

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 Expired  Transfer from EPD Waiver to NF | ❑  ❑  ❑ | Initial NF Placement  Conversion 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:**  Physician  Physician Assistant  Nurse 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.**

**9240 Centreville Rd.**

**Easton, MD 21601**

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

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

**1-800-971-8101**