Government of the District of Columbia

Department of Health Care Finance

Request for Medicaid Nursing Facility Level of Care

Please Print Clearly and Be Sure to Complete All Sections

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Level of Care Requested: | ❑ | Nursing Facility | ❑ | Adult Day Treatment | ❑ | Elderly and Individuals with Physical Disabilities (EPD) Waiver |

|  |  |  |
| --- | --- | --- |
| **Reason for Request for Nursing Facility (NF) Services:** | **Reason for Request for Adult Day Treatment Services:** | **Reason for Request for EPD Waiver Services:** |
| ❑❑❑ | Return from Hospital within Medicaid Bedhold Days (Number of Bedhold Days Left \_\_\_\_\_\_)Return from Hospital after Medicaid Bedhold has ExpiredTransfer from EPD Waiver to NF | ❑❑❑ | Initial NF PlacementConversion from Any Other Pay Source to Medicaid (Start On \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_)Transfer from NF to NF  | ❑ | Initial Assessment | ❑❑❑ | Initial Assessment Annual Reassessment Transfer from NF to EPD Waiver |

**Part A**

Date of Request \_\_\_/ \_\_\_/ \_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle Initial

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Medicaid # (if not available, state if pending) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permanent Address (include name of NF, if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_ – \_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Representative (Power of Attorney or Legal Guardian). Indicate N/A, if applicable. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present Location of Individual (Name and Address of Hospital/NF/Community if Different From Above)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part B**

(Please check one box in each row below)

|  |  |  |  |
| --- | --- | --- | --- |
| Activities | Only Independent(Needs no help) | Supervision or Limited Assistance(Needs oversight, encouragement or cueing **OR** highly involved in activity but needs assistance) | Extensive Assistance or Totally Dependent (May help but cannot perform without help from staff **OR** cannot do for self at all) |
| **Activities of Daily Living (ADLs)** |
| Bathing | ❑ | ❑ | ❑ |
| Dressing | ❑ | ❑ | ❑ |
| Overall Mobility | ❑ | ❑ | ❑ |
| Eating | ❑ | ❑ | ❑ |
| Toilet Use | ❑ | ❑ | ❑ |
| **Instrumental Activities of Daily Living (IADLs)** |
| Medication Management | ❑ | ❑ | ❑ |
| Meal Preparation | ❑ | ❑ | ❑ |
| Housekeeping | ❑ | ❑ | ❑ |
| Money Management | ❑ | ❑ | ❑ |
| Using Telephone | ❑ | ❑ | ❑ |

Is the individual ventilator-dependent? ❑ Yes ❑ No

If additional supporting documents are included please list them here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Completing Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_ – \_\_\_\_\_\_\_\_

Signature of Person Completing Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

**Part C - Must be Completed by a Physician, Physician Assistant, or Nurse Practitioner Responsible for Patient Care**

The information presented above appropriately reflects the patient’s functional status.

|  |  |  |  |
| --- | --- | --- | --- |
| Name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ ❑❑  | **Please check appropriate box:**PhysicianPhysician AssistantNurse Practitioner |
| Address | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone | (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | NPI \*  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date  | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ |

\*Physician assistants should include their supervising physician’s NPI number

**Part D - To be completed by the Quality Improvement Organization (if needed)**

|  |  |  |  |
| --- | --- | --- | --- |
| Level of Care | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Certification Period (for EPD Only) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Authorized Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date | \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Delmarva Foundation, Inc.**

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**Easton, MD 21601**

#### Telephone: (800) 999-3362

#### ALL FORMS ARE TO BE FAXED TO THE FOLLOWING NUMBER:

**1-800-971-8101**