Appendix 36 ▪ Institutionalization Form (Optional)

Participant Name:_____ MSSP ID: _____

Indicate all MSSP participant hospitalization (in-patient and out-patient), nursing facility admits, & emergency room visits as follows:

Indicate Facility Name & Type	Admit Date	Discharge Date	Number of Days	Reason	Record Requested (optional)	Comments (optional)
☐ Hospital ☐ Nursing Facility ☐ Emergency Room						
☐ Hospital ☐ Nursing Facility ☐ Emergency Room						
☐ Hospital ☐ Nursing Facility ☐ Emergency Room						

Indicate Facility Name & Type	Admit Date	Discharge Date	Number of Days	Reason	Record Requested (optional)	Comments (optional)
☐ Hospital ☐ Nursing Facility ☐ Emergency Room						
☐ Hospital ☐ Nursing Facility ☐ Emergency Room						
☐ Hospital ☐ Nursing Facility ☐ Emergency Room						