Keystone ACO
SKILLED NURSING FACILITY PRE-CERT CARE ASSESSMENT PLAN

PLEASE FILL OUT COMPLETELY

Fax completed form (3 pages) to 570-953-0368ATTN: SNF Case Managers

PLEASE ***PRINT*** LEGIBLY – USE ONLY STANDARD ABBREVIATIONS WHERE NECESSARY			
Date of Admission to SNF:		**SNF Name:**	
Beneficiary Name:		**SNF Fax #:**	
Medicare ID#:		**Member DOB:**	
Other Insurance Info:			

PRE-ADMISSION INFORMATION

Diagnosis:	**ICD#:**	
Additional Current Diagnoses:		

Skilled or Rehab Service Need: **Anticipated LOS:**

Pertinent PMH: ☐ CAD ☐ CHF ☐ COPD ☐ CVA ☐ DM ☐ DJD ☐ HTN ☐ PVD ☐ ESRD ☐ Dementia

Other (please specify)

_____

Past Surgical History: ☐ Amputation ☐ CABG ☐ Joint Replacement ☐ Spinal ☐ Other

Prior Level of Function: _____

Patient Lives: ☐ Alone ☐ With Spouse ☐ PCH/ALF ☐ ICF ☐ Other _____

Home: Levels Steps Bedroom on Floor Bathroom on _____ Floor

Spouse/Other Able to Care for Beneficiary at Home ☐ Yes ☐ No If other, please identify _____

Services Requested: ☐ PT ☐ OT ☐ ST ☐ RT ☐ Skilled Nursing

Keystone ACO Participating Physician:

I hereby certify the above noted Medicare Beneficiary is qualified for the beneficiary meets requirements to receive covered SNF services under the MSSP Track 1+ SNF Waiver Program as described in 425.612(a)(1)(ii).

Requesting Physician's Name (Please print legibly): _____

Requestor's Phone Number: _(___)_____ Requestor's Fax Number: _(___)_____

Requesting Physician's Signature: _____ Date: _____

Keystone ACO Participating SNF Admission Designate:

I hereby certify the above noted Medicare Beneficiary is qualified for the beneficiary meets requirements to receive covered SNF services under the MSSP Track 1+ SNF Waiver Program as described in 425.612(a)(1)(ii).

SNF Designate Name (Please print legibly): _____

SNF Designate Phone Number: _(___)_____ SNF Designate Fax Number: _(___)_____

SNF Designate' s Signature: _____ Date: _____

MEDICAL STATUS	***Beneficiary Name:***
DATE FORM COMPLETED:	**REMARKS:**
***Mental Status**:*	
Alert:	
Oriented:	
Follows Commands:	
***Tube Feedings*:**	
Peg: J. Tube: Date Placed:	
Bowel/Bladder:	
Ostomy: Yes or No Type:	
Approx. Date of Ostomy:	
Foley or Straight Cath:	
Weight (in pounds): ***Height:***	
Skin Integrity:	
Intact:	
Wound Care:	
Decubitus:	
Surgical:	
Respiratory:	
O2:	
Vent:	
C-PAP/BiPAP:	
Trach:	
Suctioning:	
Treatments:	
Medications:	
IV Med:	
Via: Frequency:	
Pain Management:	
Specialty Equipment Needs:	
Medically Stable/Hemodynamically Stable: Yes: ☐ No: ☐	
If yes, please explain below:	

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FUNCTIONAL STATUS						***Beneficiary Name:***		
I = Independent	**Mod I = Modified Independent**	**SU= Set Up**	**SPV = Supervision**	**CG = Contact Guard**	**MIN = Min Assist**	**MOD = Mod Assist**	**MAX = Max Assist**	**D = Dependent**

WHAT DATE WAS THE FOLLOWING INFO PROVIDED BY THERAPY:	**REMARKS:**
Bed Mobility:	
Supine – Sit	
Transfer:	
Bed (Sit – Stand)	
Toilet TX	
Ambulation:	
Weight Bearing Status	
Distance (in Feet)	
Assistive Device	
Amount of Assistance	
Stairs	
Balance:	
Standing	
Sitting	
ADL Status:	
Self Feeding	
Grooming	
Upper Extremity Dressing	
Lower Extremity Dressing	
Toileting	
Upper Extremity Bathing	
Lower Extremity Bathing	
Adaptive Equipment	
Orthotic/Prosthetic	
Speech Therapy	
Dysphagia	
Diet	
Communication	
Cognition	

Additional Contact Information

Keystone ACO OutPatient Care Manager or Hospital Liaison Contact Information:

Name :_____

Phone:_____

Fax:_____

Care Management Plan Inquiries can be directed to:

Melody Danko-Holsomback, BSN, RN | Director of Operations, Keystone ACO

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