MorseLife
Honoring Senior Living

PHILOSOPHY:
The Joseph L. Morse Geriatric Center, Inc. is a Not-For-Profit Company that is a non-sectarian facility designed and dedicated to service the specialized needs of the elderly. The Center shall operate its Dietary Department according to the tradition of Kashruth. Religious services are conducted according to Jewish customs and traditions. Individuals who are assessed to need rehabilitative or long-term care services will be considered for admission. Residents admitted to this facility are rendered services without distinction due to race, color, nation origin, or handicapping condition. This facility complies fully with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.

ELIGIBILITY:
A. Each individual will be assessed for the ability of the Center to meet his/her needs.
B. No resident who is suffering from communicable disease shall be admitted or retained unless the Medical Director or attending physician certifies that adequate or appropriate isolation measures are available to control transmission of the disease.
C. Residents may not be retained in the facility that require services beyond those for which the facility is licensed or has the functional ability to provide as determined by the Medical Director and the Vice President of Clinical Services in consultation with the facility Administrator.
D. All applicants must be at least sixteen (16) years of age.

ORDER OF ADMISSIONS:
Applicants will be offered admission by the appropriate bed availability.

FINANCIAL ARRANGEMENTS:
All residents receive the necessary care, service and room placements without regard to financial status. All financial information relating to applicants and residents is kept strictly confidential.

When financial assistance is required, the resident, family or other responsible parties are expected to provide a full disclosure of assets and to cooperate and start the application process for financial assistance with the Department of Children and Families.

SPECIAL PRIORITY ADMISSIONS:
Applicants who meet the criteria for special priority admission are residents on the Campus in our independent/assisted living or are Holocaust Survivors. These applicants will be considered for placement and put at the top of the waitlist for the appropriate bed availability. We must be able to meet all of the applicants needs for placement.

SEXUAL OFFENDER BACKGROUND CHECKS:
In conjunction with the admissions process, the Center will conduct a sexual offender background check using the nation predator website (http://www/nsopr.gov). A copy of the findings will be kept in the resident's admission file prior to admission.

Instructions/Checklist For Completion

Resident Name:_____ **Date:**_____

Please complete the attached application in its entirety. A checklist is provided below for the documentation required with the application. Please refer to the Fee Schedule for the current cost for long term care. A minimum of one month payment is required prior to admission. ***Additional documents may be required.***

- ☐ Proof of Residency:
  - Driver's license, tax assessment or voter's registration for the applicant
- ☐ Insurance Cards (copy of front and back):
  - Medicare OR Primary Insurance Card
  - Supplemental Insurance Card(s)
- ☐ Social Security Card
- ☐ Advance Directives (if any):
  - Durable Power of Attorney
  - Living Will, and/or Health Care Surrogate Designation
  - Guardianship Documentation (if applicable)
- ☐ Irrevocable Trust and/or Qualified Income Trust Document(s)
- ☐ Bank Statements: If family is assuming financial responsibility we will need verification of the source of payment. <u>For private pay</u>, a minimum of 3 months of statements are required for **all** accounts.
  - CD
  - Savings
  - Checking
  - Securities
  - Stocks, Bonds
  - Money Markets, IRA/401k
  - Burial Policy(s)
  - Cash Value Life Insurance Policies
  - <u>Income related to:</u> Social Security Benefits, Pension Benefits, Interest or Dividends from Investments, Long Term Care Insurance Policy(s)
- ☐ Federal Income Tax Returns – full copies of the returns for three previous years
- ☐ Real Estate Tax Assessment
- ☐ Medical Documentation to be completed by the applicant's physician:
  - History & Physical – if applicable – dementia diagnosis documentation
  - Medications – list of current medications taken including dosage
  - PASRR Form
  - 3008 Form
  - Chest x-ray or PPD results
- ☐ Pacemaker card (if applicable)

IF THE APPLICANT CURRENTLY HAS HMO INSURANCE COVERAGE:

- Prior to admission to the facility, the applicant must disenroll from this coverage and re-enroll in the traditional Medicare program. We will require a copy of the disenrollment form from the HMO insurance carrier when this has been completed.

