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 _____)	❑ Initial NF Placement	❑ Initial Assessment	❑ Initial Assessment
❑ Return from Hospital after Medicaid Bedhold has Expired	❑ Conversion from Any Other Pay Source to Medicaid (Start On ____/____/_____)		❑ Annual Reassessment
❑ Transfer from EPD Waiver to NF	❑ Transfer from NF to NF		❑ 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	❑	❑	❑

Name _____ Medicaid #_____

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.

			Please check appropriate box:
Name	_____	❑	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 _____

_____

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ALL FORMS ARE TO BE FAXED TO THE FOLLOWING NUMBER:

1-800-971-8101