carelon

**Skilled Nursing Facility Continued Stay Request Form**

***PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 833-623-3039***

***Questions? Call 800-222-9579***

**FOR FASTER AUTHORIZATION, PLEASE VISIT:**
https://providers.carelonmedicalbenefitsmanagement.com/postacute/

| Date of Request: | ☐ Standard<br>☐ Retro | ☐ Urgent Request:<br>*Note: Expedited organization determinations (urgent requests), can only be requested by the Member, Member Representative, or a Physician and only if applying the standard timeframe could seriously jeopardize the life or health of the member. (see CMS regulation: 40.8)* |
|---|---|---|

| *Member Information:* | | |
|---|---|---|
| Member Name: | Member ID: | Date of Birth: |

| *Requesting Facility Information:* | | |
|---|---|---|
| Facility Name: | | |
| NPI: | Attending Physician: | Is there a medical power of attorney?<br>☐ Yes ☐ No ☐ Unknown |
| Phone: | Attending Physician NPI: | |
| Fax: | | Name and relationship to patient: |
| SNF Facility Contact Name: | SNF admission date: | |
| SNF Facility Contact Phone: | Anticipated SNF Discharge date: | *If available, please attach POA/AOR with request* |
| SNF Facility Contact Fax: | Is member currently in your facility? ☐ Y ☐ N | Does the patient have an advanced directive?<br>☐ Yes ☐ No ☐ Unknown |

Submission MUST include the following as part of your referral package:

- ☐ All pages of this referral form (fully completed – include comments).
- ☐ SNF H & P
- ☐ Specialty consultations
- ☐ Overall plan of care
- ☐ Admission Orders
- ☐ Current medication list/record
- ☐ Interdisciplinary Team Assessment (if completed)
- ☐ 3 days of most recent physician notes.
- ☐ 1-2 days of most recent nursing notes.
- ☐ 1-2 days of most recent wound care notes, if applicable.
- ☐ Therapist assessment/ current progress notes that provide relevant supplemental information. (e.g., cognitive assessment scores, strength/motor recovery information) for PT/OT/ST.
- ☐ Most recent diagnostics (CT scans / X-ray reports) and lab work.

| Admitting ICD-10 Code(s) | | | |
|---|---|---|---|
| 1(Primary) | 2 | 3 | 4 |

| Clinical Category | | | |
|---|---|---|---|
| ☐ Acute Neurologic | ☐ Wound | ☐ Major Joint Replacement or Spinal Surgery | ☐ Other |

| | | | |
|---|---|---|---|
| ☐ Acute Infections | ☐ Medical Management | ☐ Orthopedic Surgery (Except - Major Joint or Spinal Surgery) | ☐ Unknown |
| ☐ Cardiovascular | ☐ Cancer | ☐ Non-Surgical Orthopedic/Musculoskeletal | |
| ☐ Pulmonary | ☐ General weakness/deconditioning | ☐ Non-Orthopedic Surgery | |

Reason For Continued Skilled Stay:

Other Medical Conditions:

*Prior Level of Function Immediately Before Hospital Stay: Only fill in if not previously completed.*

| | |
|---|---|
| Ambulation: Select One | # Feet: |

Wheelchair Mobility: Select One

Transfers: Grooming/Hygiene: Select One

Bathing: Select One

Dressing: Select One

Previously used DME:

☐ Wheelchair ☐ Bedside Commode
☐ Walker ☐ Bath/Shower Chair
☐ Brace ☐ Unknown
☐ Cane ☐ Other(describe)

*Current Orders:*

| | |
|---|---|
| ☐ Medical and/or nursing care | Frequency: ☐ Daily ☐ Every other day ☐ Weekly ☐ Unknown |
| ☐ Physical therapy to address functional impairment | Frequency: ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5x/wk ☐ Unknown |
| ☐ Occupational therapy to address functional impairment | Frequency: ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5x/wk ☐ Unknown |
| ☐ Speech therapy to address functional impairment | Frequency: ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5x/wk ☐ Unknown |

Most recent vitals: Temp _____ Pulse _____ RR _____ BP _____ O2 sat _____ Weight _____ Height _____

| *Barriers to Discharge:* | |
|---|---|
| If there are medical barriers to discharge, please document below: | |
| ☐ Respiratory Care | ☐ Naso-pharyngeal or deep tracheal suctioning<br>☐ Ventilator management and/or weaning.<br>☐ Nebulizer treatments ≥ 2 times/day<br>☐ Tracheotomy present |

