DEPARTMENT OF HEALTH AND HOSPITALS
Aging and Adult Services

PACE Request for Nursing Facility Level of Care
☐ Deemed Continued Eligibility OR ☐ Permanent Waiver of Annual Recertification (check one)

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 Wavier 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. **A copy of the participant's PACE Plan of Care must accompany this form.**

☐ *For **Deemed Continued Eligibility**, the information provided must demonstrate 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 he/she would meet the nursing facility medical necessity criteria within the next six (6) months.**

***Important Note:** Prior to requesting Deemed Continued Eligibility, it is critical that the PACE provider follow all OAAS policies and procedures related to the annual reassessment and Level of Care 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 fax, or via secure email, no later than five (5) business days from the date of the OAAS Level of Care (LOC) ineligibility notification.

☐ **For **Permanent Wavier 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 (e.g., nearing 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], 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 Regional Office (RO) via fax, or via secure email, within **ninety (90) calendar days** from the date of the participant's annual recertification assessment date.

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

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

A copy of the participant's PACE Plan of Care must accompany a request for either Deemed Continued Eligibility, OR a request for Permanent Waiver of Annual Recertification.

As part of the decision making process, OAAS may request an onsite visit to meet with the participant, conduct its own level of care assessment and/or request additional supporting documentation. **If OAAS requests additional supporting documentation, the PACE provider must submit the requested information no later than five (5) business days from the date of receipt of OAAS' request.** If OAAS does not receive the additional, requested information by the required timeline, the **OAAS will proceed with the denial process, as applicable**. OAAS RO staff will respond within ten (10) business days from receipt of an adequate *Request for Deeming of Continued Eligibility* OR Waiver of Annual Recertification form (**OAAS-PF-13-009)** and supporting documentation.

Participant Name: _____Date Of Birth: _____

DEPARTMENT OF HEALTH AND HOSPITALS
Aging and Adult Services

PACE Request for Nursing Facility Level of Care

☐ Deemed Continued Eligibility OR ☐ Permanent Waiver of Annual Recertification (check one)

I. Participant Demographics:		
Date of PACE Request:		
Participant Name:		**Date of Birth:**
Last MDS-HC Assessment Date:		
PACE Provider Name:		
PACE Street Address:	**City:**	**Zip Code:**
PACE Contact Name & Title:		**PACE Contact Email Address:**
PACE Contact Phone #(s):		**PACE Fax #:**

II. Participant Diagnosis (check all that apply)

- ☐ Alzheimer's
- ☐ Chronic Heart Failure (CHF)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Dementia
- ☐ Diabetes
- ☐ End Stage Renal Disease (ESRD)
- ☐ Rheumatoid Arthritis (RA)
- ☐ Amyotrophic lateral sclerosis (ALS)
- ☐ Other (List):

III. Participant is Residing in a Nursing Facility

Participant is residing in a nursing facility ☐ **Yes** ☐ **No**
Participant is **permanently** residing in a nursing facility? ☐ **Yes** ☐ **No**
Admit Date to nursing facility:_____
Prognosis: ☐ **Stable** ☐ **Improving** ☐ **Deteriorating**

DEPARTMENT OF HEALTH AND HOSPITALS
Aging and Adult Services

PACE Request for Nursing Facility Level of Care

☐ Deemed Continued Eligibility OR ☐ Permanent Waiver of Annual Recertification (check one)

IV. PACE IDT Justification Summary Statement ("Paint a picture" of the participant's current condition that justifies/supports your request):

V. For OAAS Use Only	
Date OAAS Received PACE Request:	
Additional Documentation Request Date (if applicable):	**Additional Documentation Received Date:**
Date OAAS Approved Request:	
Date OAAS Denied 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 Wavier 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 required/acceptable documentation within required timeline
- ☐ Other (Explain):

OAAS Representative Signature/Title:	Date:

Participant Name: _____ **Date Of Birth:** _____