

Nursing Facility Applicant Name: \_\_\_\_\_

Applicant DOB: \_\_\_\_\_

**This form must be included with the Level I submission if the EHD or categoricals are requested.**



**Request for Exempted Hospital Discharge** *(requires physician's signature)*

As allowable under Federal Code, an individual with a known or suspected serious mental illness, an intellectual disability, or a related condition may be exempt from preadmission PASRR activities under the Exempted Hospital Discharge provision (42 CFR §483.106(b)(2)) *only if* the individual's attending physician has certified before admission to a facility that the individual is:

- 1) Likely to require less than 30 days of NF services.
- 2) Being admitted to a NF directly from a hospital after receiving acute inpatient care.
- 3) Requires NF services for the condition for which they received care in the hospital.

***The physician's signature below certifies their opinion that the individual meets the above criteria.***

Practitioner's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner's Signature: \_\_\_\_\_

**As allowable under Federal Code (42 CFR §483.130), an individual with a known or suspected serious mental illness, an intellectual disability, or a related condition may be determined to meet criteria for one of the following categories approved by the State of Louisiana.**

*As applicable, the Level I PASRR submitter should indicate the single category that applies to the individual. **Note:** The options below do not require a physician's signature.*



**Request for 90-day Convalescent Care Categorical**



**Request for Terminal Categorical**



**Request for Serious Medical Categorical**



**Request for Respite Categorical**



**Request Due to Emergency Situation Requiring Protective Services**



**Request for Provisional Admission due to Delirium**