



Date: _____

Request for Long Term Care Placement

Please attach the following documentation:

- Current History and Physical
- Medication list
- Current treatment list
- 7 days of nursing notes

Fax completed form to: Horizon NJ Health MLTSS at **1-973-274-3864**

Member ID: _____ Name: _____ DOB: _____

Date of LTC admission: _____ Name of facility: _____

Facility NJ Health ID: _____ Facility EIN: _____ Medicaid Rm/Bd rate: _____

Contact name: _____ Telephone: _____ Fax: _____

Acute hospitalizations since admission to LTC: Y N

Name of hospital: _____ Admit/Disch dates: _____ Diagnosis/Purpose: _____

Medicare coverage: Y N Last approved date under Medicare Part A: _____

Hospice coverage: Y N Last approved date for hospice care: _____

First date requested for LTC: _____

Check activities for which the member requires more than 50% assistance to perform:

See *Approval for Long Term Care Placement* document for guidance

- | | |
|---|--|
| <input type="checkbox"/> Meal preparation | <input type="checkbox"/> Bathing |
| <input type="checkbox"/> Ordinary housework | <input type="checkbox"/> Personal hygiene |
| <input type="checkbox"/> Managing finances | <input type="checkbox"/> Dressing upper body |
| <input type="checkbox"/> Managing medications | <input type="checkbox"/> Bed mobility |
| <input type="checkbox"/> Telephone use | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Stairs | <input type="checkbox"/> Locomotion |
| <input type="checkbox"/> Shopping | <input type="checkbox"/> Toilet use |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Toilet transfer |
| <input type="checkbox"/> Dressing lower body | <input type="checkbox"/> Eating |

History of falls: Y N Date of last fall: _____ Injury: _____

Incontinent of bowel: Y N Incontinent of bladder: Y N

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Can the patient receive care at the present level at home or other outpatient setting? Y N

If no, please explain:

When including other considerations in the request for long term care, please include supporting documentation when faxing the form.

Cognitive considerations supporting need for long term care placement: _____

Behavioral considerations supporting need for long term care placement: _____

Safety (other than risk for falls) considerations supporting need for long term care placement: _____

Complete form in its entirety for request to be processed. Use N/A where needed.

Incomplete forms and missing documentation slow the approval processes and may result in denied requests.