OHIO DEPARTMENT OF MEDICAID

HOSPITAL EXEMPTION FROM PREADMISSION SCREENING NOTIFICATION

Instructions for the Hospital Discharge Staff: This form must be submitted electronically. Manual submission of this form requires authorization from the local PASSPORT Administrative Agency (PAA). This form must be completed in accordance with OAC 5160-3-15.1. Form submissions that do not meet the conditions for Hospital Exemption approval will be returned.

SECTION A: IDENTIFYING INFORMATION FOR APPLICANT/PATIENT

Last Name *	First Name *		MI
Permanent Street Address *	City *	State *	Zip *
Ohio County of Residence * / Primary Telephone	Gender * ☐ Male ☐ Female	Date of Birth *(mm/dd/yyyy)* *	
Social Security Number * / Medicaid Recipient? ☐ Yes ☐ No	Managed Care? ☐ Yes ☐ No	Name of Managed Care Organization	
Hospital Name *	Discharge Planner Phone Number *(including area code)* *		
Discharge Planner Name *			

Living arrangement prior to hospital admission

Independent Living Option	Institutional Setting	Community-Based Residence
☐ Home/Apartment	☐ ICF/IID	☐ Residential Facility
☐ Homeless	☐ Incarcerated	☐ Assisted Living/ Residential Care Facility
		☐ Other: _____

SECTION B: DIAGNOSIS OF MENTAL ILLNESS, DEVELOPMENTAL DISABILITIES OR RELATED CONDITION

1) Was there an adverse PASRR determination within the past 60 days? ☐ Yes ☐ No
2) If so, indicate date of most recent adverse PASRR determination* Date *(mm/dd/yyyy)* _____

The date of most recent adverse PASRR is only applicable for individuals with diagnoses of SMI and/or DD as indicated in this section. Call the State authorities if unable to verify via local records (Ohio MHAS: 614-466-1063 and/or DODD: 1-800-617-6733)

3) Does the individual have a diagnosis of any of the mental disorders listed below? ☐ Yes ☐ No

☐ Schizophrenia	☐ Personality Disorder(s)
☐ Mood Disorder(s)	☐ Other Psychotic Disorder(s)
☐ Delusional Disorder(s)	☐ Another mental disorder that may lead to a chronic disability
☐ Panic or other Severe Anxiety Disorder(s)	If so, describe: _____
☐ Somatic Symptom Disorder(s)	

Individual Last Name	Individual First Name

3) Does the individual have a physical or mental disability, or related condition, that is **not solely caused by mental illness AND** was manifested prior to the age of 22**?** ☐ Yes ***(select all that apply below)*** ☐ No

☐ Autism	☐ Traumatic Brain Injury	☐ Intellectual Disability
☐ Epilepsy	☐ Blindness	☐ Other ***(specify condition)***
☐ Cerebral Palsy	☐ Deafness	_____

SECTION C: CERTIFICATION FOR HOSPITAL EXEMPTION

As the individual's attending physician (MD or DO), I certify that the individual:

- Is being discharged to a nursing facility directly from a hospital after receiving acute patient care at the hospital; and
- requires nursing facility services for the condition for which he/she received care in the hospital; and
- requires fewer than 30 days of nursing facility services, no later than the date of discharge

Physician's Printed Name*	License Number*
Physician's Signature*	Date *(mm/dd/yyyy)**

Please note: The individual shall not be admitted to the nursing facility through the hospital exemption unless **all** three criteria are met. If the individual does not meet the three criteria for exemption, a preadmission screening must be electronically submitted for the individual before the individual is admitted to the nursing facility. Attending physician signature and license # is required.

SECTION D: IDENTIFYING INFORMATION FOR THE NURSING FACILITY TO WHICH AN INDIVIDUAL WILL BE ADMITTED

Nursing Facility Name *("Unknown" is not valid)**	Nursing Facility Contact*		Nursing Facility County*
Street Address *	City*	State*	Zip Code*
Date of Expected Admission *(mm/dd/yyyy)*	Phone Number		Fax Number

THIS FORM MUST BE KEPT IN THE NURSING FACILITY RESIDENT'S FILE. BY ACCEPTING THE ADMISSION, THE NURSING FACILITY CONFIRMS THAT THE HOSPITAL EXEMPTION CRITERIA AND ALL APPLICABLE REQUIREMENTS OF OHIO ADMINISTRATIVE CODE RULES ARE MET.

THE NURSING FACILITY ACCEPTS THE ADMISSION ONLY AFTER RECEIPT AND REVIEW OF THIS FORM FOR 100% ACCURACY AND COMPLETION. THE NURSING FACILITY ACCEPTS RESPONSIBILITY FOR ELECTRONICALLY INITIATING A RESIDENT REVIEW *(IF REQUIRED*) PRIOR TO THE 30TH DAY FOLLOWING ADMISSION FROM THE HOSPITAL.