

# North Dakota Nursing Facilities Tracking Form



Send to: DDM Ascend, LLC  
227 French Landing Dr, Suite 250  
Nashville, TN 37228  
Fax: 877-431-9568  
Phone: 877-431-1388

## Resident/Applicant Demographic Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_  
SS#: \_\_\_\_\_ Medicaid ID#: \_\_\_\_\_  
Gender: \_\_\_\_\_ Race: \_\_\_\_\_ DOB: \_\_\_\_\_

## Type of Tracking

New Admission       Transfer       Discharge       Deceased

## Requesting Screen

I would like to request a copy of screening information. Please specify request:  
 NF       SB       HCBS       Personal Care       Level I       Level II

## New Admission/Transfer

**I am not requesting screening information.** Submission is for the purpose of notifying DDM Ascend of a **new admission or transfer.**

If New Admission or Transfer, please enter the facility information:

Admitting Facility: \_\_\_\_\_ Admission Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## Discharged/Deceased

**I am not requesting screening information.** Submission is to notify DDM Ascend of **discharge or deceased.**

If **discharge**, please enter the discharge information:

Discharge Date: \_\_\_\_\_  
Discharged To:  
 Hospital/General Medical Unit  
 Hospital/General Psychiatric Unit  
 Lower Level of Care  
 Home  
 Other Setting: \_\_\_\_\_

**Note:** DDM Ascend *must* be notified if the individual is expected to return to the nursing facility setting.

If **deceased**, please enter the deceased date: \_\_\_\_\_

Submitted by: \_\_\_\_\_ Date: \_\_\_\_\_

Facility: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_