Revised March 2007

MAP-4092

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PRE-ADMISSION SCREENING (PAS)

EXEMPTED HOSPITAL DISCHARGE
PHYSICIAN CERTIFICATION OF NEED
FOR NURSING FACILITY SERVICES

Applicant's Name _____

Social Security Number _____ **Date of Birth** _____

Name of Nursing Facility Requested _____ **Date Admitted to NF** _____

Nursing Facility Medicaid Provider Number _____

Hospital Discharged From _____ **Date of Discharge** _____

Hospital's Medicaid Provider Number _____

Level I screen triggered mental illness ☐ **Yes**

Level I screen triggered mental retardation or related condition ☐ **Yes**

Exempted Hospital Discharge: **An exempted hospital discharge means:**

1. **The applicant is being admitted to a nursing facility after receiving acute inpatient care at the hospital; and** ☐ **Yes**
2. **The applicant requires nursing facility care for the condition for which he received care in the hospital; and** ☐ **Yes**
3. **The attending physician, upon signing this document, has certified to the nursing facility that applicant is likely to require less than thirty (30) days nursing facility services.** ☐ **Yes**

Attending Physician Signature _____ **Date** _____

Print Attending Physician Name _____

Note: **If an individual enters the nursing facility as an exempted hospital discharge and is later found to require more than thirty (30) days of nursing facility care, a Level II PASRR shall be completed within forty (40) calendar days of admission. The nursing facility staff shall refer persons with mental illness, mental retardation, or related condition for a Level II PASRR evaluation prior to the end of the exempt thirty (30) days by transmitting a copy of this form to the Community Mental Health/Mental Retardation Center. (This allows ten (10) calendar days for the Level II PASRR to be completed.)**

Date Transmitted _____

Signature and Title _____

Print Name and Title _____

Original to Community Mental Health/Mental Retardation Center
Second Copy – Medical Records