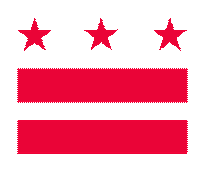
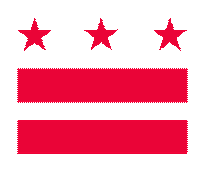
**DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE**

**Nursing Facility Annual Level of Care Attestation**

**This attestation form must be completed and then faxed to the Delmarva Foundation at (202) 698-2075 at least 90 days in advance of the level of care end date as identified on the LOC determination sheet.**

**Date of Attestation:** Click here to enter a date.

|  |  |  |  |
| --- | --- | --- | --- |
| **Section I: BENEFICIARY INFORMATION** | | | |
| Name: Enter name here  Medicaid #: Enter # here Date of birth: Click here to enter a date.  Medicaid Certification Period: Enter date here to Enter date here | | | |
| **FUNCTIONAL SCORE OF EXISTING ASSESSMENT** | | | |
| Without medication management: Click here to enter text. | | | |
| With medication management: Click here to enter text. | | | |
| **Section II: SUMMARY OF BENEFICIARY’s NEEDS** | | | |
|  | | **No Change** | **Improved** |
| **FUNCTIONAL NEEDS** | | | |
| **Bathing** | |  |  |
| **Dressing** | |  |  |
| **Eating/Feeding** | |  |  |
| **Transfer** | |  |  |
| **Mobility** | |  |  |
| **Medication Management** | |  |  |
| **Toileting** | |  |  |
| **Urinary Continence and Catheter Care** | |  |  |
| **Bowel Continence and Ostomy Care** | |  |  |
| **SKILLED CARE NEEDS** | | | |
| **Skilled nursing and therapies required by the individual** | |  |  |
| **COGNITIVE/BEHAVIORAL NEEDS** | | | |
| **Previously identified Serious Mental Illness/Intellectual Disability/Developmental Disability** | |  |  |
| **Receptive and expressive communication** | |  |  |
| **Behavior and Behavioral Symptoms** | |  |  |

|  |  |  |
| --- | --- | --- |
| **Section III: SUMMARY OF BENEFICIARY’S HEALTH STATUS** | | |
|  | **No Change** | **Improved** |
| **Health Status** |  |  |

If “Improved” is checked, the physician completing this form must request a Long Term Care Services and Supports Reassessment by submitting a Prescription Order Form to DHCF’s contractor, the Delmarva Foundation.

**Section IV:**

**ATTESTATION**

**I attest that a change in condition has occurred at the time of reassessment with enter beneficiary’s name and that a Prescription Order Form will be submitted to DHCF’s contractor, the Delmarva Foundation.**

Physician Name Click here to enter text.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Click here to enter a date.

**--------OR--------**

**I attest that enter beneficiary’s name’s health status remains unchanged at the time of reassessment, and a Long Term Care Services and Supports Reassessment by the DHCF’s contractor, the Delmarva Foundation, is not required at this time. The following documents were reviewed to make this determination (*mark all that apply*).**

Clinical notes

General Health Status

Functional/Cognitive Status

Most recent Long Term Care Services and Supports Assessment

Physician Name Click here to enter text.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Click here to enter a date.