ADMISSION AND EVALUATION DATA

Medicare Admission Date_____ Medicaid Admission Date_____

Date of Death_____ Medicaid Discharge Date_____

If no Medicare Days are used provide reason(s): _____

_____ NPI Number _____
Name of Facility

_____ Telephone Number _____
Address of Facility

_____ _____ _____ Female____ Male____
Patient's First Name M.I. Patient's Last Name

Birth Date ____ /____ /_____ Medicaid Number# ___ ___ ___- ___ ___ ___- ___ ___- ___ ___ ___ ___ -___

_____**New Admission** ____**Re-Admission** ____**Transfer Admission From** _____

____ Spend Down From Date ____ /____ /_____ To Date ____ /____ /_____

Diagnosis and Pertinent Medical Information (include medical documentation)

Medications including: route, dosage, time, treatment, diet, etc. (include medication list for the month of Medicaid admit)

Please indicate the criteria, (a. through k 1-9) the recipient meets for nursing facility care as per the Administrative Code Chapter 10, Rule Number 560-X-10-10. The criteria are listed on the Admission Criteria sheet. The nursing facility record must validate the criteria listed for the effective MEDICAID admission date appearing on this form.

Medical Criteria Met: _____

CERTIFICATION:
I certify this resident requires nursing facility care effective on the admission date appearing on this form.

_____ _____
Authorized Printed Name & Credentials Authorized Signature & Credentials

NOTE: The nurse practitioner or physician assistant cannot be employed by the facility. See number 16 in Instructions for Completion of Revised Form 161 sheet.

_____
Facility Registered Nurse Reviewer Signature & Date

ADMISSION AND EVALUATION DATA

Medicare Admission Date (1) Medicaid Admission Date (2)

Date of Death (3) Medicaid Discharge Date (4)

If no Medicare Days are used provide reason(s): _____

(5)
Name of Facility NPI Number (6)

(5)
Address of Facility Telephone Number (7)

(8) _____ _____
Patient's First Name M.I. Patient's Last Name (9) Female ____ Male ____

Birth Date (10) ____ / ____ / _____ Medicaid Number# (11) ____ ____ - ____ ____ ____ - ____ ____ - ____ ____ ____ ____ - ____

(12) New Admission ____ Re-Admission ____ Transfer Admission From _____

____ Spend Down From Date ____ / ____ / _____ To Date ____ / ____ / _____

Diagnosis and Pertinent Medical Information (attach medical documentation) (13)

Medications including: route, dosage, time, treatment, diet, etc. (attach medication list for the month of Medicaid admit) (14)

Please indicate the criteria, (a. through k.) the recipient meets for nursing facility care as per the Administrative Code Chapter 10, Rule Number 560-X-10-10. The criteria are listed on the attached sheet. The nursing facility record must validate the criteria listed for the effective MEDICAID admission date appearing on this form.

Medical Criteria Met: (15)

CERTIFICATION:
I certify this resident requires nursing facility care effective on the admission date appearing on this form.

(16)
Authorized Printed Name & Credentials

Authorized Signature & Credentials

NOTE: The nurse practitioner or physician assistant cannot be employed by the facility.

(17)
Facility Registered Nurse Reviewer Signature & Date

INSTRUCTIONS FOR COMPLETION OF REVISED FORM 161

POLICY: The completion of this form is required by all nursing facility providers for all types of admissions to your facility. The form is to be maintained in the facility files. It is to be completed for new admissions, readmissions, and transfers from an approved Medicaid facility to another approved Medicaid facility or for spend down admissions. The Form 161 should be typed or completed in ink. The Form 161 must be completed in its entirety, including the RN signature/date and the Certification signature before any Medicaid admission dates are entered into the HP LTC notification software for billing claims to Medicaid.

1. **Medicare Admission Date**: Record if the recipient has had Medicare Part A coverage just prior to this admission, please record the effective begin date of the Medicare coverage. If there has been no Medicare Part A utilization just prior to this admission, then document "NA".

2. **Medicaid Admission Date**: Record the date that the recipient meets both Medicaid medical and financial eligibility criteria associated with the current admission.

3. **Medicaid Death/Discharge Date**: Pull the admission record that matches with the current discharge or death and record the date in this location. An example is resident that was admitted to the facility on January 1, 2014 and discharged to the hospital on January 10, 2014. The form with the admission date of January 1, 2014 should be the one where the Medicaid discharge date is recorded.

