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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 Illness  Wound 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](mailto:LTSSPLACEMENTSUPPORT@Mass.gov)