LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

PACE Request for Nursing Facility Level of Care

Check One: ☐ Deemed Continued Eligibility OR ☐ Permanent Waiver of Annual Recertification

Instructions for Completion of PACE Request for Deemed Continued Eligibility OR Permanent Waiver of Annual Recertification

Please use this form to submit your request for either **Deemed Continued Eligibility OR** for a **Permanent Waiver of Annual Recertification.** Include information from the participant's medical record, Plan of Care (POC), as well as any relevant supporting documentation to support your request.

☐ For **Deemed Continued Eligibility**, the information provided **MUST** demonstrated that:

1) **In the absence of PACE services, the participant would reasonably be expected to experience a decline in functioning or health to the degree that they would meet the nursing facility medical necessity criteria within the next 6 months.**

   Important Note: Prior to requesting Deemed Continued Eligibility, it is critical that the PACE provider follow ALL Office of Aging and Adult Services (OAAS) policies and procedures related to the annual reassessment and Level of Care (LOC) review process in order to rule out the possibility that the participant meets LOC eligibility criteria on any one LOC Pathway. All required information must be submitted to the OAAS Regional Office (RO) via secure email, **no later than 5 business days** from the date of the OAAS LOC ineligibility notification.

☐ For **Permanent Waiver of Annual Recertification**, the information provided **MUST** include evidence of the following:

1) A fragile medical condition(s) with no reasonable expectation of improvement or significant change in the participant's condition due to the severity of a chronic condition or the degree of functional capacity (nearing the end of life, living with a chronic, progressive, irreversible disease, including, but not limited to, diagnoses of end stage renal disease [ESRD], chronic heart failure [CHF], or amyotrophic lateral sclerosis [ALS]), **OR**

2) The participant is **permanently** residing in a nursing facility.

   Important Note: All required information must be submitted to the OAAS RO via fax or secure email within **60 calendar days** from the date of the participant's annual recertification assessment date.

The **Justification Summary Statement** and supporting documentation for either the Deemed Continued Eligibility or Permanent Waiver of Annual Recertification may include, but is not limited to:

- Physician assessment(s)/Physician notes
- Physician's diagnosis(es)
- Nurses notes
- Social Worker notes
- Frequency of medical appointments
- Frequency of medical treatments and/or interventions
- PACE program services/benefits that the participant currently receives (e.g. PT, OT, ST, dietary management, blood pressure checks etc.)

Participant Name: _____ **Date of Birth:** _____

LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

PACE Request for Nursing Facility Level of Care

Check One: ☐ Deemed Continued Eligibility OR ☐ Permanent Waiver of Annual Recertification

NOTE: A copy of the relevant part of the participant's PACE POC should accompany a request for either the Deemed Continued Eligibility OR a request for Permanent Waiver of Annual Recertification

I. PARTICIPANT DEMOGRAPHICS			
Date of PACE Request:		**Date of Last iHC Assessment:**	
Participant Name:			
PACE Provider Name:			
PACE Address:			
PACE Contact Name & Title:		**PACE Contact Email Address:**	
PACE Contact Phone #(s):		**PACE Fax #:**	

II. PARTICIPANT DIAGNOSES (Check all that apply)

☐ Alzheimer's Disease ☐ Chronic Heart Failure ☐ Chronic Obstructive Pulmonary Disease ☐ Dementia ☐ Diabetes

☐ End Stage Renal Disease (ESRD) ☐ Rheumatoid Arthritis (RA) ☐ Amyotrophic Lateral Sclerosis (ALS) ☐ Other (List below):

III. Nursing Facility			
Is the participant currently residing in a nursing facility:	☐ Yes ☐ No	**If yes, admission date to the nursing facility:**	
What is the participant's prognosis?	☐ Stable ☐ Improving ☐ Deteriorating		

LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

PACE Request for Nursing Facility Level of Care

Check One: ☐ Deemed Continued Eligibility OR ☐ Permanent Waiver of Annual Recertification

IV. PACE Interdisciplinary Team Justification Summary (Paint a picture of the participant's current condition that supports your request.)

V. FOR OAAS USE ONLY			
Date OAAS Received the PACE Request:			
Additional Documentation Request Date (if applicable)**:**		**Additional Documentation Received Date:**	
Date OAAS Approved Request:			
Date OAAS Denied Request:			

Indicate Reason(s) for Denial Below:

- ☐ Justification summary statement does not meet Continued Deemed Eligibility criteria.
- ☐ Justification Summary statement does not meet Permanent Waiver of Annual Recertification criteria.
- ☐ Supporting documentation does not meet Continued Deemed Eligibility Criteria
- ☐ Supporting documentation does not meet Permanent Waiver of Annual Recertification criteria.
- ☐ Failure to submit the required/acceptable documentation within the required timeline.
- ☐ Other (Explain):

OAAS Representative Signature/Title:	**Date:**

Participant Name: _____ **Date of Birth:** _____