SNF Continued Stay Review

**Please complete all areas of this survey.

FAX: **1-800-416-9195**

Please review all eight parts to this form and fill in the applicable sections

- Part One – Patient Information
- Part Two – Prior Level of Function
- Part Three – Clinical Review
- Part Four – Physical Therapy
- Part Five – Occupational Therapy
- Part Six – Speech Therapy
- Part Seven – Discharge Plan
- Part Eight – Protected Health Information (PHI)

DATE FORM COMPLETED	ADMISSION DATE TO POST ACUTE FACILITY

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PART ONE – PATIENT INFORMATION

Demographic information	Responses
Member Name:	
DOB:	
Member ID#:	
Reference/case number:	
SNF Facility name:	
Facility NPI:	
Facility address, city, state, zip:	
Contact name/department:	
Contact phone number and fax number:	
****Can the member tolerate one hour of therapy 5 days a week with full participation: (yes/no)**	

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PART TWO – PRIOR LEVEL OF FUNCTION

Question	Answer
Does the member ambulate?	O Yes O No
Does the member have gait limitations? (If yes specify limitation and assistance required.)	O Yes O No Specify: _____
Wheelchair mobility?	O Yes O No
What is the patient's transfer level of assistance?	O Independent O Modified Independence O Supervision O Contact Guard Assist O Minimal Assistance O Moderate Assistance O Maximum Assistance O Total Assistance/Dependent
Does the patient need assistance with activities of daily living?	O Independent O Modified Independence O Supervision O Contact Guard Assist O Minimal Assistance O Moderate Assistance O Maximum Assistance O Total Assistance/Dependent
Does member have DME at home? If yes, specify	O Yes O No Specify: _____
Are there community or other resources already in place: (meals on wheels, HHC, caregivers, etc.)	O Meals on Wheels OHHC O Caregivers O Other: _____
What is the patient's baseline mental status?	
Does the member have any cognitive issues such as communication difficulty, memory deficits, perception or processing deficits?	O Yes O No Specify: _____
Does the member have any physical inability or limitations such as wound location unreachable, contractures, obesity, motor strength, comorbidity such as blindness or paralysis?	O Yes O No Specify: _____
Is the home environment not conducive to care such as no running water, no phone, no temperature control, no elevator, no access to home care agency or outpatient services, any physical or emotional abuse at home?	O Yes O No Specify: _____

Question	Answer
Does the patient need home oxygen:	O Yes O No Specify: _____

Home set up	Responses
# steps to enter home:	
Rails:	O Yes O No
Bed on first or second floor: (1st floor/2nd floor)	O 1st O 2nd
Bath on first or second floor: (1st floor/2nd floor)	O 1st O 2nd
Availability for first floor setup: (yes/no)	O Yes O No
Who does the member live with currently: (home alone, home with caregiver/family/significant other, personal care home, assisted living facility, long term residential care)	O Home Alone O Caregiver, significant other, Family O Personal Care Home O Assisted Living Facility O Long Term Residential Care

PART THREE – CLINICAL REVIEW

Continued Stay Requests must be requested within 24 hours from the last covered day.

Category	Information
Date:	
Vitals:	
Mental status: Able to follow commands: (yes/no)	O Yes O No
Abnormal Labs (if being monitored or treated):	
Will member receive IV medications: If yes name, frequency and stop date.	O Yes O No Frequency: _____ Stop Date: _____
Respiratory: include o2 flow, teaching needs, o2 sats, nebulizers and how often, trach (date placed, size, suctioning frequency) What is the goal: decannulation, home with trach, home oxygen, wean off oxygen, home nebs.	O o2 Flow O Teaching Needs O o2 Sats O Nebulizers O Trach Specifications: _____ Goal: _____
Oral diet: (yes/no) if yes, type	O Yes O No Type: _____
NG/Peg: (include date placed, what feeds receiving, rate, goal rate, are they tolerating)	
TPN: (yes/no) if yes stop date, rate, were they on TPN at home	O Yes O No Stop Date: _____ Rate: _____ TPN at Home: O Yes O No
Wounds/treatment: (include stage, tx, measurements, frequency dressing, appointment with wound specialist.)	

PART FOUR - PHYSICAL THERAPY

Continued Stay Requests must be requested within 24 hours from the last covered day.

Member is participating: O Yes O No

Category:	As of date:	Independent	Modified Independent	Supervision	Contact Guard Assistance	Minimal Assistance	Moderate Assistance	Maximum Assistance	Dependent
Bed mobility									
Rolling side to side									
Supine to sit									
Sit to stand									
Bed to chair									
Sitting balance static/dynamic									
Standing balance static/dynamic									
Steps with number of steps included									
Gait assistance									
Gait distance in steps/feet: _____ Assistive device used: _____									

Category:	As of date:	independent	modified independent	supervision	contact guard assistance	minimal assistance	moderate assistance	maximum assistance	dependent
Wheelchair assistance									
Wheelchair distance: _____									
Endurance: _____									
Strength: _____									
PT Goals-Short term and Long term: _____									

PART FIVE – OCCUPATIONAL THERAPY

Continued Stay Requests must be requested within 24 hours from the last covered day.

Member is participating: O Yes O No

Category	As of date	Independent	Modified Independent	Supervision	Contact Guard Assistance	Minimal Assistance	Moderate Assistance	Maximum Assistance	Dependent
feeding									
grooming									
Bathing UE									
Bathing LE									
Dressing UE									
Dressing LE									
Toileting/ hygiene									
Toilet/ functional transfer									
Household management									

OT Goals:
Short term _____

Long term _____

PART SIX - SPEECH THERAPY

Continued Stay Requests must be requested within 24 hours from the last covered day.

Member is participating: O Yes O No

Number of minutes participating in therapy: _____

As of date:	Responses
Cognition: (alert and oriented, can member follow commands)	
Language deficit: can they express needs?	O Yes O No
Memory deficits:	
Safety judgement/problem solving: (are they impulsive, require a sitter)	
Swallowing deficits:	O Yes O No
What type of diet/liquids:	
Goals: Short term and long term:	Short Term: _____ Long Term: _____

PART SEVEN - DISCHARGE PLAN

Items to Complete	What's Been Completed
Has Caregiver Training been completed? Any barriers to Caregiver Training?	
Anticipated disposition: (home alone, home with caregiver/family/significant other, personal care home, assisted living facility, long term residential care)	
Caregiver available to assist: (yes/no) include hours available to assist, If no please specify.	
Are there any social determinates: (social connections, transportation needs, safety, financial resource strain, health literacy, housing stability, food insecurity)	
DME needs: (if yes, please specify)	
Is a home evaluation planned/needed prior to discharge: (yes/no)	
Will the member require home health care, outpt therapy, other -please explain:	
Community resources needed: (if yes, what)	
Next MD appointment:	
Any additional pertinent information or other discharge barriers:	

PART EIGHT – PROTECTED HEALTH INFORMATION (PHI)

These documents contain PHI. Federal and state laws prohibit inappropriate use of PHI. If you are not the intended recipient or the person responsible for delivering these documents, you must properly dispose of them. If you need instructions, please call the facility phone number listed in the demographic area above.

Providers. You are required to return, destroy, or further protect any PHI you received pertaining to a patient that you are not currently treating. You are required to immediately destroy any such PHI, or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

9/17/2021