



## Election Response Form

Response must be postmarked by **May 30, 2003**

### Option 1 - Election to Print Classification Notices

*Elect one of the following; place an "X" by facility choice*

\_\_\_\_\_ (A) The facility elects to print the case mix classification notices from information on the MN Case Mix Validation report (which is available electronically within 24 hours of submission of MDS forms and acceptance into the Minnesota case mix database) and distribute notices to the residents/ resident's representatives within three (3) business days of printing the MN Case Mix Validation Report.

\_\_\_\_\_ (B) The facility elects to have the Minnesota Department of Health print and mail the case mix classification notices to the facility. The facility will distribute the notices to the residents/resident's representatives within three (3) business days of receipt.

### Option 2 - Election of Default Rate for Short Stay Residents

*Elect one of the following; place an "X" by facility choice*

\_\_\_\_\_ (A) The facility elects to accept a default case mix classification for **all** residents who are admitted to the facility and discharged prior to the end of day 14. The default classification includes residents who are discharged to the hospital prior to the end of day 14 and a return to the facility is anticipated. The default classification has a case mix weight of 1.00.

\_\_\_\_\_ (B) The facility elects to complete a MDS Admission assessment (AA8a=01) for **all** residents who are admitted to the nursing facility, regardless of the length of stay. The case mix classification for the resident will be determined by the initial admission assessment.

If no "X" under an option or no response is received from the facility postmarked by **May 30, 2003**; MDH will print all classification notices for the facility and the facility will complete Admission assessments (AA8a=01) for all residents admitted for the time period July 1, 2003, through June 30, 2004.

***These elections are effective from July 1, 2003, through June 30, 2004.***

Facility Name: \_\_\_\_\_ City: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Print/Type above name: \_\_\_\_\_ Date: \_\_\_\_\_, 2003

Facility ID # \_\_\_\_\_ E-mail address: \_\_\_\_\_

Return Election Response Form to: Minnesota Department of Health  
Case Mix Review Program  
P.O. Box 64938  
St. Paul, MN 55164-0938

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