COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PRE-ADMISSION SCREENING AND RESIDENT REVIEW

Exempted Hospital Discharge
Physician Certification of Need for Nursing Facility Services

Applicant's Name_____

Social Security Number_____ Date of Birth_____

Hospital Discharged from_____ Date of Discharge_____

Name of Nursing Facility _____ Date of Admission_____

Nursing Facility Medicaid Provider Number_____

Level I Screen triggered mental Illness ☐ **Yes**

Level I Screen triggered Intellectual Disability or Related Condition ☐ **Yes**

An Exempted Hospital Discharge means ALL of the following:

1. The applicant is being admitted to a Nursing Facility from an acute care setting; **and**
2. The applicant requires continued nursing facility care of the condition for which he was in the Hospital; **and**
3. This admission is expected to be less than thirty (30) days.

When signing this Document the Attending Physician has certified that the Applicant is likely to require less than thirty (30) days of nursing facility care.

NOTE: If an individual enters the nursing facility as an exempted hospital discharge, and is later found to require more than thirty (30) days of nursing facility care, a Level II PASRR must be completed within forty (40) calendar days of admission for the Facility to remain in compliance. The nursing facility staff shall make the referral for persons with mental illness, or an intellectual disability, or related condition for a Level II PASRR evaluation prior to the end of the exempt thirty (30) days).by submitting a copy of the MAP 409 Form. The CMHC has 9 days after the date of referral to complete the Evaluation process.

Attending Physician Signature_____ Date_____

Print Attending Physician Name_____

Date Transmitted_____

Signature and Title_____

Print Name and Title_____

Original remains in Chart Copy to Medical Records