON OR ORGANIZATION:**
Bostick Nursing Center	1700 Bostick Circle, Milledgeville GA 31061

***I want this information released because:** I am applying for Medicaid in the state of Georgia.

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date_____ to date_____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

***Address:** _____

Relationship (if not the subject of the record): _____ ***Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)