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 after Medicaid Bed-hold has Expired	❑ Initial NF Placement	❑ Initial Assessment	❑ Initial Assessment
❑ Transfer from EPD Waiver to NF	❑ Conversion from Any Other Pay Source to Medicaid (Start On ____/____/_____)		❑ Annual Reassessment
If Medicaid Bed-hold days ≤18 No Level of Care is required.	❑ 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 _____

_____

ALL FORMS ARE TO BE FAXED TO THE FOLLOWING NUMBER:

1 (877) 294-1033

Government of the District of Columbia

Level I Pre-Admission Screen/Resident Review for SMI, ID or Related Conditions

BENEFICIARY INFORMATION

Last Name: | First: | M.I.: | Gender: ☐ M ☐ F | Medicaid ID: | Social Security Number:

Date of Birth:

Assessment Type: ☐ Preadmission ☐ Significant Physical Change ☐ Significant Mental Change ☐ Suspicion of SMI or ID

LEGAL STATUS

☐ Commitment ☐ Legal Guardian-Conservator ☐ Legal Representative/POA | Location: ☐ Home ☐ Hospital ☐ Nursing Facility ☐ Other

Applicant agrees to legal guardian and/or family participation? ☐ Yes ☐ No

Interpreter Required? ☐ Yes ☐ No ☐ Spanish ☐ Amharic ☐ Chinese ☐ Korean ☐ Other

Interpreter Name:

Legal Guardian/Family Member:

Street Address:

Telephone: | City: | ST: | ZIP Code:

Power of Attorney:

Street Address:

Telephone: | City: | ST: | Zip Code:

SECTION A: EXEMPTING CRITERIA*

Beneficiary admitted to nursing facility directly from hospital after receiving acute inpatient care? ☐ Yes ☐ No
Beneficiary requires nursing facility services for the condition he/she received acute inpatient care? ☐ Yes ☐ No
Attending physician certifies beneficiary is likely to require less than 30 days nursing facility services? ☐ Yes ☐ No

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud

Print Name: | SIGN HERE | Date:

Title:

**Further completion of this form IS NOT NECESSARY if the beneficiary meets all of the exemptions listed in Section A. If exempting criteria is not met, proceed to Section B. Beneficiary is being admitted under the 30-day hospital discharge exemption. If the beneficiary's length of stay exceeds 30 days , the Level II evaluation must be completed no later than the 40th day of admission, on or before the date:*

SECTION B: EVALUATION CRITERIA FOR SERIOUS MENTAL ILLNESS (SMI)♦

1. Does the beneficiary have a known diagnosis of a major mental disorder? If yes, list diagnosis and DSM Code_____ ☐ Yes ☐ No ☐ Unknown
2. Does the beneficiary have a diagnosis or evidence of a major mental illness limited to the following disorders: schizophrenia, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; Somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or another mental disorder that may lead to chronic disability? ☐ Yes ☐ No ☐ Unknown. Specify diagnosis based on DSM-5 or current ICD criteria. →
3. Does the beneficiary have a history of any substance-related disorder diagnosis? ☐ Yes ☐ No ☐ Unknown Specify diagnosis →
4.

SMI Determination Based Upon: ☐ Documented History ☐ Behavioral Observation ☐ Medications ☐ Individual/Legal Guardian/Family Report

♦*The beneficiary is considered to have a positive serious mental illness (SMI) if (1) questions 1 or 2 in Section B are answered "Yes".* With a positive screen for SMI the beneficiary must be referred to the District of Columbia Department of Behavioral Health for a Level II evaluation.

SECTION C: SYMPTOMS

1. Does the beneficiary have any current or historical significant impairment in functioning related to a suspected or known diagnosis of mental illness? ❑ Yes (❑ Current ❑ Past: When) ❑ No

   Check box preceding description if any subcategories below are applicable:

   ❑ ***Interpersonal functioning.*** The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationships and social isolation.

   ❑ ***Concentration, persistence, and pace.*** The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these task.

   ❑ ***Adaptation to change.*** The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, , self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability or requires intervention by mental health or judicial system.

2. Within the last two years has the beneficiary (check either and/or both if applicable).

   ❑ experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g., had inpatient psychiatric care: was referred to a mental health crisis/screening center; has attended partial care/hospitalization; or has received Program of Assertive Community Treatment (PACT) or Integrated Case Management Services); and/or:

   ❑ due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community, or intervention by housing or law enforcement officials?

   Narrative information including dates: _____

   _____

   _____

   _____

   _____

   The beneficiary's behaviors/symptoms are stable and not presenting a risk to self or others? ❑ Yes ❑ No

If questions 1 and 2 In Section B are checked "No", but question 1 in Section C is "Yes" and a box is checked in question 2, the Level 1 form must be sent to the District of Columbia Department of Behavioral Health to determine if a Level II evaluation is needed.

