VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
NURSING FACILITY ADMISSION, DISCHARGE or LEVEL OF CARE CHANGE

Date: ___/___/___ **Reason for Submission**: [ ] Admission [ ] Discharge [ ] Level of Care Change

This form is to communicate between Nursing Facilities and Health Plans for individuals who are Commonwealth Coordinated Care Plus (CCC Plus) members. This form is submitted to the respective health plan at the time of the member's admission to a nursing facility. If a Medicaid member is FFS or Medallion (not enrolled in CCC Plus) the Nursing Facility must enter enrollment, discharge information or level of care change into the LTC portal directly and retain this form in the individual's record.

I. IDENTIFICATION INFORMATION

First name	**Middle Initial**	**Last Name**
Birthdate _ _/_ _/_ _ _ _		**Gender**
Medicaid Number		**Social Security Number**
Nursing Facility Name and Address		**NPI Number**
Admission Date _ _/_ _/_ _ _ _ **Check LOC at Admission** Intermediate Care (1) ☐ Skilled Nursing Care (2) ☐ **Discharge Date** _ _/_ _/_ _ _ _		**Level Of Care (LOC) Change** _ _/_ _/_ _ _ _ (effective date) If LOC Change, please check one of the following: Intermediate Care (1) ☐ Skilled Nursing Care (2) ☐
Name of Health Plan		**Health Plan Fax #**

Has the Nursing Facility **reviewed** a complete Medicaid LTSS Screening package that indicates the individual met Level of Care Criteria and was authorized for LTSS services?

[ ] Yes
[ ] No

If NO, one of the six regulatory Special Circumstances must be documented and checked OR original authorization for LTSS occurred prior to 7.1.2019 as noted below.

☐ 1. Private pay individual who will not become financially eligible for Medicaid within six months from admission to a Virginia nursing facility (as indicated by the hospital staff).
☐ 2. Individual who resides out-of-state and seeks direct admission to a Virginia nursing facility.
☐ 3. Individual who is an inpatient in an out-of-state hospital, in-state or out-of-state veteran's hospital, or in-state or out-of-state military hospital and seeks direct admission to a Virginia nursing facility.
☐ 4. Individual who is a patient or resident of a state owned/operated facility by Department of Behavioral Health and Developmental Services (DBHDS) and seeks direct admission to a Virginia NF.
☐ 5. A screening shall not be required for enrollment in Medicaid hospice services as set out in 12 VAC 30-50-270.
☐ 6. Wilson Workforce Rehabilitation Center (WWRC) staff shall perform screenings of the WWRC clients.
☐ 7. The individual was receiving CCC Plus waiver services and admitted to the nursing facility. Provide date of original CCC Plus waiver authorization: ___/___/___
☐ 8. The individual was admitted to a nursing facility prior to July 1, 2019. Provide original nursing facility admission date: ___/___/___

All individuals eligible for Medicaid at the time of nursing facility admission must have a full LTSS screening unless one of the reasons stated above has been cited.

Change in Level of Care:
A person who was a non-Medicaid admission developed a need for Medicaid LTSS within six months. Please check if one of the following situations occurred (as indicated by the hospital staff prior to admission) resulting in an approved Medicaid LTSS Screening not being conducted.

☐ The LTSS screening process determined failure to meet nursing facility level of care criteria; or

☐ The individual refused the Medicaid LTSS Screening and was admitted for a short-term skilled stay.

Upon request, please be prepared to present documentation of change of level of care via the MDS and physician certification.

II. SUMMARY OF PROVIDERS:

	Provider Name/Location	NPI Number	Date of Admission	Date of Discharge
Prior:				
Current:				

IV. CURRENT PAYMENT SOURCE

☐ Medicare/Medicaid (Dual) ☐ Medicaid only ☐ Private Pay ☐ Commercial Insurance

COMMENTS:_____

I certify that the information contained herein is representative of the individual's status as documented in the individual's medical record.

_____ _____
Name of person completing this form **Telephone number**

_____ _____
Signature of person completing form **Date**

CONFIDENTIAL-CONTAINS PATIENT IDENTIFIABLE INFORMATION

This electronic message transmission (FAX) contains patient-identifiable information, which is being forwarded to a Commonwealth Coordinated Care Plus Health Plan. It is intended for the review and use of no one but the identified FAX individual listed above. State and Federal laws prohibit misuse or disclosure of this information. If you have received this communication in error, please notify the sender at the address listed above immediately.

HEALTH PLAN USE ONLY

Contact Name:_____ Email _____ Phone#_____

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
DMAS-80 INSTRUCTIONS

- **Date:** Please enter the date that the form is completed.
- **Reason for Submission:** This form is used for all Medicaid eligible individuals upon admission and discharge to a nursing facility, and those needing a level of care change.
- **Name:** Please enter the individual's complete name.
- **Birth date:** Please enter the individual's complete date of birth.
- **Gender:** Please mark the appropriate box.
- **Medicaid Number**: Please enter the individual's complete 12-digit Medicaid number which is necessary to process the form. Do not complete this form for 'pending' Medicaid individuals.
- **Social Security Number**: Please enter the individual's complete social security number.
- **Nursing Facility Name, Address and NPI Number:** Please enter the facility's business name, complete address and 10 to 12 digit NPI number.
- **Admission or Discharge Date for the Individual:** Please enter the admission date and if applicable discharge date for the individual.
- **Level of Care (LOC) Change:** Please enter the date of the LOC change and check either Intermediate Care (1) or Skilled Nursing Care (2).
- **Health Plan Name and FAX number**: Please enter the corresponding managed care health plan information for the individual.
- **Questions:** Please answer the questions as listed on the form for the individual named. Please note that individuals should not be admitted without review of the LTSS Screening Packet unless the NF has documented, through discussion with hospital staff where relevant, that one of the allowed Special Circumstances or noted exceptions exist.
- **Summary of Providers:** If known, please enter the information related to providers who were providing services to the individual prior to admission to your facility. This is especially important for transfers from facility to facility.
- **Current Payment Source**: Please mark the appropriate box.
- **Comments:** This section is optional, you may provide any additional information as needed.
- **Name, Signature of Person Completing Form and Date:** Please have the person who completed this form sign and date. This form does not have to be completed by a Registered Nurse. Any staff that the Administrator chooses may complete it.

Please return the completed form by fax to the individual's CCC Plus health plan.

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