

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 or transfer date.

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

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

Date

Submit request via either fax: 513-810-3360 or email: preadmissionreview@help4seniors.org.