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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:  Bathing  Dressing  Overall Mobility  Eating  Toilet Use  IADLs:  Medication Management  Meal Preparation  Housekeeping  Money Management  Using Telephone | ❑  ❑  ❑  ❑  ❑  ❑  ❑  ❑  ❑  ❑ | ❑  ❑  ❑  ❑  ❑  ❑  ❑  ❑  ❑  ❑ | | | ❑  ❑  ❑  ❑  ❑  ❑  ❑  ❑  ❑  ❑ | |
| Beneficiary ventilator dependent? ❑ Yes ❑ No  Name 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](mailto:ProviderPortalHelp@qualishealth.org).

Revised Oct 19, 2015