OUT-OF-STATE NURSING FACILITY PLACEMENT PACKET INSTRUCTIONS

Before approval for an Out-of-State (OOS) Nursing Facility placement, all appropriate Nevada in-State options must be explored and denied. Contact the Division of Health Care Financing and Policy (DHCFP) Long Term Services and Supports (775) 684-3619 or (775) 684-3661 for assistance with difficult placements. Submit (fax) the completed Out-of-State Nursing Facility Placement Packet (form FA-30) to the Nevada Medicaid Out-of-State Coordinator (775) 687-8724.

Determination for OOS placement (approval or denial) will be communicated to the provider. Once an approval is received, providers may contact the OOS nursing facilities for placement.

Finding the Form and Instructions Online

Form FA-30 and these instructions are online at www.medicaid.nv.gov (select "Forms" from the "Providers" menu, and scroll down until you see form FA-30 and instructions FA-30-I).

General Form Instructions

All form fields must be completed.

Please print or type information on this form. If information is illegible, processing may be delayed. You can enter information directly into the form on your computer clicking in any field and typing. You can check and uncheck the check boxes by clicking them.

Completing the Form

The following sections describe the information to enter in each form field.

DATE OF REQUEST: Enter the date you submit the form to Nevada Medicaid.

SECTION I: RECIPIENT INFORMATION

- Recipient Name – Enter the recipient's last name, first name and middle initial.
- Check Male or Female.
- Date of Birth and Age – Enter the recipient's Date of Birth (DOB) and age.
- Marital Status - Check the appropriate box for the recipient's marital status: M (married), W (widowed), D (divorced) or S (single).
- Recipient Medicaid ID – Enter 11-digit number shown on the front of the recipient's Medicaid card.
- Social Security # if Medicaid ID is Unknown – If the recipient's Medicaid ID is unknown, please enter the recipient's Social Security Number.
- Guardian Name – Enter the name of the guardian or responsible person, if applicable.
- Guardian (or responsible person) Telephone Number – Enter the guardian's (or responsible person's) telephone number.
- Guardian (or responsible person) Address – Enter the guardian's (or responsible person's) address.
- Please indicate if guardianship has been applied for – Enter Yes, No or Not Applicable.
- Recipient's living arrangements prior to admit – Enter the recipient's living arrangements (if known) prior to admission to the current facility. Examples of responses would be a group home, parents'

home, an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or skilled nursing facility (SNF).

SECTION II: CLINICAL INFORMATION

- Is this a request for ICF/IID? – Check Yes or No. If the response is Yes, an ICF/IID placement requires a Physician Order.
- Diagnosis/Medications/Records/Notes – Check each box next to the clinical information you are attaching to this request.
    - Diagnoses (attach H&P and Physician Progress Notes)
    - Medications (attach medication record including PRN medications)
    - Psychosocial Narrative, Behavioral Tracking/Monitoring Records (if OOS placement due to behaviors)
    - Nursing Progress Notes (attach if describes behaviors making OOS placement needed)
    - Case Management/Social Worker Discharge Planning Notes
- Reason for seeking out-of-state placement – This section must be complete. Check each reason that applies. More than one box can be checked. Please attach documentation to support any checked items if they are not included in the attached clinical information.
    - Exit Seeking/Flight Risk Behavior
    - Wandering Behavior
    - Violent Behavior
    - Danger to Self
    - Danger to Others
    - Other Inappropriate Behaviors
    - Requires a Locked Facility
    - No Appropriate Beds Available In-State
    - Requires Specialty Care (Bariatric, Pediatric, etc.)
    - Recipient is unable to return to their prior living situation
    - Previous facility refusing readmission
- List of all Nevada facilities contacted, date, contact person and reason for denial – Attach the list of all facilities that were contacted when attempting to locate a Nevada facility for this recipient.

