COVER LETTER FOR NON-MEDICAID AND OUT-OF-STATE NF ADMISSIONS

The following individual is being admitted to _____

_____ on _____. A PASRR review is being requested.

Individual's Name: _____

Current address and phone number: _____
___ Check if out of state _____
(___) _____

This individual is being admitted from:
__Private Home __Independent Living __Assisted Living __ ER/Observation Bed

Primary Contact Person: _____

Relationship: _____ POA?_____GUARDIAN?_____
Current address and phone number: _____
_____
(___) _____

Please check the following if applicable:
_____ Individual is Hospice enrolled
_____ Individual is expected to be in the NF for less than 90 days
_____ Individual is covered by Medicare, Medicaid HMO, or other private insurance
_____ Individual will not deplete funds in the next 6 months
_____ Individual does not have support in the community to return home

What is the individual's ADL ability: (A= hands on assist.; S = supervision; I = independent)

A__S__I__Mobility A__S__I__Bathing A__S__I__Eating

A __S__I__Grooming A__S__I__Toileting A__S__I__Dressing

A__S__I__Medication Administration ____24 hour supervision due to cognitive impairment

Submitter's Name:_____

Phone Number _____ Fax number _____

If you would like to be contacted by E mail please add your address:_____

PLEASE FAX THIS COVER LETTER, ALONG WITH THE COMPLETED PASRR SCREEN AND A HISTORY AND PHYSICAL THAT WAS SIGNED BY THE MD (NOT A PHYSICIAN'S ASSISTANT OR NURSE PRACTICIONER) WITHIN THE PAST 180 DAYS TO 513-345-8618. THANK YOU.