****Fax this request to Council on Aging/Pre-Admission Review at (513) 810-3350****

If your request is *complete* and the client 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 client's discharge.

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

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

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

Client's Name: _____ **SSN:** _____

Reason for Request (please check the appropriate scenario):

1. Client will transfer to _____ on _____ with traditional FFS Ohio Medicaid as the payment source.
2. Client is currently a resident at _____ but out of bed hold days. Anticipated hospital discharge date: _____.
3. Client was at _____ prior to the hospital and will transfer to _____ upon discharge. Anticipated hospital discharge date: _____.

Please check ALL that apply to your request:

□ **PASRR** completed via HENS.

1. Patient was in the community (home, assisted living, group home, etc.) prior to hospital.
2. Expected NF stay **>30 days**.

□ **Convalescent exemption from PASRR (Form 7000)** completed via HENS.

1. Patient was in the community (home, assisted living, group home, etc.) prior to hospital.
2. Expected NF stay **<30 days**.
3. Client status at the hospital is "**inpatient**" (NOT on observation or in the ER).
4. Hospitalization is **not** a psychiatric hospitalization.

□ **No PASRR** documentation needed. Patient was in another Ohio nursing facility prior to hospital.

□ **Medicaid Level of Care** (ONLY needed for clients who will require traditional FFS Ohio Medicaid to pay for 100% of NF care upon admission):

- ☐ Completed COC/transfer form, signed and dated by the MD.
- ☐ All medications, treatments, professional services.
- ☐ PT/OT/ST frequency to be given at NF: _____5 to 7x/wk _____Less than 5x/wk
- ☐ Client needs hands on assistance with: **Circle all that apply:** Med admin., bathing, toileting, mobility, dressing, grooming, eating, shopping, laundry, housekeeping, transportation.
- ☐ Client needs 24-hour supervision due to a cognitive deficit: _____YES _____ NO
- ☐ LOC requested:
  _____ ILOC (Client is stable – client's condition does not change frequently)
  _____ SLOC (Client is unstable – client's condition, care needs, orders change frequently or rapidly requiring close monitoring. NOT the same as "skilled" per Medicare).
- ☐ Statement that MD has reviewed all information and that it is a true and accurate reflection of the client's condition.