

DIVISION OF SENIOR &
DISABILITIES SERVICES
550 W 8th AVENUE
ANCHORAGE AK 99501



LONG TERM CARE FACILITY
AUTHORIZATION

SEGMENT CONTROL NUMBER:

SECTION 1 - TO BE COMPLETED BY THE RECEIVING FACILITY

1. TYPE OF REQUEST: _____ 2. RECIPIENT NAME _____

- INITIAL
 REAUTHORIZATION
 CORRECTIONS**

- LAST NAME, FIRST MI
 RETROACTIVE REQUEST
 LEVEL OF CARE CHANGE
 PASRR DETERMINATION
 NON MEDICAID
 TRAVEL REQUEST

3. MEDICAID ID NUMBER _____

4. GENDER: M F

5. BIRTHDATE: _____ 6. AGE: _____

7. RECIPIENT PRESENTLY AT: HOME ACUTE CARE OTHER (PLEASE SPECIFY IN SPACE 7a)

7a. NAME OF FACILITY CURRENTLY AT: _____

REQUESTING PLACEMENT AT:

8. NAME OF FACILITY: _____

9. FACILITY ID#: _____

10. DATE OF ADMISSION: _____ 11. PERIOD OF CARE REQUESTED: _____ TO _____
(PLANNED OR ACTUAL)

12. RECOMMENDED LEVEL OF CARE: SNF ICF SWING AW DAYS ICF/MR

13. ADMISSION STAFF: _____ DATE: _____

SIGNATURE

SECTION II - TO BE COMPLETED BY ATTENDING PHYSICIAN

14. PRIMARY DIAGNOSIS: _____

15. SECONDARY DIAGNOSIS: _____

16. MEDICATIONS (requiring LTC): _____

17. PHYSICIAN RECOMMENDED LEVEL OF CARE: SNF ICF SWING AWD ICF/MR

18. PERIOD OF CARE REQUESTED: _____ TO _____

19. PHYSICIAN NAME: _____ 20. CERTIFY 30 DAY STAY OR LESS _____

FOR PURPOSES OF EXEMPTION FROM LEVEL II EVALUATION

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE. THE REQUESTED SERVICES ARE CLINICALLY INDICATED AND NECESSARY.

21. PHYSICIAN SIGNATURE: _____ 22. DATE: _____

SECTION III - TO BE COMPLETED BY DSDS (DIVISION OF SENIOR & DISABILITIES SERVICES)

23. DATE RECEIVED IN DSDS: _____ 24. ACTION TAKEN: APPROVED AS REQUESTED

APPROVED AS MODIFIED

DENIED DATE _____

25.* APPROVED LEVEL OF CARE: SNF ICF SWING AWD ICF/MR

26.* PERIOD APPROVED FOR: _____ TO _____ (*25 & 26 ONLY IF MODIFIED BY REVIEWER)

27. COMMENTS: _____

28. DSDS SIGNATURE: _____ 29. DATE _____

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

30. RECIPIENT'S NAME _____

SECTION IV - SNF & ICF – TO BE COMPLETED BY NURSING, REHAB PERSONNEL OR DISCHARGE PLANNER. (ITEMS 31, 34-35. REQUIRED ON INITIAL, COMPLETE BOTH PAGES 1 & 2 ON REAUTHORIZATION REQUEST.)

31. CURRENT NURSING NEEDS. (SERVICES RECIPIENT REQUIRES THAT CAN ONLY BE PROVIDED BY LICENSED NURSING PERSONNEL) DOCUMENT WITH ATTACHED CURRENT HX & PHYSICAL OR PHYSICIAN ORDERS

32. REHABILITATION GOALS: MAINTENANCE ACTIVE REHAB. (IF ACTIVE, STATE GOALS, PROGRESS AND PROJECTED TIME FRAME.)

33. DISCHARGE PLAN: YES NO (IF YES, STATE PLAN WITH TIME FRAME, IF NO, INDICATE WHY NOT.)

34. SIGNATURE OF PERSON COMPLETING THIS SECTION

35. DATE

34a. PRINTED NAME OF PERSON COMPLETING THIS SECTION

34b. TITLE