Long Term Care (LTC) Facility Authorization Request

This form may be completed by hospital discharge staff or a person with knowledge of the applicant for initial admission, or by LTC facility staff if individual is already a resident. The information provided must be accurate and complete. Senior and Disabilities Services (SDS) cannot process incomplete forms. SDS uses the information on this form to comply with LTC placement and payment determinations. All information requested on this form is required.

Submit complete form, with all required signatures and attachments, by direct secure messaging (DSM) to: ***dsds.ltcauthorizations@hss.soa.directak.net***

Section 1: Identifying Information

Name of Individual (Last, First, MI)

Alaska Native/American Indian

Yes ☐ No ☐

DOB

Medicaid #

Address (Street, City, Zip)

Telephone Number

Name of Individual's referring provider

Does referring provider work for a tribal health organization? Yes ☐ No ☐

Name of THO

Applicant

- ☐ New Admission
- ☐ Inter-facility Transfer (from one facility to another)
- ☐ Retroactive Medicaid (was initially admitted under alternative payment source and now has Medicaid)

Date of discharge or DOD (if applicable):

Resident

- ☐ Continued Placement
- ☐ Significant Change (Resident Review)
- ☐ Condition improvement- LOC from SNF to ICF
- ☐ Condition decline- LOC from ICF to SNF
- ☐ New diagnosis

Current Location

- ☐ Hospital/acute care facility
- ☐ Home/residence
- ☐ LTC Facility & Medicaid Provider ID #:
- ☐ Other (specify):

Placement Category

- ☐ LTC
- ☐ Swing Bed
- ☐ AWD (Administrative Wait Days)

Payment Source

- ☐ Medicaid
- ☐ Other (specify):

Recommended Level of Care

ICF ☐ SNF ☐

Proposed/Actual Admission

Date:

Requested Period of Coverage

From:

To:

Travel Authorization Request

Traveling from:

Traveling to:

Dates:

Name of Individual:	Admitting Facility ID #:

Name of Proposed/ Admitting LTC Facility and ID#	Address (Street, City, Zip)	Telephone Number	Email	Contact Name/Title

☐ If new admission, LTC facility contacted and agrees to consider individual for admission. If multiple faclities are being considered, please identify these here (Facility ID# and Name):

Name of Individual's Representative	Address (Street, City, Zip)	Telephone Number	Type of Representative (POA, Guardian, Surrogate Decision Maker)

Only for LTC Placements that Involve Travel

I certify that I am the authorized representative of the facility utilization review committee and that the committee reviewed this request for:

☐ **Authorization to admit the applicant**
☐ **Reauthorization**
☐ **Change in level of care**

And determined the facility has personnel with the qualifications necessary to provide the direct care needed by the applicant. As required, I attached the following for SDS to review:

☐ **Current history and physical**
☐ **Medication record and orders**
☐ **Therapy notes and orders**
☐ **Plan of care established by the attending physician**

Facility utilization review committee authorization representative:

Signature of the admitting long term care facility representative: _____

Date: _____

Print name: **Title:**

Section 2: Discharge Planning

Supports Needed for Community Placement:
Reasons Why Alternative Placement is not Feasible or Appropriate:
Plan for Discharge:

Name of Individual:	Admitting Facility ID #:

Section 3: Physician Certifications

Name of Physician	License #	Name of Person Completing on the Physician's Behalf/Title	Telephone Number	Email

Provide Both Diagnosis and Code	Primary Diagnosis and Code (ICD-10)	Secondary Diagnosis and Code (ICD-10)	Additional Diagnoses and Codes (ICD-10)
Admitting Diagnosis			
Discharge Diagnosis			

Medical Reason for Admission (for an applicant) or Continued Stay (for a resident):	
Level Of Care Recommendation:	☐ SNF ☐ ICF
Certification of Intended Length of Stay:	☐ Less than 30 days ☐ Convalescent Care (less than 90 days) ☐ Long Term Placement (more than 90 days)

Please attach the attending physician's orders for nursing home placement or continued stay

Section 4: Individual Needs

Prescribed Medications	Dosage/Frequency	Route	Purpose

Name of Individual:	**Admitting Facility ID #:**

Capacity for Independent Living and Self-Care	**Self-Performance Score**	**Support Score**	**Capacity for Independent Living and Self-Care**	**Self-Performance Score**	**Support Score**
Medication management			Toilet use		
Bed mobility			Personal hygiene		
Transfers			Bathing		
Locomotion			Eating		
Dressing					

