



DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE
Annual Level of Need Attestation for
Long Term Care Services and Supports



This attestation form must be completed and then faxed to the Delmarva Foundation at (202) 698-2075 at least 60 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. Beneficiary Address: Click here to enter text. Medicaid Certification Period: Enter date here To Enter date here	
FUNCTIONAL SCORE OF EXISTING ASSESSMENT	TOTAL PCA HOURS
Without medication management: Click here to enter text.	Hours/Day: Click here to enter text.
With medication management: Click here to enter text.	Hours/Week: Click here to enter text.

Section II: SUMMARY OF BENEFICIARY'S NEEDS			
	No Change	Improved	Declined
FUNCTIONAL NEEDS			
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating/Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Continence and Catheter Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Continence and Ostomy Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKILLED CARE NEEDS			
Skilled nursing and therapies required by the individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COGNITIVE/BEHAVIORAL NEEDS			
Previously identified Serious Mental Illness/Intellectual Disability/Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receptive and expressive communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior and Behavioral Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section III: SUMMARY OF BENEFICIARY'S HEALTH STATUS			
	No Change	Improved	Declined
Health Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

¹ If "Improved" or "Declined" is checked, the Supervisory RN/Case Manager 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 (for Individuals enrolled in State Plan Personal Care Services ONLY)

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.

Supervisory RN Name [Click here to enter text.](#)

Home Care Agency [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;
- Home care agency plan of care;
- Most recent Long Term Care Services and Supports Assessment

Supervisory RN Name [Click here to enter text.](#)

Home Care Agency [Click here to enter text.](#)

Signature _____

Date [Click here to enter a date.](#)

ATTESTATION (for Individuals enrolled in the Elderly and Persons with Disabilities (EPD) Waiver ONLY)

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.

Case Manager Name [Click here to enter text.](#)

Case Management Agency [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*).

- General Health Status
- Functional/Cognitive Status
- Environment Access/Safety Status
- Psychosocial/Caregiver Support Status
- Beneficiary Freedom of Choice/Rights & Responsibilities Form
- Person Centered Plan

Case Manager Name [Click here to enter text.](#)

Case Management Agency [Click here to enter text.](#)

Signature _____

Date [Click here to enter a date.](#)