DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE
Nursing Facility Annual Level of Care Attestation

As part of the Long Term Care (LTC) Medicaid renewal packet, this attestation form must be completed by a Nursing Facility physician or an Advance Practice Registered Nurse (APRN).
Date of Attestation: Click here to enter a date.

Section I: BENEFICIARY INFORMATION
Name: Enter name here Medicaid #: Enter # here Date of birth: Click here to enter a date. Medicaid Certification Period: Enter date here to Enter date here
FUNCTIONAL SCORE OF EXISTING ASSESSMENT
Without medication management: Click here to enter text.
With medication management: Click here to enter text.

Section II: SUMMARY OF BENEFICIARY's NEEDS		
	No Change	**Improved**
FUNCTIONAL NEEDS		
Bathing	☐	☐
Dressing	☐	☐
Eating/Feeding	☐	☐
Transfer	☐	☐
Mobility	☐	☐
Medication Management	☐	☐
Toileting	☐	☐
Urinary Continence and Catheter Care	☐	☐
Bowel Continence and Ostomy Care	☐	☐
SKILLED CARE NEEDS		
Skilled nursing and therapies required by the individual	☐	☐
COGNITIVE/BEHAVIORAL NEEDS		
Previously identified Serious Mental Illness/Intellectual Disability/Developmental Disability	☐	☐
Receptive and expressive communication	☐	☐
Behavior and Behavioral Symptoms	☐	☐

Section III: SUMMARY OF BENEFICIARY'S HEALTH STATUS		
	No Change	**Improved**
Health Status	☐	☐

If "No Change" is checked in Section III, the attestation form must be submitted to ESA along with the LTC Medicaid renewal application as part of the complete renewal packet.

If "Improved" is checked in Section III, the physician/ APRN must request a reassessment by submitting a Prescription Order Form directly to Delmarva by fax at (202) 698-2075.

Section IV:

ATTESTATION

I attest that a change in condition has occurred at the time of reassessment with enter beneficiary's name and that a Prescription Order Form will be submitted to DHCF's contractor, the Delmarva Foundation.

Physician Name Click here to enter text.

Signature _____ Date Click here to enter a date.

--------OR--------

I attest that enter beneficiary's name's health status remains unchanged at the time of reassessment, and a Long Term Care Services and Supports Reassessment by the DHCF's contractor, the Delmarva Foundation, is not required at this time. The following documents were reviewed to make this determination (*mark all that apply*).

☐Clinical notes
☐General Health Status
☐Functional/Cognitive Status
☐ Most recent Long Term Care Services and Supports Assessment

Physician Name Click here to enter text.

Signature _____ Date Click here to enter a date.