

Nursing Home Monthly Liability Claim Information



Refer to section 400.147(9), Florida Statutes. This form is required to be completed and submitted monthly to the Agency for Health Care Administration, only if liability claims were filed in the preceding month. Please send this report by the 10th of each month for claims filed the preceding calendar month.

NOTE: Requests for medical records alone should not be reported on this form. The reporting requirement applies to claims for which the facility received a Notice of Intent to Litigate. Adverse incidents or summaries of adverse incidents cannot be reported on the Monthly Liability Claim Report – use the Confidential Nursing Home Adverse Incident forms (1-Day and 15-Day) for this purpose.

Send the completed form to:

Agency for Health Care Administration
Central Systems Management Unit
2727 Mahan Drive, MS-47
Tallahassee, FL 32308
Phone: (850) 410-3400 FAX: (850) 487-0470

AHCA Use Only:	Perm ID:
Date Received:	
Route: CSMU _____	
LTC _____	

Date report submitted: _____

Report period: _____
(i.e.: June 1, 2001 through June 30, 2001)

Nursing Home Information

Name: _____

Street Address: _____

City: _____ County: _____ Zip: _____

Phone: _(_____) _____ FAX: _(_____) _____

The total number of pages included in this report: _____ (insert number of pages including this page).

Report completed by:

Authorized Nursing Home Representative Name

Signature

Date

Position Title

E-mail Address

Attachments: Specific liability claim information for each claim filed during report period

Nursing Home Monthly Liability Claim Information

Nursing Home Name: _____

Report Period: _____

Enter claim information for each claim filed:

Claim Information

Name of resident: _____

Social Security Number: _____

Resident Medicaid ID#: _____
(if applicable)

Date(s) of incident (if specific dates are not provided, indicate the resident's dates of the residency in the facility):

Type of injury, select all that apply:

- ____ 1. Death
- ____ 2. Brain or spinal damage
- ____ 3. Permanent disfigurement
- ____ 4. Fracture or dislocation of bones or joints
- ____ 5. A limitation of neurological, physical, or sensory function
- ____ 6. Any condition that required medical attention to which the resident has not given his or her informed consent, including failure to honor advanced directives
- ____ 7. Any condition that required the transfer of the resident, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the resident's condition prior to the adverse incident
- ____ 8. Abuse, neglect or exploitation as defined in 415.102
- ____ 9. Abuse, neglect and harm as defined in 39.01
- ____ 10. Resident elopement
- ____ 11. Event reported to law enforcement
- ____ 12. Other: _____

Violation alleged (summarize the allegations in the Notice of Intent, e.g. failure to provide adequate nourishment; failure to protect resident from abuse): _____

Claim Information

Name of resident: _____

Social Security Number: _____

Resident Medicaid ID#: _____
(if applicable)

Date(s) of incident (if specific dates are not provided, indicate the resident's dates of the residency in the facility):

Type of injury, select all that apply:

- ____ 1. Death
- ____ 2. Brain or spinal damage
- ____ 3. Permanent disfigurement
- ____ 4. Fracture or dislocation of bones or joints
- ____ 5. A limitation of neurological, physical, or sensory function
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Attach additional pages as needed