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.