Out-of-State Nursing Facility Placement Packet

Complete the following information and fax the completed Out-of-State Nursing Facility Placement Packet with all supporting documents to the Division of Health Care Financing and Policy (DHCFP) Long Term Services and Supports Nevada Medicaid Out-of-State Coordinator.

Fax this request to: (775) 687-8724 For questions regarding this form, call: (775) 684-3619

DATE OF REQUEST: _____ /_____ /_____

SECTION I: RECIPIENT INFORMATION

Recipient Name: (last, first, MI)		☐ Male ☐ Female
Date of Birth:	Age:	Marital Status: ☐ M ☐ W ☐ D ☐ S
Recipient Medicaid ID:	Social Security # if Medicaid ID is Unknown:	
Guardian Name (or responsible person) if applicable:	Guardian (or responsible person) Telephone Number:	
Guardian (or responsible person) Address:		
Please indicate if guardianship has been applied for: ☐ Yes ☐ No ☐ Not applicable		
Recipient's living arrangements prior to admit (e.g., group home, parents, ICF/IID, SNF, etc):		

SECTION II: CLINICAL INFORMATION

Is this a request for ICF/IID? ☐ Yes ☐ No If Yes, ICF/IID OOS placement requires a Physician Order.

☐ Diagnoses (attach H&P and Physician Progress Notes)

☐ Medications (attach medication record including PRN medications)

☐ Psychosocial Narrative, Behavioral Tracking/Monitoring Records (if OOS placement due to behaviors)

☐ Nursing Progress Notes (attach if describes behaviors making OOS placement needed)

☐ Case Management/Social Worker Discharge Planning Notes

Reason for seeking out-of-state placement *(this section must be complete; more than one box can be checked)*

☐ Exit Seeking/Flight Risk Behavior ☐ Wandering Behavior ☐ Violent Behavior ☐ Danger to Self

☐ Danger to Others ☐ Other Inappropriate Behaviors ☐ Requires a Locked Facility

☐ No Appropriate Beds Available In-State ☐ Requires Specialty Care (Bariatric, Pediatric, etc.)

☐ Recipient is unable to return to their prior living situation ☐ Previous facility refusing readmission

Please attach documentation to support any checked items above if not included in the attached clinical information.

☐ List of all Nevada facilities contacted, date, contact person and reason for denial (attach)

SECTION III: SERVICING PROVIDER INFORMATION

Current Provider Name and Unit:		
Telephone Number:	Fax Number:	Admit Date:
Name of Case Manager:	Contact Number:	

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Recipient Name: (last, first, MI):_____	
Recipient Medicaid ID:_____ Social Security # if Medicaid ID is Unknown:_____	
PASRR screening request submitted: ☐ Yes ☐ No If the response is Yes, enter date the request was submitted: _____	
Level of Care (LOC) request submitted: ☐ Yes ☐ No If the response is Yes, enter date the request was submitted: _____	
Medicaid eligibility verified by EVS: ☐ Yes ☐ No	
Name of person completing this form (please print):	
Title of person completing this form:	
Telephone number of person completing this form:	
Signature of person completing this form:	Date:

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Recipient Name: (last, first, MI):_____

Recipient Medicaid ID:_____ Social Security # if Medicaid ID is Unknown:_____

SECTION IV: OUT-OF-STATE NURSING FACILITY PLACEMENT RECIPIENT ACKNOWLEDGEMENT AND CONSENT

Admission has been denied by all Nevada nursing facilities that could meet my medical requirements; therefore, I recognize Out-of-State Nursing Facility placement is necessary.

Recipient, Legal Representative or Guardian must print:

I_____ give my consent for Out-of-State Nursing Facility Placement.

Recipient, Legal Representative or Guardian must sign: Signature:	Date:
Witnessed by:	Date:

SECTION V: OUT-OF-STATE FUNERAL BURIAL RECIPIENT ACKNOWLEDGEMENT

I understand that no Medicaid benefits are payable after death, and Medicaid cannot be responsible for funeral or burial costs including the return of a deceased's remains to Nevada.

The recipient has a Burial Plan: ☐ Yes ☐ No

Name of Burial Plan Company: _____

Plan ID Number: _____ Company's Phone Number: _____

If there is no plan, burial assistance from the county of origin may be available and can be applied for at the time of death.

Signature of Recipient, Legal Representative or Guardian:	Date:

Printed Name and Relationship *(if the above is not the recipient):*

Name: Relationship:

SECTION VI: FOR DHCFP USE ONLY

This request for Out-of-State Placement has been: ☐ Approved ☐ Denied

If request is denied, reason for denial:

Reviewer Name (please print):

Reviewer Signature:	Date Reviewed:

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.

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Recipient Name: (last, first, MI):_____

Recipient Medicaid ID:_____ Social Security # if Medicaid ID is Unknown:_____

SECTION VII: OUT-OF-STATE NURSING FACILITY PLACEMENT TRACKING

Providers must notify DHCFP when recipients are placed in an Out-of-State Nursing Facility.

Please complete and fax this page to DHCFP at (775) 687-8724 or call DCHFP at (775) 684-3619.

Name of Out-of-State Nursing Facility where recipient has been placed:	
Date recipient was discharged to the above named Out-of-State Nursing Facility:	
Name of person completing this form (please print):	
Title of person completing this form:	
Telephone number of person completing this form:	
Signature of person completing this form:	Date: