

**REQUEST FOR
“FREQUENT CHANGE IN CARE SETTING”
Section 67.02-7**

“Frequent Change in Care Setting” shall mean three (3) or more moves from one care setting to another care setting, including the following settings: home, residential care facility, nursing facility or other specialized facility, excluding hospitals, within the previous nine (9) month period. Hospital admissions/discharges are not counted as a change in care setting or move. Each change in care setting counts as one move, e.g., -moving from home to NF counts as one move; -moving from home to NF and back home counts as two moves. A change in the “level of care” within a facility is not a “change in care setting” under this section.

The following criteria must be met:

- **The resident has lost medical eligibility for NF services at least twice, while receiving covered services in the NF, during the past nine (9) month period; and**
- **The resident has a chronic or unstable medical condition that would likely result in re-admission to the NF within three (3) months of discharge; and**
- **The various settings (including home), within the last nine (9) months, must be listed, each facility identified with admission and discharge dates documented; and**
- **The resident (or resident’s guardian, or resident’s agent or surrogate, as defined in 18-A MRSA Sec. 5-801 and evidenced by a valid, signed document on file at the NF, available upon request) chooses to continue to stay in the NF, as documented by a signed Choice Letter.**

The Department will determine the resident eligible pursuant to the requirements of this Section. The NF shall submit the above required information to the Department with a request for classification under this Section. If approved, a classification period will be established. The resident must be reassessed within five (5) calendar days prior to the end date of the resident’s approved classification period. If an additional classification period is requested under this section, the Department shall consider the resident’s recent history of frequent changes in care settings as well as health status, and may continue to classify him/her for NF coverage under this section as appropriate.

APPLICATION: "FREQUENT CHANGE IN CARE SETTING"

PLEASE FAX COMPLETED FORM AND DOCUMENTATION TO: (207) 624-5361, Bureau of Elder and Adult Services, Attn: Ellen Field

Date of Request: _____

Resident's Name: _____

MaineCare #: _____

Social Security number: # _____

DOB: _____

Facility: _____

Phone # _____

Address: _____

Fax # _____

Does the resident have a legal guardian or some other family member who should also be notified of the "Frequent Change" determination?

Name: _____ Relationship: _____

Address: _____

Name of person completing form: _____

Start date for the 9 months under review: _____

End date for the 9 months under review: _____

Eligibility determination: Dates of MaineCare NF denials that occurred within the past nine months of the date of this application: (must have at least 2 denials during the past 9 month period while receiving covered services in the NF)

Date	Assessment request type	Outcome
1.		
2.		
3.		

Medical condition: Please describe the resident’s chronic condition and current medical status and expected outcome that will probably or definitely necessitate re-admission to the NF within 3 months of discharge. Please provide any supporting documentation, physician notes, lab or test values, x-ray results or pertinent information that indicates a pattern in management of the consumer’s medical condition that will likely cause deterioration and result in readmission for treatment.

Care settings: Please list the care settings, including home but NOT INCLUDING HOSPITAL STAYS, within the last 9 months. Be sure to provide the admission date, reason for admission, level of care, payment source, reason for discharge, and discharge dates for each moves or transfer. **Submit copies of movement cards to BEAS to verify the moves.**

Care setting/ Facility name:	Admit Date	Reason for Admission	Level- NF, SNF RES, N/A	Paymt source	Reason for discharge	D/C date
1.						
2.						
3.						

Choice letter: Submit a copy of the signed choice letter to verify that the resident has been offered the choice of home and/or community-based services and has chosen NF care.

Please provide the last date of MaineCare payment: _____

Has the resident filed an appeal of the most recent NF denial? Yes No

NOTE: If the resident has filed an appeal, the BEAS will delay review of the application until receipt of the Commissioner’s final decision.

Have you included: completed 2-page application form, documentation of chronic medical diagnosis/ condition, copies of movement cards, choice letter signed by the resident?