



SECTION A: BENEFICIARY							
Last Name:	First:	MI:	Medicaid ID:	SSN:	Birth date:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Permanent Street Address:			City:	ST:	ZIP:	Phone:	
Present Location of Beneficiary (if different than above):						Date of Request:	

<input type="checkbox"/> Intermediate Care Facility	<input type="checkbox"/> Out of Area Nursing Facility
<input type="checkbox"/> Initial assessment <input type="checkbox"/> Annual reassessment	<input type="checkbox"/> Annual reassessment

SECTION C: LEGAL REPRESENTATIVE <input type="checkbox"/> POA <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> NA				
Name:	Street Address:	City:	ST:	ZIP:

SECTION D: BENEFICIARY FUNCTIONAL STATUS			
Activities	Independent (needs no help)	Supervision or Limited Assistance (needs oversight, encouragement or cueing or highly involved, but requiring assistance)	Extensive Assistance or Totally Dependent (may help, but cannot perform w/o help from staff or cannot do for self at all)
<u>ADLs:</u>			
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>IADLs:</u>			
Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beneficiary ventilator dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No		List additional supporting documents here:	
Name of Person Completing Form:		Title:	Phone:
Signature:		Date:	



SECTION E: CLINICIAN ATTESTATIONS & AUTHORIZATIONS

<input type="checkbox"/> Physician <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner		Street Address:	City:	ST:	ZIP:
Phone:	NPI #:	Date:	Signature:		
I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud.		Print Name:		Title:	
				Date:	

SECTION F: QUALITY IMPROVEMENT ORGANIZATION AUTHORIZATIONS

Level of Care: <input type="checkbox"/> Intermediate Care Facility <input type="checkbox"/> Nursing Facility (Remote)	Certification Period:	Date:
Authorized Signature:	Comments:	

To submit this form electronically after completion, visit the Qualis Health Provider Portal at www.qualishealth.org. Then select one of the choices in the Healthcare Professional Drop-Down Menu: DC Medicaid or Provider Resources. You can obtain additional assistance in registering for the Qualis Health Provider Portal by contacting ProviderPortalHelp@qualishealth.org.