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| **REQUEST FOR ALL NURSING FACILITY RATE ADD-ON's**  |
|   |  **A Completed PASRR Level I and Level II (if appropriate) is required for All nursing facility rate add-on requests** |
| **This request form and all required documentation for each Add-on should be emailed to: LTSSPLACEMENTSUPPORT@MASS.GOV** |
| **Nursing Facility** | **Nursing facility Staff Name:** |   | **Title:** |
| **Phone:** |   | **Email:** |
| **Date of request:** |  |   |
| **Facility Name:** |   |
| **MassHealth Provider ID**  |   |
|  **MH Member** | **Patient Name:** |   | **Date of Birth:**  |
| **MassHealth ID:** |   |   |
| **MassHealth Coverage Type:** |   | *If Other, please specify here* |
| **If enrolled in a MassHealth health/managed care plan, has the Plan been contacted?** |  | *Please include the name and contact information for the person you are working with at the MassHealth Health Plan:*  |
| **Date of anticipated admission to nursing facility**  |   |   |
| **If known, indicate short term or long-term placement needed:** |   |   |

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|  | ***Medically Complex Add-on Request***[ ] Substance Use Disorder [ ]  1:1 Staffing required  |
| **Required Documentation**  | **Please check off all Medically complex needs and complete the anticipated daily cost for each** |  [ ]  Other[ ] Ventilator[ ]  Wound Care [ ]  Dementia[ ]  Pain Management [ ] Tracheostomy[ ]  Serious Mental IllnessWound Care[ ] Dialysis |  |
| **Please confirm that that you have attached the required documentation**  |   |
| **\*If Other daily costs have been entered, please detail those costs here:** |  |

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|   | ***Bariatric Nursing Facility Rate add-on*** |
| **Required Documentation**  | **Please indicate the Body Mass Index (BMI) for Member**  |  **Admission ICD-10 (if known)**  |
| **Please confirm that that you have attached the required documentation**  |     [ ]  Hospital Discharge Summary[ ]  Documentation supporting members' BMI, need for assistance with transfers, personal care, and/or bed mobility by 2-staff. |
| ***Homelessness Nursing Facility Rate add-on***  |
| **Please confirm that that you have attached the required documentation**  |     [ ]  Hospital Discharge Summary |

 [ ]  Documentation that supports member meets the Homelessness requirement.

For general questions regarding the complicated high-cost care needs add-on or any of the nursing facility rate -add-ons, please email: LTSSPLACEMENTSUPPORT@Mass.gov