Fax or email this request to Council on Aging/Pre-Admission Review at (513) 810-3350 or preadmissionreview@help4seniors.org

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If your request is complete and the patient does not require further review for SMI/MRDD, your request will be processed within one business day. If your request is not complete, it may delay the patient's review. Please note: a Medicaid LOC from COA is only needed for those individuals for whom traditional Medicaid will be the primary payer upon admission to the nursing facility.

Date: _____ **Submitter's phone:** _____

Submitter: _____ **Submitter's fax:** _____

Hospital: _____ **Submitter's email:** _____

Patient's Name _____ **SSN** _____ **D/C date** _____

Reason for Request (please check the appropriate scenario):

- ☐ Patient will transfer to _____ with traditional Ohio Medicaid as the only payer source.
- ☐ Patient is currently a resident at _____ NF but is out of bed hold days.
- ☐ Patient admitted to hospital from _____ NF and will transfer to _____ NF at discharge.

Please check the appropriate PASRR information:

- ☐ PASRR has been completed in HENS. The patient admitted to the hospital from home/community setting.
- ☐ No new PASRR documentation is needed. The patient admitted to the hospital from an **Ohio** NF.

Per a 2025 directive from the Ohio Department of Medicaid, a level of care can no longer be authorized with only a hospital exemption in place.

Please make sure the following information is included on the LOC documentation provided:

- ☐ Completed COC/transfer form, including a statement signed and dated by an MD, DO, CNP, or PA that he or she has reviewed all information and that it is a true and accurate reflection of the patient's condition.
- ☐ All medications, treatments, professional services ordered upon discharge.
- ☐ PT/OT/ST frequency to be given at the NF: _____5 to 7x/week _____Less than 5x/week
- ☐ Patient needs hands-on assistance with: (circle all that apply):

  Medication / Bathing / Toileting / Mobility / Dressing / Grooming / Eating / Shopping / Laundry / Housekeeping / Transportation
- ☐ Patient needs 24-hour supervision due to a cognitive deficit: _____ YES _____ NO
- ☐ LOC requested:

  ____ ILOC (Patient is stable – patient's condition does not change frequently)

  ____ SLOC (Patient is **unstable** –condition, care needs, orders change frequently or rapidly requiring close monitoring. **"Skilled" per Medicaid is NOT the same as "skilled" per Medicare**).