PRE-ADMISSION HOSPITAL EXEMPTION TO THE NURSING FACILITY or SWING BED

1. Send this notification to the nursing facility and Maximus (pasrr@state.sd.us) PRIOR to discharge from the hospital.
2. This form must be completed fully (Sections A-D) for the nursing facility to accept payment for services.
3. Incomplete forms will be returned.

SECTION A: IDENTIFYING INFORMATION FOR APPLICANT

Last Name	First Name	MI

Living arrangement prior to the hospital admission:

☐ group home ☐ psychiatric hospital ☐ own home/apt - alone
☐ own home/apt – with friend or relative ☐ homeless ☐ prison
☐ nursing facility ☐ other (please specify)

Street Address	City	State	Zip

SD County of Residence	Sex ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)

Social Security #	Medicaid Recipient ☐ yes ☐ no ☐ pending

Hospital Name	Hospital Phone #

Hospital Contact	Discharge from Psychiatric Unit to NF? ☐ yes ☐ no

SECTION B: DIAGNOSIS OF SERIOUS MENTAL ILLNESS or INTELLECTUAL and DEVELOPMENTAL DISABILITIES

1) If applicable, date of most recent Level II PASRR determination*_____(mm/dd/yyyy) ☐ not applicable

* The date of the most recent Level II PASRR is only applicable for persons with diagnoses of serious mental illness or intellectual and developmental disabilities as indicated in this section. Contact Maximus if unable to verify.

2) Does the individual have a diagnosis of any of the mental illness as defined in the DSM-IV most recent version? ☐ yes ☐ no
If yes please list below.

☐ schizophrenia
☐ mood disorder
☐ delusional (paranoid) disorder
☐ panic or other severe anxiety disorder
☐ somatoform disorder
☐ personality disorder
☐ other psychotic disorder
☐ another mental disorder other than ID
If so, describe _____

3) Does the individual have a diagnosis of intellectual or developmental disability (ID/DD) (mild, moderate, severe or profound) as described in the ARSD? 67:54:04:05. ☐ yes ☐ no

4) Does the individual have a severe, chronic disability that is attributable to a condition other than intellectual disability (ID), but is closely related to ID because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with ID and requires treatment or services similar to those required for persons with ID?
☐ yes ☐ no If yes, please specify:

SECTION C: CERTIFICATION FOR HOSPITAL EXEMPTION

As the individual's medical provider (physician or mid-level), I certify that the individual:
*Is discharging to a nursing facility or swing bed directly from a hospital after receiving acute inpatient hospital care; and
*Requires nursing facility services for the condition for which he/she received care in the hospital; and
*As the medical provider, I certify, no later than the date of discharge, that the individual requires less than 30 days of nursing facility or swing bed services.

Medical Provider Printed Name	
Medical Provider Signature	Date (mm/dd/yyyy)

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 "PASRR Screening Form" and referral to Maximus, if applicable.

SECTION D: 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/yyyy)	Phone #	Fax #	

Printed Name of Hospital Staff completing this form	Time emailed to Maximus
Signature of Hospital staff completing this form	Date (mm/dd/yyyy) emailed to Maximus

THIS NOTIFICATION FORM MUST BE KEPT IN THE NURSING FACILITY RESIDENT'S ACTIVE FILE. BY ACCEPTING ADMISSION, THE NURSING FACILITY CONFIRMS THAT THE HOSPITAL EXEMPTION CRITERIA AND ALL APPLICABLE REQUIREMENTS OF SOUTH DAKOTA'S PASRR PROGRAM 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) FROM MAXIMUS PRIOR TO THE 30th DAY FOLLOWING ADMISSION FROM THE HOSPITAL.