REQUEST FOR LEVEL OF CARE REVIEW

Submit to: Ohio District 5 Area Agency on Aging Inc., 2131 Park Ave. West, Ontario, Ohio 44906

Phone: 567-247-6439 **Fax: 419-522-7711** **Email: pre-ad@aaa5ohio.org**

Date_____

Submitter: _____ Facility Name: _____ Phone#_____

Return Fax#_____ #Pages _____

Reason for Request: *** Required to begin Processing* see ODM's most common Scenarios**

_____Pay Conversion:

_____ Medicare to Medicaid _____Hospice to Medicaid _____Out of Bed hold days _____Private pay to Medicaid _____Managed care to Medicaid

_____ NF to NF transfer: Date of 1st NF Admission: _____

Transfer to _____From_____

Is the Resident in your facility: _____No_____Yes LOC effective Date requested: _____

Forms required:

____PAS Review Results letter---OR--- Hospital Exemption Form with the Resident Review for the expired exemption (and applicable Review Results Letter if after December 30, 2019) ******If PAS Review Results letter indicates a Level II referral, please send a copy of the PAS and the Level II determination letter**

AND

____ODM 3697 with current signature by Physician, Nurse Practitioner, or Physician's Assistant (signer MUST date own signature) & Physician's Orders for month requested.

OR

____MDS+& Physician's Orders for month requested. If using MDS 3.0, send Sections **A, C, D, E, G, I, M, N & O** only!

Resident's Name: _____Date of Birth: _____

Medicaid #_____Or Application Date_____Social Security #_____County_____

Guardian/Authorized Rep/DPOA/Sponsor, please list:

Name:_____Address/Phone:_____

Resident capable of self-administering medication? _____No_____Yes

Per Doctor's order requires 24-hour supervision due to a cognitive impairment to prevent harm? _____No_____Yes

If yes, please explain: __

IADL *(Instrumental Activities of Daily Living)*		**No Help**	**Supervision**	**Hands On Assistance**
a) Shopping				
b) Meal Preparation				
c) Environmental	(1) House Cleaning			
	(2) Heavy Chores			
	(3) Yard Work/Maint.			
d) Laundry				
e) Community Access:	(1) Telephone			
	(2) Transportation			
	(3) Legal/Finance			

Physician's Certification (must be signed and dated by Physician, Nurse Practitioner, or Physician's Assistant within the last 30 days)

I have reviewed the enclosed MDS or ODM 3697 and certify that it is an accurate statement of the Resident's physical, mental and social/emotional status. I certify the Resident requires:

(Check one) Intermediate Level of Care_____ Skilled Level of Care_____

Resident's condition is: (check one) ***Stable_____*** ***Unstable_____***

Physician's Signature_____Date_____

Revised 5/5/2022