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 The Estates at Chateau	3 612-874-1603	4 1417495987	5	6
	Street Address	**Attending Physicians Name**			**Physician's NPI**
	7 2106 2nd Ave S	8 Joe Greenberg			9 1114169356
	City/State/ZIP	**Date Physician Signed Order**	**Date of this Admission**		**Anticipated Discharge Date (See back)**
	10 Minneapolis, MN 55404	11	12		13

RECIPIENT INFORMATION

	Recipient name (Last, First, Initial)	Recipient Medical Assistance Number	If applying, place X in box 15a	Birthdate	Gender
	14	15		16	17

	Primary Diagnosis/Reason for Admission	DIAG Code
	18	19

	Secondary Diagnosis	DIAG Code
	20	21

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.