IOWA | Health and Human Services

Level of Care Certification for Swing Bed Facility

PLEASE PRINT OR TYPE

Fax form to: Iowa Medicaid Medical Services (515) 725-0420

Today's Date	Iowa Medicaid Member Name	Social Security or State ID #	Birth Date

Medical Professional completing form (MD, DO, PA-C or ARNP required)

Name	Telephone Number with Area Code	
Address		
Hospital Admission Date		
Date/Anticipated Date of Admission to Swing Bed	Anticipated Length of Swing Bed Stay (number of days)	
Swing Bed Hospital Name	NPI	Telephone Number
Address		Fax Number

ATTACH MEDICATION AND DIAGNOSES LIST (WITH ICD CODES) SEPARATELY

Skilled Nursing Needs: Check all boxes that apply.

Therapies provided 5 days a week: ☐ Physical ☐ Occupational ☐ Speech Duration expected:	**Medications** provided daily: ☐ Intravenous ☐ Intramuscular Drug name, dose, length of treatment:	**Stoma care** in early postop phase requiring daily care: ☐ Colostomy ☐ Ileoconduit ☐ Suprapubic catheter site ☐ Ileostomy ☐ Nephrostomy
Respiratory therapy daily: ☐ Nasotracheal suctioning ☐ Tracheostomy care ☐ Ventilator at least 8 hours/day	**Tube feeding**: ☐ More than 50% of nutrition via tube daily Name/brand, dose, length of treatment:	**Wound care** for at least Grade 4 ☐ Sterile dressing change daily ☐ Wound vac care

Nursing Facility Care Needs: Check all boxes that apply.

Cognition ☐ No problem ☐ Language barrier ☐ Short/long term memory problem ☐ Problems with decision making ☐ Interferes with ability to do ADLs	**Dressing** ☐ Independent ☐ Supervision or cueing needed ☐ Physical assistance needed Frequency of needed assistance: ☐ 1-2 x weekly ☐ 3-4 x weekly ☐ >4 x weekly	**Medications** ☐ Independent ☐ Requires setup ☐ Administered by others ☐ Insulin, set dosage ☐ Insulin, sliding scale ☐ Frequent lab values
Ambulation ☐ Independent ☐ Cane ☐ Walker ☐ Wheelchair ☐ Motorized scooter ☐ Needs human assistance ☐ Transfer assist ☐ Restraint used	**Behaviors** ☐ None ☐ Requires 24-hour supervision ☐ Noncompliant ☐ Destructive or disruptive ☐ Repetitive movements ☐ Antisocial ☐ Aggressive or self-injurious ☐ Anxiety ☐ Depression	**Eating** ☐ Independent ☐ Assistive devices ☐ Requires human assistance **Skin** ☐ Intact ☐ Ulcer - Stage _____ ☐ Open wound ☐ Daily treatment ☐ Treatment as needed
Bathing/Grooming ☐ Independent ☐ Has assistive devices, independent ☐ Supervision or cueing needed ☐ Physical assistance needed Frequency of needed assistance: ☐ 1-2 x weekly ☐ 3-4 x weekly ☐ >4 x weekly	**Elimination** ☐ Continent ☐ Bladder incontinence ☐ Bowel incontinence ☐ Urinary catheter ☐ Chronic colostomy/ostomy ☐ Chronic nephrostomy	**Respiratory** ☐ No issue ☐ O2 use daily ☐ O2 as needed

Additional comments: _____

Hospital discharge planner attests there is not an available nursing facility placement in accordance with Iowa Administrative Code 78.3(16) rules and has completed Attachment A of this document. Signature of Discharge Planner:	Signature with title of medical professional completing certification form (MD, DO, PA-C, ARNP):

Form 470-5156, *Attachment A – Swing Bed Facility Contacts for Alternative Placement*, must be completed and submitted with this form.

Instructions for Level of Care for Swing Bed Facility

Purpose — Form 470-5156, *Level of Care Certification for Swing Bed Facility*, provides a mechanism for a medical professional (MD/DO/ARNP/PA-C) to report level of care needs for a Medicaid member's swing bed admission or subsequent service review.

Source — This form is available on the HHS website under Provider Forms.

Completion — A provider (MD/DO/ARNP/PA-C) must complete the form when a:

- Medicaid member is going to be admitted to a swing bed.
- Medicaid member has an ongoing need for subsequent services in a swing bed.

Distribution — Providers fax the certification for level of care form to the Iowa Medicaid Medical Services Unit at 515-725-0420.

The Iowa Medicaid Medical Services Unit will make a level of care determination upon receipt of the form.

Data — **Today's Date:** The date the form is completed (MM/DD/YYYY).

Iowa Medicaid Member Name: The Medicaid member's first name, middle initial, and last name as it appears on the eligibility card.

Social Security or State ID #: The member's social security number or state identification number as it appears on the eligibility card.

Birth Date: The Medicaid member's birth date (MM/DD/YYYY) as it appears on the eligibility card.

Medical Professional Section

Name, Telephone Number with Area Code, and Address: The contact information that Iowa Medicaid will use to obtain additional information, if needed.

Hospital Admission Date: The date the member was admitted to the hospital (MM/DD/YYYY).

Date/Anticipated Date of Admission to Swing Bed: The expected or actual date of admission to the swing bed (MM/DD/YYYY).

Anticipated Length of Swing Bed Stay (# days): Total number of days expected in swing bed.

Swing Bed Hospital Name, NPI, Telephone Number with Area Code, Address, and Fax Number: The facility information including the swing bed NPI and the preferred fax number to receive authorization notice of decision.

ATTACH MEDICATION AND DIAGNOSES LIST (WITH ICD CODES) SEPARATELY: Provide current medication and diagnoses lists as separate attachments.

Skilled Nursing Needs Section

Check all boxes that apply to the member regarding skilled nursing needs for therapy, medications, wound care, stoma care, ventilator, tracheostomy cares or tube feedings. Also complete the nursing facility care needs section below.

Nursing Facility Care Needs Section

Check all boxes that apply to the member for nursing facility care needs for swing bed admission or subsequent stay.

Additional comments: Additional pertinent comments from the medical professional.

Hospital discharge planner attests by signing the form that there is not an available nursing facility placement in accordance with 441 Iowa Administrative Code 78.3(16).

Signature with title of medical professional MD/DO/PA-C/ARNP: Signature of the medical professional completing the form.

Swing Bed Facility Contacts for Alternative Placement

The hospital discharge planner attests the following nursing facilities (NF) have been contacted. Include all information requested below for each facility contacted: (1) name of nursing facility, (2) NF staff name and title, (3) date and time contact made, (4) the reason for refusal (e.g., no available beds to serve the member's LOC needs, no available beds, etc.). Use additional pages as necessary. This attachment must be submitted with form 470-5156, *Level of Care Certification for Swing Bed Facility*.

Nursing Facility Name	NF Staff Name and Title	Date and Time Contacted (mm/dd/yyyy)	(time)	Reason Refused