

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 513-810-3360. THANK YOU.**