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

<table>
<tr><td rowspan="6">Nursing Facility</td><td>Nursing facility Staff Name:</td><td></td><td>Title:</td></tr>
<tr><td>Phone:</td><td></td><td>Email:</td></tr>
<tr><td>Date of request:</td><td></td><td></td></tr>
<tr><td>Facility Name:</td><td colspan="2"></td></tr>
<tr><td>MassHealth Provider ID</td><td colspan="2"></td></tr>
<tr><td rowspan="6">MH Member</td><td>Patient Name:</td><td></td><td>Date of Birth:</td></tr>
<tr><td>MassHealth ID:</td><td></td><td></td></tr>
<tr><td>MassHealth Coverage Type:</td><td></td><td>If Other, please specify here</td></tr>
<tr><td>If enrolled in a MassHealth health/managed care plan, has the Plan been contacted?</td><td></td><td>Please include the name and contact information for the person you are working with at the MassHealth Health Plan:</td></tr>
<tr><td>Date of anticipated admission to nursing facility</td><td></td><td></td></tr>
<tr><td>If known, indicate short term or long-term placement needed:</td><td></td><td></td></tr>
</table>

Medically Complex Add-on Request

<table>
<tr><td rowspan="3">Required Documentation</td><td>Please check off all Medically complex needs and complete the anticipated daily cost for each</td><td>☐ 1:1 Staffing
☐ Substance Use
☐ Pain Management
☐ Dementia
☐ Tracheostomy
☐ Wound Care
☐ Ventilator
☐ Other
☐ Serious Mental Illness</td><td>Daily Cost of needed medical supplies ☐
Daily Cost of required DME ☐
Daily Cost of additional staffing ☐
*Other Daily costs ☐</td></tr>
<tr><td>Please confirm that that you have attached the required documentation</td><td colspan="2"></td></tr>
<tr><td>*If Other daily costs have been entered, please detail those costs here:</td><td colspan="2"></td></tr>
</table>

Required Documentation	Bariatric Nursing Facility Rate add-on	
	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