



Level of Care Certification for Swing Bed Facility

PLEASE PRINT OR TYPE

Fax form to: Iowa Medicaid Enterprise Medical Services (515) 725-0420

Today's Date / /	Iowa Medicaid Member Name	Social Security or State ID #	Birth Date / /
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Medical Professional completing form (MD, DO, PA-C or ARNP required)

Name		Telephone Number with Area Code	
Address			
Hospital admission date: / /			
Date/anticipated date of admission to swing bed: / /		Anticipated length of swing bed stay: days	
Swing Bed Hospital Name:		NPI:	Telephone Number:
Address:			Fax Number:

ATTACH MEDICATION AND DIAGNOSES LISTS (WITH ICD CODES) SEPARATELY

Skilled Nursing Needs: Check all boxes that apply.

<p>Therapies provided 5 days a week:</p> <input type="checkbox"/> Physical <input type="checkbox"/> Occupational <input type="checkbox"/> Speech Duration expected: _____	<p>Medications provided daily:</p> <input type="checkbox"/> Intravenous <input type="checkbox"/> Intramuscular Drug name, dose, length of treatment: _____	<p>Stoma care in early postop phase requiring daily care:</p> <input type="checkbox"/> Colostomy <input type="checkbox"/> Ileoconduit <input type="checkbox"/> Suprapubic catheter site <input type="checkbox"/> Ileostomy <input type="checkbox"/> Nephrostomy
<p>Respiratory therapy daily:</p> <input type="checkbox"/> Nasotracheal suctioning <input type="checkbox"/> Tracheostomy care <input type="checkbox"/> Ventilator at least 8 hours/day	<p>Tube feeding:</p> <input type="checkbox"/> More than 50% of nutrition via tube daily Name/brand, dose, length of treatment : _____	<p>Wound care for at least Grade 4</p> <input type="checkbox"/> Sterile dressing change daily <input type="checkbox"/> Wound vac care

Nursing Facility Care Needs: Check all boxes that apply.

<p>Cognition</p> <input type="checkbox"/> No problem <input type="checkbox"/> Language barrier <input type="checkbox"/> Short/long term memory problem <input type="checkbox"/> Problems with decision making <input type="checkbox"/> Interferes with ability to do ADLs	<p>Dressing</p> <input type="checkbox"/> Independent <input type="checkbox"/> Supervision or cuing needed <input type="checkbox"/> Physical assistance needed Frequency of needed assistance: <input type="checkbox"/> 1-2 x weekly <input type="checkbox"/> 3-4 x weekly <input type="checkbox"/> >4 x weekly	<p>Medications</p> <input type="checkbox"/> Independent <input type="checkbox"/> Requires setup <input type="checkbox"/> Administered by others <input type="checkbox"/> Insulin, set dosage <input type="checkbox"/> Insulin, sliding scale <input type="checkbox"/> Frequent lab values
<p>Ambulation</p> <input type="checkbox"/> Independent <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Motorized scooter <input type="checkbox"/> Needs human assistance <input type="checkbox"/> Transfer assist <input type="checkbox"/> Restraint used	<p>Behaviors</p> <input type="checkbox"/> None <input type="checkbox"/> Requires 24-hour supervision <input type="checkbox"/> Noncompliant <input type="checkbox"/> Destructive or disruptive <input type="checkbox"/> Repetitive movements <input type="checkbox"/> Antisocial <input type="checkbox"/> Aggressive or self-injurious <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression	<p>Eating</p> <input type="checkbox"/> Independent <input type="checkbox"/> Assistive devices <input type="checkbox"/> Requires human assistance <p>Skin</p> <input type="checkbox"/> Intact <input type="checkbox"/> Ulcer - Stage _____ <input type="checkbox"/> Open wound <input type="checkbox"/> Daily treatment <input type="checkbox"/> Treatment as needed
<p>Bathing/Grooming</p> <input type="checkbox"/> Independent <input type="checkbox"/> Has assistive devices, independent <input type="checkbox"/> Supervision or cueing needed <input type="checkbox"/> Physical assistance needed Frequency of needed assistance: <input type="checkbox"/> 1-2 x weekly <input type="checkbox"/> 3-4 x weekly <input type="checkbox"/> >4 x weekly	<p>Elimination</p> <input type="checkbox"/> Continent <input type="checkbox"/> Bladder incontinence <input type="checkbox"/> Bowel incontinence <input type="checkbox"/> Urinary catheter <input type="checkbox"/> Chronic colostomy/ostomy <input type="checkbox"/> Chronic nephrostomy	<p>Respiratory</p> <input type="checkbox"/> No issue <input type="checkbox"/> O2 use daily <input type="checkbox"/> O2 as needed

Additional comments: _____

<p>Hospital discharge planner attests there is not an available nursing facility placement in accordance with Iowa Administrative Code 78.3(16) rules. Signature of Discharge Planner:</p>	<p>Signature with Title of Medical Professional completing certification form (MD, DO, PA-C, ARNP):</p>
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Instructions for Level of Care for Swing Bed Facility

Purpose: Form 470-5156, *Level of Care Certification for Swing Bed Facility*, provides a mechanism for a medical professional (MD/DO/ARNP/PA-C) to report level of care needs for a Medicaid member's swing bed admission or subsequent service review.

Source: This form is available on the DHS web site under Provider Forms.

Completion: A provider (MD/DO/ARNP/PA-C) must complete the form when:

- Medicaid member is going to be admitted to a swing bed.
- Medicaid member has an ongoing need for subsequent services in a swing bed.

Distribution: Providers fax the certification for level of care form to the IME Medical Services Unit at (515-725-0420).

The IME Medical Services Unit will make a level of care determination upon receipt of the form.

Data: Today's Date: The date the form is completed (MM/DD/YYYY).

Iowa Medicaid Member Name: The Medicaid member's first name, middle initial, and last name as it appears on the eligibility card.

Social Security Number or State ID #: The member's social security number or state ID number as it appears on the eligibility card.

Birth Date: The Medicaid member's birth date (MM/DD/YYYY) as it appears on the eligibility card.

Medical Professional Section

Name, Telephone Number with Area Code, and Address: The contact information that IME will use to obtain additional information, if needed.

Hospital admission date: The date the member was admitted to the hospital. (MM/DD/YYYY).

Date of admission to swing bed or anticipated date: The expected or actual date of admission to the swing bed. (MM/DD/YYYY).

Anticipated length of swing bed stay (# days): Total number of days expected in swing bed.

Swing Bed Hospital

Name, NPI, Telephone Number with Area Code, Address, and Fax number: The facility information including the swing bed NPI and the preferred fax number to receive authorization notice of decision.

ATTACH MEDICATION AND DIAGNOSES LIST (WITH ICD CODES) SEPARATELY: Provide current medication and diagnoses lists as separate attachments.

Skilled nursing needs section: Check all boxes that apply to the member regarding skilled nursing needs for therapy, medications, wound care, stoma care, ventilator, tracheostomy cares or tube feedings. Also complete the nursing facility care needs section below.

Nursing facility care needs: Check all boxes that apply to the member for nursing facility care needs for swing bed admission or subsequent stay.

Additional comments: Additional pertinent comments from the medical professional.

Hospital discharge planner attests by signing the form that there is not an available nursing facility placement in accordance with Iowa Administrative Code 78.3(16) rules.

Signature with title of medical professional MD/DO/PA/ARNP: Signature of the medical professional completing the form.