IF THE APPLICANT CURRENTLY HAS COMMUNITY OR DIVERSION MEDICAID:

- Applicant must disenroll from this coverage and apply for ICP/Nursing home Medicaid. We will require a copy of the Notice of Case Action stating that the applicant is approved for ICP/Nursing Home Medicaid. Applicant must be approved for ICP Medicaid prior to admission. <u>*Please note that only the third floor of the Mack Pavilion is Medicaid approved.*</u>

JOSEPH L. MORSE GERIATRIC CENTER
4847 Fred Gladstone Drive
West Palm Beach, FL 33417
(561) 472-2900
Fax (561) 615-0949

APPLICATION FOR ADMISSION

Date Received in Admissions Office _____ Received By (Admission Personnel) _____

PLEASE COMPLETE ALL INFORMATION BELOW IN TYPE OR PRINT

Last Name First Name Middle _____ Race _____ Sex _____ Former Occupation _____

Current Address Street City State Zip County Telephone # _____

Date of Birth _____ Birthplace _____ Citizen of (Country) _____ Military Service _____

Social Security Number _____ Medicare Number _____ Medicaid Number – Specify State _____

Marital Status _____ Name of Spouse _____ Applying together – Yes or No _____

Address of Spouse Street City State Zip County Telephone # _____

Applicant's Father's Name _____ Applicant's Mother's Name (Include Maiden) _____

Highest Level of Education _____ Physician Telephone Number _____

Emergency Contacts:

1. _____ _____
   Name/Relationship Telephone #

   _____ _____
   E-mail Address Cell Phone #

   _____
   Complete Address and Zip Code

2. _____ _____
   Name/Relationship Telephone #

   _____ _____
   E-mail Address Cell Phone #

   _____
   Complete Address and Zip Code

3. _____ _____
   Name/Relationship Telephone #

   _____ _____
   E-mail Address Cell Phone #

   _____
   Complete Address and Zip Code

If "Yes" to any of the Advance Directives, please provide a copy to the Admissions Office.

Yes	No	
		Health Care Surrogate
		Durable Power of Attorney
		Living Will

_____

Applicant's Religion Church/Synagogue Telephone #

_____

Local Funeral Home Desired Address Telephone #

List below all previous admissions to hospitals, psychiatric institutions or nursing homes within the previous five years:

	Institution Name	Date (Adm/Disch)	Reason for Admission
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Does applicant manage own finances? _____Yes _____No

If no, designated family member(s) assuming financial liability for applicant:

Name: _____ Relationship: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

_____ Business Phone: _____

Email: _____

FINANCIAL DATA INFORMATION

List below **ALL monthly income:**

Source	Amount
Social Security	_____
SSI	_____
Railroad Retirement	_____
Pension	_____
Rental Income	_____
Interest Income	_____
Annuity	_____
Other:	_____
Other:	_____

List below all bank accounts including savings, checking, IRA's, etc.:

	Account Number	Bank	Balance
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

List below all securities, stocks, etc.:

	Type	Estimated Value
1.	_____	_____
2.	_____	_____
3.	_____	_____

REQUIRED INSURANCE INFORMATION

PLEASE PROVIDE COPIES OF ALL INSURANCE CARDS (FRONT AND BACK). If you are unable to provide copies of the cards, please complete the below information.

Primary Insurance:

Name: _____ Phone #: _____

Policy Number: _____ Group Number: _____

Plan Type (HMO / PPO): _____

Supplemental Insurance:

Name: _____ Phone #: _____

Policy Number: _____ Group Number: _____

Plan Type (HMO / PPO): _____

Prescription Insurance:

Name: _____

Policy Number: _____

Phone # _____

If Medicaid Pending, please complete the below for the HRS Payments Worker:

_____

Name Address Telephone Number

_____ _____ _____

ICP Medicaid Number State Providing Coverage Initial Eligibility Date

List below all life insurance policies:

	Company	Beneficiary	Face Value	Yearly Premium
1.				
2.				
3.				

List below all real estate:

	Description and Location	Assessed Value	Current Mortgage Amount
1.			
2.			
3.			
4.			