SECTION III: SERVICING PROVIDER INFORMATION

- Current Provider Name and Unit – Please enter the facility name and nursing unit/hall where the recipient is located.
- Telephone Number and Fax Number – Enter the servicing provider's telephone and fax numbers.
- Admit Date – Enter the date the recipient was admitted to the facility
- Name of Case Manager and Contact Number – Case manager's name and telephone number.
- Recipient Name and Medicaid ID or Social Security Number – Enter the recipient information at the top of page 2 of the form.
- PASRR screening request submitted – Check Yes or No. If the response is Yes, enter the date the request was submitted.
- Level of Care (LOC) request submitted – Check Yes or No. If the response is Yes, enter the date the request was submitted.
- Medicaid eligibility verified by EVS – Check Yes or No.
- Name of person completing this form – Please print the name of the person completing the

Out-of-State Nursing Facility Request form.

- Telephone number of person completing this form: – Enter the telephone number of the person completing this form.
- Signature of person completing this form – The person completing this form must sign.
- Date – Enter the date this form is completed.

Continue to page 3 of the packet.

- Recipient Name and Medicaid ID or Social Security Number – Enter the recipient information at the top of page 3 of the packet.

SECTION IV: OUT-OF-STATE NURSING FACILITY PLACEMENT RECIPIENT ACKNOWLEDGEMENT AND CONSENT

The recipient must acknowledge that admission has been denied by all Nevada nursing facilities that could meet the recipient's medical requirements and must sign the form to recognize Out-of-State Nursing Facility placement is necessary.

- Recipient, Legal Representative or Guardian must print – Recipient or the recipient's legal representative or guardian must print his/her name to provide consent for Out-of-State Nursing Facility Placement.
- Recipient, Legal Representative or Guardian must sign – Recipient or the recipient's legal representative or guardian must sign his/her name and enter the date.
- Witnessed by – The signature must be witnessed and the witness must sign and date the form.

SECTION V: OUT-OF-STATE FUNERAL BURIAL RECIPIENT ACKNOWLEDGEMENT

The recipient must acknowledge that he/she understands that no Medicaid benefits are payable after death, and Medicaid cannot be responsible for funeral or burial costs including the return of a deceased's remains to Nevada.

- The recipient has a Burial Plan – Check Yes or No. If the response is Yes, enter the following:
  - Name of Burial Plan Company
  - Plan ID Number
  - Company's Phone Number
- Signature of Recipient, Legal Representative or Guardian and Date – Recipient or the recipient's legal representative or guardian must sign and date.
- Printed Name and Relationship – Print Legal Representative's or Guardian's Name and enter the person's relationship to the recipient.

SECTION VI: FOR DHCFP USE ONLY

Please leave Section VI blank.

How to Submit the Out-of-State Nursing Facility Placement Packet

After completing the form, fax the form and all supplemental documentation to the Nevada Medicaid Out-of-State Coordinator (775) 687-8724. This fax number is also listed near the top of the form.

SECTION VII: OUT-OF-STATE NURSING FACILITY PLACEMENT TRACKING

Providers must notify DHCFP when recipients are placed in an Out-of-State Nursing Facility.

Please complete and fax SECTION VII to DHCFP at (775) 687-8724 or call DHCFP at (775) 684-3619.

- Recipient Name and Medicaid ID or Social Security Number – Enter the recipient information at the top of page 4 of the packet.
- Name of Out-of-State Nursing Facility where recipient has been placed – Enter the name of the Out-of-State Nursing Facility.
- Date recipient discharged to the above named Out-of-State Nursing Facility – Enter the discharge date.
- Name of person completing this form (please print) – Please print the name of the person completing this form.
- Title of person completing this form – Enter the title of the person completing this form.
- Telephone number of person completing this form – Enter telephone number of the person completing this form.
- Signature of person completing this form and date – The person completing this form must sign and date the Facility Placement Tracking Section VII.

Questions

If you have any questions regarding any section of this form, contact the Division of Health Care Financing and Policy (DHCFP) Long Term Services and Supports (775) 684-3619 or (775) 684-3661. This telephone number is also listed near the top of the form.