MEDICAID LEVEL OF CARE REQUEST COVER SHEET

Facility Name:_____

Resident's Name:_____ DOB:_____

SSN:_____MEDICAID #:_____

Level of Care effective date:_____

Scenario:
- ☐ NF to different NF: _____ to _____
- ☐ NF to hosp to NF – Leave expired
- ☐ Private Pay to Medicaid
- ☐ Out of state to Ohio NF
- ☐ Hospice to Medicaid
- ☐ Medicare to Medicaid
- ☐ Community to NF
- ☐ Hospital to NF
- ☐ Other _____

Original date of admission (to any NF without return to community):_____
* If the resident has been in other nursing facilities please attach a list of facility names and dates of stay

Does the resident require hands on assistance with medications? _____

Rehab Potential: ☐ Poor ☐ Fair ☐ Good **Prognosis**: ☐ Poor ☐ Fair ☐ Good

Anticipated discharge to caregiver in community? ☐ YES ☐ NO

Estimated length of stay:_____

LOC Requested:
- ☐ ILOC (RESIDENT IS STABLE), OR
- ☐ SLOC (RESIDENT IS UNSTABLE)

Primary Diagnosis (**ONLY ONE**):_____

Submitted by/Contact Person:_____

Phone Number:_____ Fax:_____

If you would like to be contacted by E mail, please provide your email address: _____

Doctor's Orders

I have reviewed the enclosed MDS and physician's orders and certify that it is a true and accurate statement of the resident's physical, mental, and social/emotional status as of the above stated Medicaid effective date.

_____ _____

Physician's Signature Date of Signature

*****IF RESIDENT WAS ADMITTED UNDER A HOSPITAL EXEMPTION, PLEASE SEND 7000/HENS AND RESIDENT REVIEW PASRR DOCUMENTATION*****