

Applicant Name

Ohio Department of Job and Family Services
**HOSPITAL (CONVALESCENT) EXEMPTION
FROM PREADMISSION SCREENING NOTIFICATION**

Instructions for the Hospital Discharge Staff: Use black ink and print clearly. Submit the notification to the nursing facility and 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
Living arrangement prior to the hospital admission:				
<input type="checkbox"/> a) Group Home		<input type="checkbox"/> b) Psychiatric Hospital		<input type="checkbox"/> c) Own Home/Apartment - Alone
<input type="checkbox"/> d) Own Home/Apartment - With Friend or Relative		<input type="checkbox"/> e) Homeless		<input type="checkbox"/> f) Prison
<input type="checkbox"/> g) Nursing Facility		<input type="checkbox"/> h) Other (please specify)		
Street Address		City	State	Zip
Ohio County of Residence		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (mm/dd/yy)
Social Security #		Medicaid Recipient <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending <input type="checkbox"/> Managed Care Plan		
Hospital Name			Hospital Phone #	
Hospital Contact			Discharge from Psychiatric Unit to NF? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

1) If applicable, date of most recent adverse PAS/RR determination* _____ (mm/dd/yy) Not Applicable
**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 ODODD: 614-728-2556).*

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

<input type="checkbox"/> a) Schizophrenia	<input type="checkbox"/> f) Personality Disorder
<input type="checkbox"/> b) Mood Disorder	<input type="checkbox"/> g) Other Psychotic Disorder
<input type="checkbox"/> c) Delusional (Paranoid) Disorder	<input type="checkbox"/> h) Another Mental Disorder Other Than MR that may lead to a chronic disability . If so, describe _____
<input type="checkbox"/> d) Panic or Other Severe Anxiety Disorder	
<input type="checkbox"/> e) Somatoform Disorder	

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?
 Yes No
If YES, please specify

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SECTION C: CERTIFICATION FOR HOSPITAL (CONVALESCENT) EXEMPTION

As the individual's physician, 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 less 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 all 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: RETURN TO COMMUNITY LIVING REFERRAL

1) Prior to discharge to the NF, did you share with the individual any service and support alternatives to the nursing facility?
 Yes No

2) If service and support alternatives are not appropriate due to care needs, please explain why alternatives are not appropriate at this time.

Brief Explanation

3) Does this individual expect to return to live in the community following the short term stay in the nursing facility?
 Yes No

4) Do you believe that this individual could benefit from talking to someone about returning to the community following the short term stay in the nursing facility? Yes No

5) Was this individual employed prior to the hospital admission?
 Yes No Occupation, if applicable

6) Does the individual need assistance obtaining and/or returning to employment upon return to a community setting following the nursing facility stay?
 Yes No

7) What challenges or barriers do you believe could impede this individual's return to the community?

Check all that apply and provide a brief description.

- | | |
|--|--|
| <input type="checkbox"/> a) Care needs are likely greater than community capacity | <input type="checkbox"/> e) Affordable housing limited |
| <input type="checkbox"/> b) Limited or no family/friend support available | <input type="checkbox"/> f) Accessible housing limited |
| <input type="checkbox"/> c) Guardian/Family likely to not support community living | <input type="checkbox"/> g) Limited income to support community living |
| <input type="checkbox"/> d) Lost housing while in the hospital | <input type="checkbox"/> h) Other, please describe below |

Please provide a description on the next page

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Brief Description

Does the Individual Need Help Returning to Community Living?

If the individual already has, or is likely to have following admission to the facility, a combined stay in the hospital/nursing facility/ICF-MR facility of 6 months or longer and could benefit from community transition assistance, a referral to the HOME Choice Transition Program is recommended. Please visit <http://jfs.ohio.gov/OHP/consumers/HCconsumers.stm> to submit an application or call 1-888-221-1560 for more information regarding program benefits and application procedures.

Application submitted on _____ (mm/dd/yy)

Ohio's twelve area agencies on aging offer free long-term care consultations. As requested, a consultant (most often a nurse or social worker) will meet with the individual and their family for a free evaluation of the current situation and future options. The consultant will explain services available, discuss eligibility requirements and financial resources required and help determine needs and wishes. Call toll-free 1-866-243-5678 to be connected to the area agency on aging serving your community.

Long Term Care Consultation requested on _____ (mm/dd/yy) Request sent to _____ Area Agency on Aging

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

Facility Name		Facility Contact	
Street Address	City	State	Zip
Date of Expected Admission (mm/dd/yy)	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.