<u>Self-performance score</u> (Score 1 – 8 for activities, not including set-up, occurring during the last 7 days, or last 24 to 48 hours if individual in hospital.) **0** = *Independent: no help or oversight, or help/oversight provided only 1 or 2 times* **1** = *Supervision: oversight, encouragement, or cueing provided 3 times, or supervision plus non-weight bearing physical assistance provided 1 or 2 times* **2** = *Limited assistance: individual highly involved in activity; received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3+ times, or limited assistance plus weight-bearing1 or 2 times* **3** = *Extensive assistance: weight-bearing support, or full staff/caregiver performance 3+ times* **4** = *Total dependence: full staff/caregiver performance every day of period* **5** = *Cueing: spoken instruction or physical guidance to perform activity* **8** = *Activity did not occur* *(No score of 6 or 7)*	*<u>Support score</u> (Score 1 – 8 for the most support provided for each activity during last 7 days, or last 24 to 48 hours if individual in hospital.)* **0** = *no setup or physical help from staff/caregiver* **1** = *setup help only* **2** = *one-person physical assist* **3** = *two or more person physical assist* *(No score of 4)* **5** = *Cueing support every day.* *(No score of 6 or 7)* **8** = *Activity did not occur*

Cognition		
Short-Term Memory	☐ OK	☐ Problem:
Long-Term Memory	☐ OK	☐ Problem:
Orientation	☐ OK	☐ Problem:
Cognitive Abilities	☐ OK	☐ Problem:
Decision Making	☐ OK	☐ Problem:

Therapy Services (Check all that apply and specific frequency)			
☐ Physical Therapy	# of Days per Week:	☐ Speech-Language Therapy	# of Days per Week:
☐ Occupational Therapy	# of Days per Week:	☐ Other:	# of Days per Week:

Check all that are attached	☐ H&P (required for all new admissions) ☐ Plan of Care ☐ Current psychological evaluation (if applicable) ☐ Other (specify):

Name of Individual:	Admitting Facility ID #:

Section 5: Signatures and Contact Information

Name and Title of Person Completing this Application	Date	Telephone Number	Email
Signature:			

Name of Individual:	Admitting Facility ID #:

State of Alaska use only

Long Term Care Authorization and PASRR (Preadmission Screening and Resident Review) Determination

Segment Control Number:			
Date Received:	**Date Reviewed:**	**Date of Determination:**	
Level of care determination ☐ SNF ☐ ICF			
Admission determination ☐ Approved as requested ☐ Approved as modified ☐ Denied			
Placement category ☐ ICF ☐ SNF ☐ Swing bed ☐ AWD			
Placement duration of care From:	**To:**		
Travel authorization ☐ **Approved as requested** ☐ **Approved as modified** ☐ **Denied**			
Name of SDS Reviewer:	**Contact Information:**		
Applicable Category	***Based on the information reviewed by SDS, the following determination is made. If admission or continued placement for this individual is approved, all services as identified by the PASRR Level II evaluation must be provided, by collaborative effort with the state, to meet the individual's nursing and disability-specific needs. A copy of the PASRR evaluation report will be provided for inclusion in the medical record; the recommendations made in that report must be incorporated into the plan of care. A notice has been provided to the individual and/or his/her representative of the need for a Level II evaluation if applicable, and a summary of the PASRR Level II evaluation report.***		
Negative Screen	☐ PASRR Level I screening does **not** indicate need for Level II PASRR evaluation. Applicant may be admitted to the LTC facility.		
Exempted Hospital Discharge	☐ Placement in facility for 30 days or less, as certified by physician. If the individual stays beyond the 30 days, an individualized PASRR Level II evaluation must be completed by the state on or before the 40th day. The facility shall notify SDS on day 25 that it anticipates the resident will need services more than 30 days. **Day 25 is:**		
Primary Dementia/Mental Illness	☐ Primary dementia in combination with mental illness. May be admitted to the LTC facility.		
PASRR Categorical Determinations (certain circumstances that are time-limited that require an abbreviated PASRR Level II evaluation report)	☐ Convalescent care for a period of 90 days or less, as certified by the physician. If the individual stays beyond the 90 days, an individualized PASRR Level II evaluation must be completed. The facility shall notify SDS on day 85 that it anticipates the resident will need services more than 90 days. **Day 85 is:**		
	☐ Primary dementia in combination with a diagnosis of intellectual disability or related condition applies. A Level II evaluation may be required, if there is a substantial change in condition.		
	☐ Terminal illness, as certified by attending physician. A Level II evaluation may be required, if there is a substantial change in condition.		
	☐ Severe physical illness. A Level II evaluation may be required, if there is a substantial change in condition.		
Resident Review	☐ May be considered appropriate for continued placement in the LTC facility, without specialized services for disability-specific needs.		
	☐ May not continue to reside in LTC facility. Alternative placement and services are developed by the state in cooperation with the facility. Payment continues until transfer completed.		
Level II PASRR Evaluation needed	☐ Mental Illness ☐ Intellectual disability ☐ Related condition	Date referred for Level II evaluation: Date Level II report received:	