**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 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 ❑Request for Out-of-State Placement Form ❑Proof of Contact of In-State Nursing Facilities ❑ *(a minimum of five (5) DC facilities must be contacted and deny placement)*  *(a minimum of two (2) DC facility denials for ventilator and hemodialysis placements)* Level of Care approval from the Quality Improvement Organization (Delmarva) ❑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) ❑ ❑ NACopy of the most recent physician and nurse notes (as needed) ❑ ❑ NA |

**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](mailto:providerportalhelp@qualishealth.org).

Revised: June 1, 2015