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| section A: BENEFICIARY |
| Last Name: First: MI:   | Medicaid ID: | SSN: | Birth date:  | Gender: |
| ❑ M | ❑ F |
| Permanent Street Address:  | City:  | ST:  | ZIP:  | Phone:  |
| Present Location of Beneficiary (if different than above): | Date of Request: |

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| section B: LEVEL OF CARE |
| ❑ Nursing Facility | ❑ Adult Day Treatment | ❑ Elderly & Individuals w/Physical Disabilities (EPD) Waiver |
| Reason |
| ❑ Return from hospital after Medicaid  bed-hold expired\*❑ Transfer from EPD Waiver to NF❑ Annual reassessment❑ Initial NF placement❑ Conversion from other payor source to  Medicaid. Start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❑ Transfer from NF | ❑ Initial assessment |  ❑ Initial assessment ❑ Annual reassessment ❑ Transfer from NF to EPD Waiver |

\**If Medicaid bed-hold days <18 days no level of care required*

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| section C: LEGAL REPRESENTATIVE ❑ POA ❑ legal guardian ❑ NA |
| Name:  | Street Address:  | City:  | ST:  | ZIP:  |

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| section D: BENEFICIARY FUNCTIONAL STATUS |
| **Activities** | **Independent**  (needs no help) | **Supervision or Limited Assistance** (needs oversight, encouragement or cueing or highly involved, but requiring assistance) |  **Extensive Assistance or Totally Dependent** (may help, but cannot perform w/o help from staff or cannot do for self at all) |
| ADLs:BathingDressingOverall MobilityEatingToilet UseIADLs:Medication ManagementMeal PreparationHousekeepingMoney ManagementUsing Telephone | ❑❑❑❑❑❑❑❑❑❑ | ❑❑❑❑❑❑❑❑❑❑ | ❑❑❑❑❑❑❑❑❑❑ |
|  Beneficiary ventilator dependent? ❑ Yes ❑ NoName of Person Completing Form: | List additional supporting documents here:   |
| Title:   | Phone:  | Date:  |
| Signature:  |

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| SECTION E: CLINICIAN ATTESTATIONS & AUTHORIZATIONS |
| ❑ Physician ❑ Physician Assistant ❑Nurse Practitioner | Street Address:  | City: | ST: | ZIP:  |
| Phone:  | NPI #: | Date:  | Signature:  |
| I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud  | Print Name:   | Title:  |
|  | Date: |

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| section F: QUALITY IMPROVEMENT ORGANIZATION AUTHORIZATIONS |
| Level of Care: ❑ Nursing Facility ❑Adult Day Treatment ❑ EPD Waiver | Certification Period (for EPD only): | Date:  |
| Authorized Signature:   | Comments: |
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| I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud  | Print Name:   | Title:  |
|  | Date: |

To submit this form electronically after completion, visit the Qualis Health Provider Portal at [www.qualishealth.org](http://www.qualishealth.org). Then select one of the choices in the Healthcare Professional Drop-Down Menu: DC Medicaid or Provider Resources. You can obtain additional assistance in registering for the Qualis Health Provider Portal by contacting ProviderPortalHelp@qualishealth.org.

Revised Oct 19, 2015