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

Request for Out-of-State Placement

Please print clearly and be sure to complete all sections.

_____ / _____ / _____
Date of Request

Reason out-of-state nursing facility placement is requested _____

_____

_____

Name of Beneficiary

_____
Last First Middle Initial

Permanent Address _____

_____

Phone (_____) _____ – _____ Date of Birth _____ / _____ / _____ Sex _____

SS# _____-_____-_____ Medicare # _____ Medicaid # _____

Diagnosis

_____

Prognosis

_____

Treatment Required and Frequency (check all that apply)

	Daily	Weekly	Biweekly	Monthly
Behavioral Modification	❑	❑	❑	❑
Occupational Therapy	❑	❑	❑	❑
Physical Therapy	❑	❑	❑	❑
Respiratory Care	❑	❑	❑	❑
Speech/Hearing	❑	❑	❑	❑