ADDITIONAL DATA ELEMENTS

Applicant Name____________________________ Medicaid #_____________________
Applicant Current Address____
Medicaid Effective Date____
Authorized Representative, If Any____
Most Current Admission Date (Not Readmission)___________________________
Facility Name, If Current Resident____
Estimated Length of NF Stay:
_____0-30 Days _____ 31-90 Days _____91-180 Days_____ OVER 180 Days
Medication Administration :
_____Independent ______ Needs Meds Setup
_____Needs Verbal Assistance ______ Needs Meds Administered
Mental/Behavioral Status:
______ Danger to self ______ Depressed
______Danger to others ______Abusive
______Impaired judgment ______Impaired memory

In answering the following, please consider the applicant's potential for returning to the community. This assists us is determining the need for a delayed assessment.
Rehabilitation Potential: _____ Improve Function _____Maintain Function
_____Retard Loss of Function _____None
Prognosis: _____Good _____Fair _____Poor _____ Terminal

Brief summary of capacity for independent living, learning, self direction, and communication skills:

Brief summary of informal support system:

Attending Physician Certification: I certify that I have reviewed the information contained herein, and the information is a true and accurate reflection of the individual's condition. I certify that the level of care recommended is required at the time of requested vendor payment change. (Please check one below)

______Skilled ______Intermediate ______Intermediate/Mental Retardation-Developmental Disabilities ______Protective ________None
Physician Signature __________________________________ Date______________
www.longtermcareohio.com