Person(s) Completing this Form:

Name: _____

Address: _____

Telephone Number: _____ Cell Phone: _____

Email Address: _____

Relationship to Resident: _____

MorseLife
Honoring Senior Living

The attached AHCA MedServ Form 3008 (page one and page two), as well as the PASRR must be completed by the applicant's physician.

Please have the **physician provide**:

a. The most recent history and physical (dated within the past 30 days)
b. Neurology and Psychiatric notes (if applicable)
c. Medication list including dosage
d. Chest X-ray or PPD results
e. Initial Assessment (attached)

Admissions Office Fax Number: 561-615-0949

State of Florida Agency for Health Care Administration
Pre-Admission Screen and Resident Review (PASRR)

LEVEL I SCREEN

For Serious Mental Illness (SMI) and/or Intellectual Disability or Related Conditions (ID)
Use for Medicaid Certified Nursing Facility (NF) Only

_____ _____ _____
Name of Individual Being Evaluated (print) Social Security Number* Date of Birth

☐ Male ☐ Female Age _____

_____ _____ _____
Present Location of Individual Being Evaluated Street Address, City State, Zip

☐ NF ☐ Hospital ☐ Home ☐ Assisted Living Facility ☐ Group Home ☐ Other_____

_____
Individual's or Residency Phone Number

_____ _____ _____
Legal Representative's Name (if applicable) Street Address, City State, Zip

Representative's Phone Number _____

_____ _____
Medicaid Number if Applicable Screening Date (mm/dd/yyyy)

_____
Other Health Insurance Name and Number if Applicable

☐ Private Pay

*WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER? Federal law permits the State to use your social security number for screening and referral to programs or services that may be appropriate for you. 42 CFR § 435.910. We use the number to create a unique record for every individual that we serve, and the SSN ensures that every person we serve is identified correctly so that services are provided appropriately. Any information the State collects will remain confidential and protected under penalty of law. We will not use it or give it out for any other reason unless you have signed a separate consent form that releases us to do so or if required by law.

Name of Individual Being Evaluated _____ Date of Birth _____

Section I: PASRR Screen Decision-Making

A. SMI or suspected SMI (check all that apply):

- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Depressive Disorder
- ☐ Dissociative Disorder
- ☐ Panic Disorder
- ☐ Personality Disorder
- ☐ Psychotic Disorder
- ☐ Schizoaffective Disorder
- ☐ Schizophrenia
- ☐ Somatic Symptom Disorder
- ☐ Other (specify):

☐ Substance Abuse

B. ID or suspected ID (check all that apply):

- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Down Syndrome
- ☐ Epilepsy
- ☐ Intellectual disability with an IQ lower than 70 (specify) _____
- ☐ Prader-Willi Syndrome
- ☐ Spina Bifida
- ☐ Other (specify):

If known:
Age of onset for ID? _____Years
Age of onset for any related condition? _____Years

Finding is based on: (check all that apply)

- ☐ Documented History
- ☐ Medications
- ☐ Behavioral Observations
- ☐ Individual, Legal Guardian or Family Report
- ☐ Other (specify):

Additional Information:

Section II: Other Indications for PASRR Screen Decision-Making

1. Is there an indication within the past 3 to 6 months the individual has a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage? ☐Yes ☐No

2. Does the individual typically have at least one of the following characteristics on a continuing or intermittent basis?

A. Interpersonal functioning: The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, fear of strangers, avoidance of interpersonal relationships, social isolation, or has been fired. ☐Yes ☐No

B. Concentration, persistence, and pace: The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like

structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks. ☐Yes ☐No

C. Adaptation to change: The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system. ☐Yes ☐No

3. Is there an indication that the individual has received recent treatment for a mental illness with an indication that the individual has experienced at least one of the following?