| | |
|---|---|
| ☐ IV/IM Medications | ☐ IV medication ≥ 2 times/day that patient cannot self-administer. Patient does not have assistance at home and cannot practically travel to an infusion center.<br>☐ IM medication ≥ 2 times/day and patient cannot self-administer.<br>☐ Central line or multiple peripheral IV lines<br>Type of line: Insertion Date:<br>Medication: Name: Dosage: Frequency:<br>Estimated stop date: |
| ☐ Nutritional Support | Diet Type: Select One Other:<br>Route: ☐ NG ☐ PEG ☐ J Tube ☐ Dobhoff<br>Insertion date:<br>Formula: Amount/Rate:<br>☐ Initiation of tube feedings ≥ 500 ml daily or ≥ 26% of daily caloric intake is required.<br>☐ Initiation of intravenous (TPN) feeding requires skilled nursing care. |
| ☐ Ostomy Care | ☐ Colostomy care during the early post-operative period (≤ 14 days from surgery) in the presence of complications requiring skilled nursing care. |
| ☐ Urinary | ☐ Initial clinical management of a urinary catheter (suprapubic or "in and out" catheterization) is required.<br>☐ Individual or caregiver requires complex teaching services that can only be delivered in a 24-hour SNF setting and cannot be completed at home.. |

| | | |
|---|---|---|
| ☐ Wound Care | ☐ Multiple Stage II<br>☐ Stage III or IV Decubitus Wound(s)<br>☐ Other wound(s) that require(s) multiple dressing changes within a 24-hour period<br>Location:<br>Date of Measurement:<br>Size: LxWxD (cm) ____ x _____ x ____<br>Stage: Select One<br>Description:<br>Wound Vac: ☐ Yes ☐ No<br>Location:<br>Date of Measurement:<br>Size: LxWxD (cm) ____ x _____ x ____<br>Stage: Select One<br>Description:<br>Wound Vac: ☐ Yes ☐ No | Location:<br>Date of Measurement:<br>Size: LxWxD (cm) ____ x _____ x ____<br>Stage: Select One<br>Description:<br>Wound Vac: ☐ Yes ☐ No<br>Location:<br>Date of Measurement:<br>Size: LxWxD (cm) ____ x _____ x ____<br>Stage: Select One<br>Description:<br>Wound Vac: ☐ Yes ☐ No<br>Location:<br>Date of Measurement:<br>Size: LxWxD (cm) ____ x _____ x ____<br>Stage: Select One<br>Description:<br>Wound Vac: ☐ Yes ☐ No |

| | | |
|---|---|---|
| Dialysis: ☐ Yes ☐ No | ☐ Acute ☐ Chronic<br>☐ HD ☐ Peritoneal<br>Frequency:<br>Access: | |
| Other: | Describe: | |
| Comments: | | |

If there are physical barriers to discharge, please document below:

| |
|---|
| Date of Current Therapy Status: |
| Weight Bearing Status: Select One |
| Ambulation: Select One # of Feet: _____ |
| Wheelchair Mobility (if applicable): Select One |
| Bed Mobility: Select One |
| Transfers: Select One |
| Stairs: Select One # of Stairs: _____ |
| Feeding: Select One |
| Grooming/Hygiene: Select One |
| Bathing: Select One |
| Dressing: Select One |
| Toileting: Select One |
| Additional DME required for discharge:<br>☐ Wheelchair ☐ Bedside Commode<br>☐ Walker ☐ Bath/Shower Chair<br>☐ Cane ☐ Unknown<br>☐ Brace ☐ Other (describe) |

**If there are Cognitive/Mood/Speech barriers to discharge, please document below:**

Mental Status: Baseline Current: Oriented X :

Level of consciousness: Select One

Other: Select One

Speech: Select One

Comment:

Care Conference Date/Discussion:

Planned d/c living situation □ Home alone □ Home with spouse □ Home with Family/Caregivers □Long Term Care □ Supportive housing □ Unknown

Discharge Planning (general):

Previous living situation

- ☐ Home alone
- ☐ Home with spouse
- ☐ Home with family/caregiver
- ☐ Long Term Care
- ☐ Supportive Housing
- ☐ Homeless
- ☐ Unknown
- ☐ Other (describe):

Planned d/c living situation

- ☐ Home alone
- ☐ Home with spouse
- ☐ Home with family/caregivers
- ☐ Long Term Care
- ☐ Supportive Housing
- ☐ Unknown
- ☐ Other(describe):

For discharge plans to return home:

Is there a caregiver identified and able to assist the patient? Select One

[IF YES] Select One

[IF YES] Caregiver ability to provide care: Select One

[IF YES] Is it anticipated that the caregiver(s) can be adequately trained to meet the patient's care needs fully and safely? Select One

[IF YES] Has caregiver training been completed? Select One

Home Living Environment:

# of steps to enter:_____ Rails: Select One

Is there a ramp to enter? Select One

Bed 1st Floor Select One

Bath 1st Floor Select One

Is there ability for first floor setup? Select One

If d/c plan includes home health, has patient been referred to a home health agency willing to accept the patient? Select One

If yes, Name of Company:

For discharge plans to long term care or supportive housing:

Has a facility been chosen? Select One

[IF YES] Name of facility:

Has an application been completed? Select One

Is it anticipated that a bed/room be available for the patient? Select One

Is it anticipated that the facility will be able to provide the level of care needed at discharge? Select One

Does patient require an application for Medicaid? Select One

Discharge Plan Comment:

Additional Comment: