STATEMENT OF DILIGENT SEARCH

REFERRING AGENCY/FACILITY: _____ PAGE _____ OF _____

PROSPECTIVE RESIDENT: _____ SS#/MEDCAID ID: _____

DOB: _____ AGE: _____

BELOW LIST FACILITIES. IF ADDITIONAL SPACE IS NEEDED PROCEED TO PAGE 2.

No need to make referrals to facilities who will not accept gender of patient.

FACILITY	FACILITY PHONE #	PERSON CONTACTED	DATE CONTACTED	REASON NOT APPROPRIATE FOR FACILITY

I ATTEST TO THE ACCURACY OF THE ABOVE DOCUMENTATION: _____

SIGNATURE OF PERSON CONDUCTING DILIGENT SEARCH

PRINT AND FAX TO 1-800-807-8843

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