A. Psychiatric treatment more intensive than outpatient care more than once in the past two years (e.g., partial hospitalization or inpatient hospitalization). ☐Yes ☐No

B. Within the last two years, due to the mental illness, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. ☐Yes ☐No

4. Has the individual exhibited actions or behaviors that may make them a danger to themselves or others? ☐Yes ☐No

NOTES ON SECTIONS I AND II:

- A Level II evaluation must be completed if any box in Section I.A is checked and there is a YES checked in Section II.1, II.2, or II.3.
- A Level II evaluation must be completed if any box in Section I.B is checked and (1) the intellectual disability manifested prior to 18 years of age or a related condition manifested before age 22, and (2) the condition is likely to continue indefinitely, resulting in functional limitations in three or more of the following: self-care, understanding and use of language, learning, mobility, self-direction or capacity for independent living.
- A Level II evaluation must be completed if Section II.4 is checked YES.
- If the Level I screening is completed by a physician, a Level II evaluation is not required if the individual is found to have:
  - A primary diagnosis of dementia, including Alzheimer's Disease or a related disorder; or
  - A non-primary diagnosis of dementia unless the primary diagnosis is a serious mental illness (42 CFR 483.102(b)(1)(i)(B).

Section III: PASRR Screen Provisional Determination

☐ **Not a provisional admission**

☐ **Provisional admission (choose one of the following):**

If a provisional admission is indicated, the individual may enter an NF without a Level II evaluation/determination if the Level I screen indicated a suspicion of SMI and/or ID. However, a Level II evaluation must be completed, if required, by submitting the documentation for the Level II evaluation to the Florida Department of Elder Affair's CARES program for adults and the Florida Department of Health for children (age less than 21 years) within the time frames indicated in this section.

☐ The individual being admitted has delirium. The Level II evaluation must be completed within 7 days after the delirium clears.

☐ The individual is being admitted on an emergency basis requiring protective services. The Level II evaluation must be completed within 7 days of admission, on or before (date): _____

_____ _____

Name of Individual Being Evaluated Date of Birth

☐ The individual is being admitted for caregiver's respite. The Level II evaluation must be completed in advance of the expiration of 14 days if the stay is expected to exceed the 14 day time limit, on or before (date): _____

☐ The individual is being admitted under the 30-day hospital discharge exemption (attach Form 3008 and physician signature required below). If the individual's stay exceeds 30 days, the Level II evaluation must be completed no later than the 40th day of admission, on or before (date): _____.

An attending physician's signature is required for those individuals admitted under this 30-day hospital discharge exemption.

_____ _____

ATTENDING PHYSICIAN'S SIGNATURE DATE

Section IV: PASRR Screen Completion

Individual <u>may</u> be admitted to an NF (check one of the following):

☐ No diagnosis or suspicion of SMI or ID indicated. Level II PASRR evaluation not required.

☐ Provisional admission

Individual <u>may not</u> be admitted to an NF. Use this form and required documentation to request a Level II PASRR evaluation because there is a diagnosis of or suspicion of (check one of the following):

☐ SMI

☐ ID

☐ SMI and ID

By signing this form below, I attest that I have completed the above Level I PASRR screen for the individual to the best of my knowledge.

_____ _____

Screener's Name (Printed) **Signature**

_____ _____ _____

Credentials **Date** **Phone**

_____ _____

Place of Employment **Fax**

****************************Incomplete forms will not be accepted***************************

Completed Level I screen **distributed to**:	Notice of referral for Level II, if applicable, **distributed to** (including information on how to obtain the evaluation):
☐ Local DOH** office, under the age of 21years Date: _____	☐ Individual/Representative Date: _____
☐ Local CARES*** office, age 21years or older Date: _____	
☐ Nursing Facility Date: _____	☐ Other:_____ Date:_____
☐ Discharging Hospital (if applicable): Date: _____	

If the individual requires a Level II evaluation, submit the completed Level I screen, documented informed consent, completed AHCA 3008 form, and other relevant medical documentation including case notes, medication administration records, and any available psychiatric evaluation to CARES or DOH.