SECTION D: INTELLECTUAL DISABILITY** (ID) RELATED CONDITIONS (RC)

1. Beneficiary has diagnosis of ID? ❑ Yes ❑ No
2. Beneficiary diagnosed with ID prior to age 18? ❑ Yes ❑ No
3. Presenting evidence (cognitive or behavior functions) indicating beneficiary has ID or related condition that has not been diagnosed? ❑ Yes ❑ No
4. Referred beneficiary deemed eligible for services by an agency which serves individuals with ID or related condition? ❑ Yes ❑ No
5. Does the beneficiary have a current diagnosis, history or evidence of a related condition that may include a severe, chronic disability that is attributable to a condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior? ❑ Yes ❑ No
   Condition: ❑ autism ❑ seizure disorder ❑ cerebral palsy❑ spina bifida ❑ fetal alcohol syndrome ❑ muscular dystrophy ❑ deaf ❑ blindness ❑ closed head injury
   Impairment: ❑ mobility ❑ self-care ❑ self-direction ❑ learning ❑ understanding/use of language ❑ capacity for independent living)

   Was the date of onset prior to age 22? ❑ Yes ❑ No If yes, explain:

   _____

   _____

6. Is the beneficiary considered to have ID or a Related Condition? ❑ Yes ❑ No

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud

Print Name: SIGN HERE Date:

Title:

**Beneficiary is considered to have a positive screen for or a related condition if one of more the above questions in this section are answered yes. As a result, beneficiary must be referred to the District of Columbia Department on Disability Services for a Level II evaluation. If all of the questions are answered no, the beneficiary has a negative screen for ID or a related condition.*

SECTION E: DEMENTIA*

- ❑ The beneficiary has a diagnosis of dementia (including Alzheimer's disease or related disorder) based on criteria in the DSM-5 or current version of the ICD. (If checked specify DSM-5 or ICD codes:_____
- ❑ The following criteria were used to establish the basis for a dementia diagnosis: ❑ Mental Status Exam ❑ Neurological ❑ History Symptoms ❑ Other Diagnostics (specify):_____
- ❑ The physician documented dementia as the primary diagnosis **OR** that dementia is more progressed than a co-occurring mental illness diagnosis. Explain documentation and verification: _____

**A primary diagnosis of dementia, including Alzheimers' disease or related disorder IS NOT considered a major mental illness. Dementia applies to beneficiaries with a confirmed diagnosis of dementia that has been documented as a primary diagnosis more progressed than a co-occurring mental illness. If there is no confirmed diagnosis of dementia, check N/A❑. Only if the boxes in front of ALL THREE statements above are checked is the beneficiary designated as having a primary mental illness dementia exclusion. If none of the statements above are checked, then the beneficiary is not designated as having a primary mental illness dementia exclusion.*

SECTION F: ADVANCE GROUP DETERMINATION°

1. Is the beneficiary being admitted for convalescent care not to exceed 120 days due to an acute physical illness which required hospitalization and does not meet all criteria for an exempt hospital discharge (described in Section A)? ❑ Yes ❑ No
2. Does the beneficiary have a terminal illness (life expectancy of less than six months) as certified by a physician? ❑ Yes ❑ No
3 Does the beneficiary have a severe physical illness, such as coma, ventilator dependence, functioning at a brain stem level or other diagnoses which result in a level of impairment so severe that the beneficiary could not be expected to benefit from specialized services? ❑ Yes ❑ No
3. Is this beneficiary being provisionally admitted pending further assessment due to an emergency situation requiring protective services? The stay will not exceed 7 days. ❑ Yes ❑ No
4. Provisional Delirium: The presence of delirium in people with known or suspected MI and/or ID precludes the ability to make an accurate diagnosis. The person's Level I Screen and LOC will be updated no greater than 7 calendar days following admission to the NF (a physician signed statement certifying the delirium state must accompany this screen).
5. Is the beneficiary being admitted for a stay not to exceed 14 days to provide respite? ❑ Yes ❑ No

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud

Print Name: SIGN HERE Date:

°If the beneficiary is considered to have SMI, ID or RC, complete this section. Otherwise, skip this section and complete Section G. If any questions in this section are checked yes, there is no need for a Level II referral. ↑

SECTION G: RESULTS OF SMI/ID (CHECK ALL THAT APPLY)

❑ Beneficiary has negative screen for serious mental illness and no further action is necessary.
❑ Beneficiary has negative screen for ID or related conditions and no further action is necessary.
❑ Beneficiary has a positive screen for serious mental illness and has been referred to DBH for a Level II evaluation. Date:
❑ Beneficiary has a possible positive screen and the Level 1 form has been forwarded to DBH for review. Date:
❑ Beneficiary has a positive screen for intellectual disability and has been referred to DDS for a Level II evaluation. Date:
❑ Notice of referral for Level II, if applicable, distributed to Beneficiary/Representative Date :

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud

Print Name: SIGN HERE Date:

The District of Columbia Department on Disability Services is the contact agency for a **Level II** evaluation:

Shirley Quarles-Owens, RN MSN
Supervisory Community Health Nurse
DC Department on Disability Services
Developmental Disabilities Administration
Health and Wellness Unit
1125 15th Street, NW, 8th Floor
Washington, DC 20005
202-730-1708 (office)
202-730-1841 (fax)
202-615-8268 (mobile)
shirley.quarles-owens@dc.gov

The District of Columbia Department of Behavioral Health is the contact agency for **Level II** evaluations:

Chaka A. Curtis, RN
Psychiatric Nurse / PASRR Coordinator
Division of Integrated Care
DC Department of Behavioral Health
64 New York Ave NE - Room 310
Washington, DC 20002
202-673-6450 (office)
202-671-2972 (fax)
202-439-1143 (mobile)
chaka.curtis@dc.gov

Upload this form via the Qualis Health Provider Portal at 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