

**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:
<input type="checkbox"/> Return from Hospital after Medicaid Bed-hold has Expired <input type="checkbox"/> Transfer from EPD Waiver to NF If Medicaid Bed-hold days ≤18 No Level of Care is required.	<input type="checkbox"/> Initial Assessment	<input type="checkbox"/> Initial Assessment <input type="checkbox"/> Annual Reassessment <input type="checkbox"/> Transfer from NF to EPD Waiver
<input type="checkbox"/> Initial NF Placement <input type="checkbox"/> Conversion from Any Other Pay Source to Medicaid (Start On ___/___/___) <input type="checkbox"/> Transfer from NF to NF		

Part A

Date of Request ___/___/___ Name _____

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.

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Instrumental Activities of Daily Living (IADLs)			
Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	_____	<input type="checkbox"/>	Physician
		<input type="checkbox"/>	Physician Assistant
		<input type="checkbox"/>	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



BENEFICIARY INFORMATION

Last Name: First: M.I.: Gender: 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?, Interpreter Required?, 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? Beneficiary requires nursing facility services for the condition he/she received acute inpatient care? Attending physician certifies beneficiary is likely to require less than 30 days nursing facility services?

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:

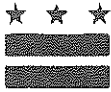
*Further completion of this form IS NOT NECESSARY if the beneficiary meets all of the exemptions listed in Section A. If exempting criteria is not met, proceed to Section B. Beneficiary is being admitted under the 30-day hospital discharge exemption. If the beneficiary's length of stay exceeds 30 days, 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
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?
3. Does the beneficiary have a history of any substance-related disorder 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.

1 Beneficiary Name: Date of Birth:



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:
[Blank lines for text entry]

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.

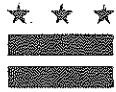
SECTION D: INTELLECTUAL DISABILITY** (ID) RELATED CONDITIONS (RC)

- Beneficiary has diagnosis of ID? Yes No
Beneficiary diagnosed with ID prior to age 18? Yes No
Presenting evidence (cognitive or behavior functions) indicating beneficiary has ID or related condition that has not been diagnosed? Yes No
Referred beneficiary deemed eligible for services by an agency which serves individuals with ID or related condition? Yes No
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:

[Blank lines for text entry]

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:



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*

- Checkboxes for dementia diagnosis criteria: DSM-5/ICD codes, criteria used (Mental Status Exam, Neurological, History Symptoms, Other Diagnostics), and physician documentation.

*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.

SECTION F: ADVANCE GROUP DETERMINATION*

- Five numbered questions regarding hospitalization, terminal illness, severe physical illness, provisional admission, delirium, and stay length.

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:



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)

- Checkboxes for screening results: negative for serious mental illness, negative for ID, positive for serious mental illness, possible positive screen, positive for intellectual disability, and notice of referral.



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:



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