PHYSICIAN CERTIFICATION

▶ Instructions on reverse

DHS-1503-ENG 10-17

1

PROVIDER INFORMATION

2 LTC Provider's Name

3 LTC Provider phone #

4 NPI

5 Own reference #

6 Today's date

7 Street Address

8 Attending Physicians Name

9 Physician's NPI

10 City/State/ZIP

11 Date Physician Signed Order

12 Date of this Admission

13 Anticipated Discharge Date (See back)

RECIPIENT INFORMATION

14 Recipient name (Last, First, Initial)

15 Recipient Medical Assistance Number

15a If applying, place X in box ☐

16 Birthdate

17 Gender

18 Primary Diagnosis/Reason for Admission

19 DIAG Code

20 Secondary Diagnosis

21 DIAG Code

PREADMISSION SCREEENING FOR SNFS AND NFS

22. Was person screened prior to this admission? ☐ Yes ☐ No

a. If yes, date screened _____ and name of agency that did screening _____

b. No screening required:
- ☐ transfer from another MN SNF/NF or certified MN Board and Care Home (BCH)
- ☐ **transfer from a MN SNF/NF/BCH to an acute care hospital, then back to a SNF/NF/BCH**
- ☐ other reason, (explain) _____

c. Screening after admit:
- ☐ emergency admit
- ☐ other reason (explain) _____

ICF-DD SCREENING ONLY

23. Date person screened _____ Was it prior to this admission? ☐ Yes ☐ No If no, attach reason why.

ADMISSION INFORMATION

24 Date of first admission

Recommended Level of Care: (“X” one) ..... SNF ☐ 25 NF Only ☐ 26 ICF-DD ☐ 27 RTC Psychiatric ☐ 28

Length of Stay: (“X” one) ..... 30 days or less ☐ 29 31 to 90 days ☐ 30 91 to180 days ☐ 31 over 180 days ☐ 32

Admitted from: (“X” one) ..... Acute-Care Hospital ☐ 33 Home ☐ 34 RTC ☐ 35 Other SNF or NF ☐ 36 ICF/DD ☐ 37

33a If Box 33 is checked indicate: Name of hospital _____

Date of hospital admission _____ Date of hospital discharge _____

PHYSICIAN'S SIGNATURE

I certify (or I certify that a physician has certified) that the recipient named above requires long term care services and that the services are being provided under a written plan of care.

X _____

38. AUTHORIZED SIGNATURE AND DATE

LOCAL COUNTY AGENCY USE ONLY

_____

39. Date this form received by Local County Agency

_____

40. Name of county

_____

41. Local county Agency Signature and Date

_____

42. Date form RETURNED TO LTC FACILITY

➤ **NOTICE:** Anyone who misrepresents essential information requested by this form may face sanctions under both state and federal law.

INSTRUCTIONS

This form must be completed by the LTC facility within 72 hours (not including weekends or holidays) after the admission of a Medical Assistance (MA) recipient or MA applicant.

Type or print all items except items 38 and 41, which should be signed.

1. Leave blank.

2., 3., 7., 10. Long-term care (LTC) facility name, telephone and address.

4. Long-term care facility's NPI.

5. Optional – may use medical record number or other number.

6. Date the form is being completed.

8. Name of attending physician.

9. Physician's NPI, if available.

11. Date physician signed orders for this admission or if physician signed DHS-1503, date physician signed line 38. For an MA recipient, date must be prior or equal to the date in box 12.

12. Enter the date of admission or readmission to the facility.

13. Enter the date the physician anticipates resident will be discharged from this (current) admission. This box is for use by the local county agency worker to determine budgeting method.

14. Recipient's name.

15. Recipient's Medical Assistance identification number. If an MA applicant leave blank, the Local County Agency will complete.

15a. If a MN Health Care Programs (MHCP) applicant, place an X in this box. If an MHCP recipient, leave blank.

16. Recipient's birth date.

17. Recipient's gender – use F for female and M for male.

18. Primary diagnosis or reason for admission.

19. Enter current primary diagnosis billing code.

20. Secondary diagnosis for admission; if none, leave blank.

21. Optional – if #20 is completed, enter current secondary diagnosis billing code.

22. If yes, complete 22a. If yes, but the date of screening is more than 60 days prior to admission, the person must be screened again. Access the Pre-Admission Screening (PAS) online referral tool at: https://mnhelpreferral.revation.com If no, check the most appropriate reason in 22b or 22c. For use of "other," please refer to Chapter 27 of MHCP Manual.

23. Must be completed for each admission, including admissions from a RTC (Regional Treatment Center) to a community ICF-DD, or transfer from one community ICF-DD to another ICF-DD or readmission of person previously discharged. If not screened prior to admission, attach reason or reasons why.

24. Enter date the individual first entered the facility either as a recipient, applicant or as private pay (including Medicare eligibles).

25 - 28. Check one box only. Note: SNF refers to a Medicare certified level of care (skilled nursing care), NF-Only refers to a Medicaid-only certified level of care (i.e. such as a certified Board and Care Home-BCH), and RTC psychiatric is only used in Regional Treatment Centers for certified psychiatric beds.

29 - 32. Check one. Length of stay means the anticipated amount of time the person will be at the facility. This is to be estimated from the date in box 12.

33 - 37. Check one box only. Note: Use home option when other choices do not apply. RTC refers to any previous RTC stay, regardless of bed type or level of care in an RTC.

33a. Complete ***only*** if person was hospitalized.

38. Signature of physician or authorized person and date signed (authorized person attests to the fact that facility maintains documentation of physician signature on file in resident's record).

39. Enter the date form is received by the Local County Agency or date stamp upon receipt.

40. Enter the county name.

41. Local County Agency representative signature and date.

42. Enter the date DHS-1503 is completed, signed and returned to the LTC facility.

Distribution: The LTC facility retains a copy and sends the completed original form to the Local County Agency. The Local County Agency retains a copy and returns the original signed/dated form to the LTC facility (to be placed in the resident's record).