Reset Form

Ohio Department of Job and Family Services

HOSPITAL EXEMPTION
FROM PREADMISSION SCREENING NOTIFICATION

Instructions for the Hospital Discharge Staff: Fill in electronically or use black ink and print clearly. Submit the original notification to the nursing facility and a copy to the local PASSPORT Administrative Agency (PAA) prior to the discharge from the hospital. This form must be completed fully in order for the Nursing Facility to accept payment for nursing facility services. Incomplete forms will be returned.

SECTION A: IDENTIFYING INFORMATION FOR APPLICANT/PATIENT

Last Name	First Name	MI

Street Address	City	State	Zip

Ohio County of Residence	Sex	Date of Birth *(mm/dd/yyyy)*

Social Security #	Medicaid Recipient
	☐ Yes ☐ No ☐ Pending ☐ Managed Care Plan

Hospital Name	Discharge Planner Phone # *(including area code)*

Discharge Planner Name	Discharge from Psychiatric Unit to NF?
	☐ Yes ☐ No

Living arrangement prior to hospital admission

Independent Living Option

- ☐ Own Home/Apartment (Alone)
- ☐ Own Home/Apartment (With friend/relative)
- ☐ Homeless

Institutional Setting

- ☐ ICF/MR
- ☐ Private Psychiatric Hospital (Hospital Name _____)
- ☐ Regional Psychiatric Hospital (Hospital Name _____)
- ☐ Prison

Community-Based Residence

- ☐ Group Home (Non ICF/MR)
- ☐ Assisted Living
- ☐ Other (please specify) _____

SECTION B: DIAGNOSIS OF SERIOUS MENTAL ILLNESS, MENTAL RETARDATION OR RELATED CONDITION

1) Was there an adverse PASRR determination within the past 60 days? ☐ YES ☐ NO

If so, indicate date of most recent adverse PAS/RR determination* _____ *(mm/dd/yyyy)*

The date of most recent adverse PAS/RR is only applicable for persons with diagnoses of SMI and/or MRDD as indicated in this section. Call the State authorities if unable to verify via local records (ODMH: 614-466-1063 and/or DODD: 1-800-617-6733).

2) Does the individual have a diagnosis of any of the mental disorders listed below? ☐ Yes ☐ No

- ☐ a) Schizophrenia
- ☐ b) Mood Disorder
- ☐ c) Delusional (Paranoid) Disorder
- ☐ d) Panic or Other Severe Anxiety Disorder
- ☐ e) Somatoform Disorder
- ☐ f) Personality Disorder
- ☐ g) Other Psychotic Disorder
- ☐ h) Another Mental Disorder Other Than MR that may **chronic disability.**

If so, describe _____

3) Does the individual have a diagnosis of mental retardation (mild, moderate, severe or profound) as described in the AAMR manual "Mental Retardation: Definition, Classifications and Systems of Support" (2002) or most recent version. ☐ Yes ☐ No

4) Does the individual have a severe, chronic disability that is attributable to a condition other than mental illness, but is closely related to MR because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR and requires treatment or services similar to those required for persons with MR **AND** was manifested prior to the age of 22? ☐ Yes ☐ No

If ***YES****, please specify* _____

SECTION C: CERTIFICATION FOR HOSPITAL EXEMPTION

As the individual's physician (MD or DO), I certify that the individual:

- is discharged to a nursing facility directly from a hospital after receiving acute patient care at the hospital; and
- requires nursing facility services for the condition for which he/she received care in the hospital; and
- as the physician, I certify, no later than the date of discharge, that the individual requires fewer than 30 days of nursing facility services.

Physician's Printed Name	License #
Physician's Signature	Date *(mm/dd/yy)*

Please note: The individual cannot be admitted to the nursing facility through the hospital exemption if <u>all</u> three criteria are not met. If the individual does not meet the three criteria for exemption, the individual may still seek nursing facility admission through a pre-admission screen via completion of the ODJFS 03622. Admission cannot occur until the pre-admission screen is completed and a determination made that nursing facility placement is appropriate. Physician Signature on this form is required.

SECTION D: IDENTIFYING INFORMATION FOR THE NURSING FACILITY TO WHICH AN INDIVIDUAL WILL BE ADMITTED

Nursing Facility Name	Nursing Facility Contact	Nursing Facility County

Street Address	City	State	Zip

Date of Expected Admission *(mm/dd/yyyy)*	Phone #	Fax #

THIS NOTIFICATION FORM MUST BE KEPT IN THE NURSING FACILITY RESIDENT'S FILE. BY ACCEPTING THE ADMISSION, THE NURSING FACILITY CONFIRMS THAT THE HOSPITAL EXEMPTION CRITERIA AND ALL APPLICABLE REQUIREMENTS OF OHIO ADMINISTRATIVE CODE RULES ARE MET. THE NURSING FACILITY ACCEPTS THE ADMISSION ONLY AFTER RECEIPT AND REVIEW OF THIS NOTIFICATION FORM FOR 100% ACCURACY AND COMPLETION. THE NURSING FACILITY ACCEPTS RESPONSIBILITY FOR REQUESTING A RESIDENT REVIEW (IF REQUIRED) PRIOR TO THE 30TH DAY FOLLOWING ADMISSION FROM THE HOSPITAL.