MEDICAID LEVEL OF CARE REQUEST COVER SHEET FOR NURSING FACILITIES

Facility Name:_____

Resident's Name: _____ Date of Birth: _____

SSN: _____ Date of admission to this NF: _____

Medicaid Level of Care effective date: (date that NF began billing **only** traditional Medicaid **OR** date of transfer): _____

Reason for LOC request (please check one):

- ☐ Transitioned from **any** Medicare/insurance plan to traditional Medicaid.
- ☐ Disenrolled from a managed **Medicaid** plan (Molina, Aetna, Buckeye, etc.) and transitioned to traditional Medicaid.
- ☐ Transitioned from private pay to traditional Medicaid.
- ☐ Transfer from/to another NF with traditional Medicaid as the only payment source on transfer date:

  from _____ NF to _____ NF.
- ☐ Disenrolled from hospice care with traditional Medicaid as the only payment source.
- ☐ From out of state to an Ohio NF with traditional Ohio Medicaid as the only payment source on admission date.
- ☐ Other (**Please explain**): _____

Did this resident admit to your facility from a hospital? (please check one and fill in the blank):

- ☐ Yes, and **before** the hospital, they were at _____
- ☐ No, they admitted to our facility from _____

LOC requested (please check one):

- ☐ **Intermediate (stable condition)** **If the resident is independent or needs supervision only with all ADLs but needs 24-hour supervision to prevent harm due to a cognitive impairment, please include a signed and dated statement from the physician attesting to this.
- ☐ **Skilled (unstable condition)** **If SLOC is requested please make sure the documentation included reflects this including the type and frequency of any skilled services.

IADLs for which hands-on assistance is required: Shopping Meal prep House chores Laundry Transportation Legal/finances

****If the resident lived alone would he or she require hands on assistance with medications? _____****

Contact person submitting request: _____

Phone: _____ Fax: _____ Email: _____

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

(Signer must sign and date each individual request –photocopied signatures cannot be accepted.)

_____ _____

Physician's Signature (MD, DO, CNP, or PA) Date