ASCEND MANAGEMENT INNOVATIONS

Nebraska Department of Health and Human Services
Categorical Determinations and Exemptions (PASRR)

Phone: (877) 431-1388
Fax: (877) 431-9568

"CONFIDENTIAL"

Please submit this form directly to Ascend by fax.

*Complete this form **only** if the individual is considered to have Serious Mental Illness, Intellectual Disability, Related Condition, or a Dual Diagnosis based on Criteria identified on the Level I PASRR form.*

SECTION I: PERSON COMPLETING FORM

Name: _____ Facility: _____ Date: _____

Phone # : _____ Fax # : _____

SECTION II: PATIENT INFORMATION

Name: _____ SS# : _____-____-_____ Date of Birth: _____
First *Last*

SECTION III: ADVANCED DEMENTIA **Supporting documentation to affirm the diagnosis must be submitted by fax.**	**No**	**Yes**
Does the individual have a diagnosis of Serious Mental Illness or Intellectual Disability or a Related Condition **and** have a diagnosis of Dementia, Alzheimer's Disease or related disorder?		
Is the diagnosis of Dementia, Alzheimer's Disease or related disorder considered the **primary** diagnosis?		
Is the individual considered to be in the advanced stages of this condition and no longer able to participate in or benefit from Intellectual Disability/Developmental Disability or specialized services?		

SECTION IV: EXEMPTED HOSPITAL DISCHARGE (EHD)

This individual's physician certifies the following:

___ Admission to a NF directly from a hospital after receiving *acute in-patient medical care* at the hospital; and
___ Requires NF services for the medical condition he/she received care in the hospital; and
___ The attending physician has certified prior to NF admission that the individual will require less than 30 days services.

Physician's Signature: _____ Date: _____
Physician's Printed Name: _____ Phone # : _____

SECTION V: TIME-LIMITED* CATEGORICAL DETERMINATIONS ***Please attach the appropriate validating documentation.**

The following categories indicate the individual requires NF services and does not require specialized services for the time specified.

☐ **Emergency Protective Service**: individual is admitted to a NF pending further assessment, in an emergency for a stay not anticipated to exceed 7 days.

☐ **Respite**: admission to a NF is needed to care for individual to provide respite for in-home caregivers to whom the MI, MR/RC individual will return. Not to exceed 30 days.

SECTION VI: OTHER CATEGORICAL DETERMINATIONS (non-limited)

Records and/or physician's certification to affirm the above medical condition exists must be submitted with the request.

☐ **Serious Medical:**
Individual has a diagnosis/medical condition of: Coma, Ventilator Dependence, functioning at a brain stem level or a End-stage Medical Condition, which results in the inability to benefit from specialized services.

The following documentation has been attached:

☐ Additional supporting documentation is attached/submitted.
☐ Physician's certification stating less than 30 day nursing facility
☐ Physician's certification/Medical records indicating Serious Medical Condition

Notes: _____