**Please print clearly and complete all sections**

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| --- |
| Section A: BENEFICIARY |
| Date:  | Last Name: First: M.I.: | Medicaid ID: | Birth date:  | Gender: |
| ❑ M | ❑ F |

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| Section B: REQUESTING FACILITY |
| Facility Name:  | Street Address:  | City: | ST:  | ZIP: |
|  |  |

|  |  |  |
| --- | --- | --- |
| Phone:  | Fax:  | Name of Person Completing Form:  |
| Title : |

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| Section C: PLACEMENT FACILITY❖ |
| Facility Name:  | Street Address:  | City: | ST:  | ZIP: |
|  |  |

|  |  |
| --- | --- |
| Phone:  | Fax:  |

❖*If different than requesting facility*

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| Section D: PLACEMENT RATIONALE |

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| Reason beneficiary is not being placed in the community. Check all that apply: **❑** Type or intensity of care required not available in the community **❑** Beneficiary prefers to receive care in a nursing facility **❑** Housing issues preclude individual from placement in the community **❑** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| SECTION E: APPLICATION CHECKLIST |
| Request for Out-of-State Nursing Facility Placement Cover Page ❑  Proof of Contact of In-State Nursing Facilities ❑ *(a minimum of one (1) DC facilities must be contacted and deny placement)* *(a minimum of one (1) DC facility denials for ventilator and hemodialysis placements)*Level of Care approval from the Long Term Care Assessment Contractor (Liberty Healthcare Corporation) ❑ Request for Medicaid Nursing Facility Level of Care (DHCF Form 1728) ❑ Pre-Admission Screen/Resident Review for Serious Mental Illness and Intellectual Disability or Related Condition ❑ Beneficiary Agreement ❑ Beneficiary’s history and physical ❑ Discharge summary (if available) ❑  Copy of the most recent physician and nurse notes (as needed) ❑  |

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. Feb. 5, 2019 *Rev. Feb. 5, 2019*

**Upload this form** via the Qualis Health Provider Portal at [www.qualishealth.org](http://www.qualishealth.org). In the Healthcare Professional Drop-Down Menu select DC Medicaid-> Provider Resources-> Qualis Health Provider Portal. You may obtain assistance in registering for the Qualis Health Provider Portal by contacting providerportalhelp@qualishealth.org.