



**Government of the District of Columbia
Department of Health Care Finance
Office of Chronic & Long-Term Care**



**Cover Page for Request for
Out-of-State Nursing Facility Placement**

Please print clearly and be sure to complete all sections. Fax completed application packet to 202-442-4799.

_____/_____/_____
Date of Request

Name of Beneficiary _____
Last First Middle Initial

Requesting Facility _____

Address _____

Phone (_____) _____ - _____ Fax (_____) _____ - _____

Name of Individual Completing Form _____

Title _____

Placement Facility (if different from above) _____

Address _____

Phone (_____) _____ - _____ Fax (_____) _____ - _____

Check the following boxes to verify all necessary documentation is included in application packet:

- | | | |
|--|------------------------------|-----------------------------|
| Cover Page for Request for Out-of-State Nursing Facility Placement | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Request for Out-of-State Placement | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Proof of Contact of In-State Nursing Facilities
(a minimum of two (2) DC facilities must be contacted and deny placement) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Level of Care approval from the Quality Improvement Organization (Delmarva) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Request for Medicaid Nursing Facility Level of Care (DHCF Form 1728) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pre-Admission Screening and Resident Review (PASRR) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Beneficiary Agreement | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Beneficiary's history and physical | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Discharge summary (if available) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Copy of the most recent physician and nurse notes (as needed) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Reason beneficiary is not being placed in the community:

- Type or intensity of care required not available in the community
- Beneficiary prefers to receive care in a nursing facility
- Housing issues preclude individual from placement in the community
- Other: _____