

PHYSICIAN CERTIFICATION

▶ Instructions on reverse



DHS-1503-ENG

10-17

1

PROVIDER INFORMATION

LTC Provider's Name	LTC Provider phone #	NPI	Own reference #	Today's date
2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>	6 <input type="text"/>
Street Address	Attending Physicians Name		Physician's NPI	
7 <input type="text"/>	8 <input type="text"/>		9 <input type="text"/>	
City/State/ZIP	Date Physician Signed Order	Date of this Admission	Anticipated Discharge Date (See back)	
10 <input type="text"/>	11 <input type="text"/>	12 <input type="text"/>	13 <input type="text"/>	

RECIPIENT INFORMATION

Recipient name (Last, First, Initial)	Recipient Medical Assistance Number	If applying, place X in box	15a <input type="checkbox"/>	Birthdate	Gender
14 <input type="text"/>	15 <input type="text"/>			16 <input type="text"/>	17 <input type="text"/>
Primary Diagnosis/Reason for Admission				DIAG Code	
18 <input type="text"/>				19 <input type="text"/>	
Secondary Diagnosis				DIAG Code	
20 <input type="text"/>				21 <input type="text"/>	

PREADMISSION SCREENING 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

Date of first admission	Recommended Level of Care:.....SNF	NF Only	ICF-DD	RTC
24 <input type="text"/>	("X" one) 25 <input type="checkbox"/>	26 <input type="checkbox"/>	27 <input type="checkbox"/>	Psychiatric 28 <input type="checkbox"/>
Length of Stay:.....30 days or less	31 to 90 days	91 to 180 days	over 180 days	
("X" one) 29 <input type="checkbox"/>	30 <input type="checkbox"/>	31 <input type="checkbox"/>	32 <input type="checkbox"/>	
Admitted from: Acute-Care Hospital	Home	RTC	Other SNF or NF	ICF/DD
("X" one) 33 <input type="checkbox"/>	34 <input type="checkbox"/>	35 <input type="checkbox"/>	36 <input type="checkbox"/>	37 <input type="checkbox"/>

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