****Department of Health**

***** Department of Elder Affairs' Comprehensive Assessment and Review for Long-Term Care Services**

MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

Patient Name: DOB:

A. PATIENT INFORMATION

Gender: ☐ Male ☐ Female
Hispanic Ethnicity: ☐ Yes ☐ No
Race: ☐ White ☐ Black ☐ Other: _____
Language: ☐ English ☐ Other:

B. SIGHT HEARING

☐ Normal ☐ Impaired ☐ Normal ☐ Impaired
☐ Blind ☐ Deaf ☐ Hearing Aid L R

C. DECISION MAKING CAPACITY (PATIENT):

☐ Capable to make healthcare decisions ☐ Requires a surrogate

D. EMERGENCY CONTACT

Name: _____ Name: _____
Phone: Phone:

E. MEDICAL CONDITION / RECENT HOSPITAL STAY

Primary Dx at discharge:
Reason for transfer (Brief Summary):

Surgical procedures performed during stay: ☐ None

Other diagnoses:

F. INFECTION CONTROL ISSUES

PPD Status: ☐ Positive ☐ Negative ☐ Not known
Screening date: _____
Associated Infections/resistant organisms:

☐ MRSA Site: _____
☐ VRE Site: _____
☐ ESBL Site: _____
☐ MIDRO Site: _____
☐ C-Diff Site: _____
☐ Other: Site: _____

Isolation Precautions: ☐ None
☐ Contact ☐ Droplet ☐ Airborne

G. PATIENT RISK ALERTS

☐ None Known ☐ Harm to self ☐ Difficulty swallowing
☐ Elopement ☐ Harm to others ☐ Seizures
☐ Pressure Ulcers ☐ Falls ☐ Other: _____

RESTRAINTS: ☐ Yes ☐ No
Types:

Reasons for use:

ALLERGIES: ☐ None Known ☐ Yes, List below:

Latex Allergy: ☐ Yes ☐ No Dye Allergy/Reaction: ☐ Yes ☐ No

H. ADVANCE CARE PLANNING

Please ATTACH any relevant documentation:

Advance Directive	☐ Yes	☐ No
Living Will	☐ Yes	☐ No
DO NOT Resuscitate (DNR)	☐ Yes	☐ No
DO NOT Intubate	☐ Yes	☐ No
DO NOT Hospitalize	☐ Yes	☐ No
No Artificial Feeding	☐ Yes	☐ No
Hospice	☐ Yes	☐ No

I. TRANSFERRED FROM

Facility Name:	
Date:	Unit:
Phone:	Fax:
Discharge Nurse:	Phone:
Admit Date: Admit Time:	Discharge Date: Discharge Time:

J. TRANSFERRED TO

Facility Name:
Address 1:
Address 2:
Phone: Fax:

K. PHYSICIAN CONTACTS

Primary Care Name:
Phone:
Hospitalist Name:
Phone:

L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION

Medication due near time of transfer / list last time administered
Script sent for controlled substances (attached): ☐ Yes ☐ No

☐ Anticoagulants	Date:	Time:
☐ Antibiotics	Date:	Time:
☐ Insulin	Date:	Time:
☐ Other:	Date:	Time:

Has CHF diagnosis: ☐ Yes ☐ No
If yes; new/worsened CHF present on admission?
☐ Yes ☐ No
Last echocardiogram: Date: LVEF %

On a proton pump inhibitor? ☐ Yes ☐ No
If yes, was it for: ☐ In-hospital prophylaxis and can be discontinued
☐ Specific diagnosis:

On one or more antibiotics? ☐ Yes ☐ No
If yes, specify reason(s):

Any critical lab or diagnostic test pending at the time of discharge? ☐ Yes ☐ No
If yes, please list:

M. PAIN ASSESSMENT:

Pain Level (between 0 - 10):
Last administered: Date: Time:

N. FOLLOWING REPORTS ATTACHED

☐ Physicians Orders ☐ Treatment Orders
☐ Discharge Summary ☐ Includes Wound Care
☐ **Medication Reconciliation** ☐ Lab reports
☐ Discharge Medication List ☐ X-ray ☐ EKG
☐ PASRR Forms ☐ CT Scan ☐ MRI
☐ Social and Behavioral History

ALL MEDICATIONS: (MAY ATTACH LIST)

MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

Patient Name: DOB:

O. VITAL SIGNS

Date:	Time Taken:	
HT:	WT:	
Temp:	BP:	
HR:	RR:	Sp02:

P. PATIENT HEALTH STATUS

Bladder: ☐ Continent ☐ Incontinent
☐ Ostomy ☐ Catheter Type: _____ date inserted: _____
Foley Catheter: ☐ Yes ☐ No **If yes, date inserted:** _____
Indications for use:
☐ Urinary retention due to: _____
☐ Monitoring intake and output
☐ Skin Condition: _____
☐ Other: _____
Attempt to remove catheter made in hospital? ☐ Yes ☐ No
Date Removed: _____
Bowel: ☐ Continent ☐ Incontinent ☐ Ostomy
Date of Last BM: _____
Immunization status:
Influenza: ☐ Yes ☐ No Date: _____
Pneumococcal: ☐ Yes ☐ No Date:

Q. NUTRITION / HYDRATION

Dietary Instructions:

Tube Feeding: ☐ G-tube ☐ J-tube ☐ PEG
Insertion Date:

Supplements (type): ☐ TPN ☐ Other Supplements:

Eating: ☐ Self ☐ Assistance ☐ Difficulty Swallowing

R. TREATMENTS AND FREQUENCY

☐ PT - *Frequency:*

☐ OT - *Frequency:*

☐ Speech - *Frequency:*

☐ Dialysis - *Frequency:*

S. PHYSICAL FUNCTION

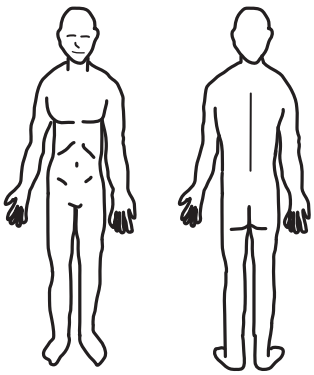
Ambulation:
☐ Not ambulatory
☐ Ambulates independently
☐ Ambulates with assistance
☐ Ambulates with assistive device

Transfer:
☐ Self
☐ Assistance
☐ 1 Assistant
☐ 2 Assistants

Devices:
☐ Wheelchair (type):
☐ Appliances:
☐ Prosthesis:
☐ Lifting Device:

Weight-bearing:
Left:
☐ Full ☐ Partial ☐ None
Right:
☐ Full ☐ Partial ☐ None

T. SKIN CARE – STAGE & ASSESSMENT



Pressure Ulcers
(Indicate stage and location(s) of lesions using corresponding number:
1.
2
3.

List any other lesions or wounds:

U. MENTAL / COGNITIVE STATUS AT TRANSFER

☐ Alert, oriented, follows instructions
☐ Alert, disoriented, but can follow simple instructions
☐ Alert, disoriented, and cannot follow simple instructions
☐ Not Alert

V. TREATMENT DEVICES

☐ Heparin Lock - Date changed:
☐ IV / PICC / Portacath Access - Date inserted:
Type: _____
☐ Internal Cardiac Defibrillator ☐ Pacemaker
☐ Wound Vac
☐ Other: _____
Respiratory - Delivery Device: ☐ CPAP ☐ BiPAP
☐ Nebulizer ☐ Other: _____ ☐ Nasal Cannula
☐ Mask: Type _____
☐ Oxygen - liters: ____% ☐ PRN ☐ Continuous
☐ Trach Size: _____ Type: _____
Ventilator Settings: _____
☐ Suction

W. PERSONAL ITEMS

☐ Artificial Eye ☐ Prosthetic ☐ Walker
☐ Contacts ☐ Cane ☐ Other
☐ Eyeglasses ☐ Crutches
☐ Dentures ☐ Hearing Aids
☐ U ☐ L ☐ Partial ☐ L ☐ R

X. COMMENTS (Optional)

Signature: _____

Printed Name: _____

Y. PHYSICIAN CERTIFICATION

☐ I certify the individual requires nursing facility (NF) services.
☐ The individual received care for this condition during hospitalization.
☐ I certify the individual is in need of Medicaid Waiver Services in lieu of nursing facility placement.

Rehab Potential (check one)
☐ Good ☐ Fair ☐ Poor

Effective date of medical condition _____

Physician/ARNP Signature: _____ Date: _____

Printed Physician/ARNP Name & Title: _____ Phone Number: _____

Person completing form: _____ Phone Number: _____ Date: _____