

Section A – Identifying Information							
1. Applicant's Name/Address: County _____				2. Medicaid Number:		3. Social Security Number	
						4. Sex Age 4A. Birthdate	
				7. Patient's Name (Last, First, Middle Initial)			
5. Type of Facility (Check One) 1. ☐ Nursing Facility 2. ☐ ICF/ID		6. Type of Recommendation 1. ☐ Nursing Facility 2. ☐ ICF/ID 3. ☐ Continued Placement		8. Date of Nursing Facility Admission / /		9. Patient Transferring From (Check One): ☐ Hospital ☐ Home ☐ Another Nursing home ☐ Private Pay ☐ Medicare	
Recipient's Home Address: Recipient's Telephone Number: _____		Date of Medicaid Application / /		9A. State Authority (MH & ID Screening) Level I/II			
This is to certify that the facility of attending physician is hereby authorized to provide the Department of Community Health, Division of Medical Assistance and the Division of Family and Children Services, Department of Human Resources with necessary information including Medical Data. 10. Signature _____ 11. Date _____ (Patient, Spouse, Parent or other Relative or Legal Representative)				Restricted Auth Code _____ Date _____			
				9B. This is not a re-admission for OBRA purposes			
				Restricted Auth Code _____ Date _____			
Section B – Physician's Report and Recommendation							
12. D iagnosis on admission to the facility (hospital transfer report may be attached) 1. Primary _____ 2. Secondary _____ 3. Other _____				1. ICD-10		2. ICD-10	
12A. D iagnosis on admission to the facility (hospital transfer report may be attached) 1. Primary _____ 2. Secondary _____ 3. Other _____				1. ICD-10		2. ICD-10	
13. Treatment Plan (Attach copy of order sheet if more convenient)				Hospital Dates: _____ to _____			
Hospital Diagnosis 1. Primary _____ 2. Secondary _____ 3. Other _____							
Medications				16. Diagnostic and Treatment Procedures			
Name		Dosage	Route	Frequency	Type		Frequency
14. Recommendation Regarding Level of Care Considered Necessary 1. ☐ Skilled 2. ☐ Intermediate 3. ☐ Intermediate Care for the Intellectually Disabled				15. Length of Time Care Needed _____ Months 1. ☐ Permanent 2. ☐ Temporary _____ estimated		16. Is Patient free of communicable diseases? 1. ☐ Yes 2. ☐ No	
17. This patient's condition ☐ could ☐ could not be managed by provisions of ☐ community care or ☐ home health services. 18. I certify that the patient requires the level of care provide by a nursing facility or an Intermediate care facility for the intellectually disabled. Physician's Signature _____				19. Physician's Name (Print) Physician's Address (Print) 20. Date Signed by Physician _____			
				21. Physician's License Number _____			
				Physician's Phone Number _____			
Section C– Evaluation of Nursing Care Needed (check appropriate box only)							
22. Diet ☐ Regular ☐ Diabetic ☐ F o r m u l a ☐ L o w Sodium ☐ Tube feeding ☐ Other		23. Bowel ☐ Continent ☐ Occas. Incontinent ☐ Incontinent ☐ Colostomy		24. Overall Condition ☐ Improving ☐ Stable ☐ Fluctuating ☐ Deteriorating ☐ Critical ☐ Terminal		25. Restorative Potential ☐ Good ☐ Fair ☐ Poor ☐ Questionable ☐ None	
26. Mental & Behavioral Status ☐ Agitated ☐ Noisy ☐ Dependent ☐ Confused ☐ Nonresponsive ☐ Independent ☐ Cooperative ☐ Vacillating ☐ Anxious ☐ Depressed ☐ Violent ☐ Well Adjusted ☐ Forgetful ☐ Wanders ☐ Disoriented ☐ Alert ☐ Withdrawn ☐ Inappropriate Reaction							
27. Decubitus ☐ Yes ☐ Surgery ☐ No Date: _____ ☐ Infected ☐ On Admission		28. Bladder ☐ Continent ☐ Occas. Incontinent ☐ Incontinent ☐ Catheter		30. Indicate Frequency Per Week			
				Physical Therapy	Occupational Therapy	Remotive Therapy	Reality Orientation
				Received			
29. Hours Out of Bed Per Day _____ ☐ Intake ☐ IV ☐ Output ☐ Bedrest		☐ Catheter Care ☐ Colostomy Care ☐ Sterile Dressing ☐ Suctioning		Needed			
31. Record Appropriate Legend							
IMPAIRMENTS				ACTIVITIES OF DAILY LIVING			
1. Severe 2. Moderate 3. Mild 4. None Sight Hear Speech Ltd. Motion Paralysis ☐ ☐ ☐ ☐ ☐				1. Dependent 2. Needs Asst. 3. Independent 4. Not App Eats Wheelchair Transfer Bath Ambulation Dressing ☐ ☐ ☐ ☐ ☐ ☐			
32. Remarks							
33. Pre-Admission Certification Number				34. Signed		35. Date Signed / /	
DO NOT WRITE BELOW THIS LINE							
Continued Stay Review Date: _____		Payment Date _____		Approved for _____		Days _____	
36. Level of Care Recommended by GMCF		LOS		37. Signature (GMCF)		Date: / /	
						38. Attachments (GMCF) 1. ☐ Yes 2. ☐ No	