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:

Section I: BENEFICIARY INFORMATION	
Name:	
Medicaid #: Date of birth:	
Medicaid Certification Period: To	
FUNCTIONAL SCORE OF EXISTING ASSESSMENT	**TOTAL PCA HOURS**
Without medication management:	**Hours/Day:**
With medication management:	**Hours/Week:**

Section II: SUMMARY OF BENEFICIARY's NEEDS			
	No Change	**Improved**	**Declined**
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**	**Declined**
Health Status	☐	☐	☐

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 and that a Prescription Order Form will be submitted to DHCF's contractor, the Delmarva Foundation.

Supervisory RN Name Home Care Agency

Signature _____ Date

--------OR--------

I attest that 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 Home Care Agency

Signature _____ 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 and that a Prescription Order Form will be submitted to DHCF's contractor, the Delmarva Foundation.

Case Manager Name Case Management Agency

Signature _____ Date

--------OR--------

I attest that 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 Case Management Agency

Signature _____ Date