4. **If no Medicare Days are used provide reason(s)**:_ Example: No Medicare coverage, no three day qualifying hospital stay, not skilled, etc.

5. **Provider Name and Address**: Record the name and address of the provider in this location.

6. **Provider Number**: Record your NPI if you have only one service location. If you have multiple locations under the same NPI record your six or eight digit Medicaid provider number.

7. **Telephone Number**: Record the Provider's phone number including the area code.

8. **Patient's Name**: The name should be recorded by first name, any known initial, and then the last name.

9. **Sex**: Please indicate the sex of the recipient by placing a check mark by the appropriate gender.

10. **Date of Birth**: Enter by the 2 Digit Month, 2 Digit Day, and 4 Digit Year.

11. **Medicaid Number**: Record the recipient's thirteen digit number.

12. **Type of Admission**: Check the appropriate admission as reflective of the Medicaid admission date.

13. **Diagnosis and Pertinent Medical Information**: This section is to be completed by the Registered Nurse assessing the level of care. The Registered Nurse assessing the medical level of care must attach

and include all pertinent medical diagnoses. This section should also contain documentation that supports an unstable medical condition requiring active treatment in the previous sixty days of admission if criteria G or K-9 are documented on the form. Please refer to www.medicaid.alabama.gov/news.aspx?t=26, alert number 449 dated 1/27/2002 regarding chronic stable state.

14. **Medications**: The Registered Nurse assessing the medical level of care must attach a list of all medications that the recipient is receiving for the requested Medicaid admission date.

15. **Criteria**: Please list criteria a-k that the recipient meets at the time of Medicaid admission date. Must document which specific K criteria are met by listing numbers for criteria, 1-9.

16. **The Physician, Nurse Practitioner or Physician Assistant must certify that the resident requires nursing facility care effective on the admission date appearing on this form.** The authorized person is attesting to the certification date to be the Medicaid admission date in the top right hand corner of this form. The nurse practitioner or physician assistant cannot be employed by the facility.

17. **Facility Registered Nurse Signature**: This should be the actual signature of the Registered Nurse completing the medical information on the form as indicated above and assessing the medical level of care as required by Medicaid guidelines stated in the Medicaid Administrative Code, Long Term Care Chapter 10.

Admission Criteria

Administrative Code Rule No. 560-X-10-10.

Listed below, but not limited to, are specific services that a resident requires on a regular basis *(The Resident must meet at least two of the a-k criteria for initial admissions)*

(a) Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment (cannot be counted as a second criterion if used in conjunction with criterion ***k-7)***

(b) Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders

(c) Nasopharyngeal aspiration required for the maintenance of a clear airway

(d) Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created

(e) Administration of tube feedings by nasogastric tube

(f) Care of extensive decubitus ulcers or other widespread skin disorders

(g) Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse (provide supporting documentation).(Cannot be counted as a second criterion if used in conjunction with criterion ***k-9)***

(h) Use of oxygen on a regular or continuing basis

(i) Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, postoperative, or chronic conditions per physician's orders

(j) Comatose resident receiving routine medical treatment

(k) Assistance with at least one of the activities of daily living below on an ongoing basis:

1. Transfer - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or multiple times per week).

2. Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet his requirement.

3. Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement (cannot be used as a second criterion if used in conjunction with criterion (***d***) if the ONLY stoma (opening) is Gastrostomy or PEG tube).

4. Toileting - The individual requires physical assistance from another person to use the toilet or to perform

incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week) (cannot be counted as a second criterion if used in conjunction with criterion (***d***) if used for colostomy, ileostomy, or urostomy).

5. Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g. how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.

6. Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g. does not know residence is a Nursing Facility).

7. Medication Administration - The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose (cannot be counted as a second criterion if used in conjunction with criterion ***a***).

8. Behavior - The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement attempts).

9. Skilled Nursing or Rehabilitative Services - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit (cannot be counted as a second criterion if used in conjunction with criterion ***g***).

NOTE:

1) **Criterion *k* should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance. Multiple criteria checked under *k* will count as one criterion.**

2) **Medicaid residents who have had no break in institutional care since discharge from a nursing home and residents who are re-admitted will need to meet only one of the a-k criteria.**