

**South Dakota  
HOSPITAL EXEMPTION  
FROM PREADMISSION SCREENING NOTIFICATION**

**Instructions for the Hospital Discharge Staff:** Use black ink and print clearly. FAX this notification to the nursing facility or swing bed and Adult Services & Aging Nurse Consultant for your region prior to discharge from the hospital. This form must be completed fully in order for the nursing facility or swing bed to accept payment for services. Incomplete forms will be returned.

<b>SECTION A: IDENTIFYING INFORMATION FOR APPLICANT/PATIENT</b>			
Last Name	First Name	MI	
Living arrangement prior to the hospital admission:			
<input type="checkbox"/> group home	<input type="checkbox"/> psychiatric hospital	<input type="checkbox"/> own home/apt - alone	
<input type="checkbox"/> own home/apt – with friend or relative	<input type="checkbox"/> homeless	<input type="checkbox"/> prison	
<input type="checkbox"/> nursing facility	<input type="checkbox"/> other (please specify)		
Street Address	City	State	Zip
SD County of Residence	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)	
Social Security #	Medicaid Recipient <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> pending		
Hospital Name	Hospital Phone #		
Hospital Contact	Discharge from Psychiatric Unit to NF? <input type="checkbox"/> yes <input type="checkbox"/> no		
<b>SECTION B: DIAGNOSIS OF SERIOUS MENTAL ILLNESS or INTELLECTUAL and DEVELOPMENTAL DISABILITIES</b>			
1) If applicable, date of most recent Level II PASRR determination* _____ (mm/dd/yyyy) <input type="checkbox"/> not applicable			
* The date of the most recent Level II PASRR is only applicable for persons with diagnoses of serious mental illness or intellectual and developmental disabilities as indicated in this section. Call Adult Services & Aging if unable to verify.			
2) Does the individual have a diagnosis of any of the mental illness as defined in the DSM-IV most recent version? <input type="checkbox"/> yes <input type="checkbox"/> no If yes please list below.			
<input type="checkbox"/> schizophrenia	<input type="checkbox"/> personality disorder		
<input type="checkbox"/> mood disorder	<input type="checkbox"/> other psychotic disorder		
<input type="checkbox"/> delusional (paranoid) disorder	<input type="checkbox"/> another mental disorder other than ID		
<input type="checkbox"/> panic or other severe anxiety disorder	If so, describe _____		
<input type="checkbox"/> somatoform disorder			
3) Does the individual have a diagnosis of intellectual or developmental disability (ID/DD) (mild, moderate, severe or profound) as described in the ARSD? 67:54:04:05. <input type="checkbox"/> yes <input type="checkbox"/> no			
4) Does the individual have a severe, chronic disability that is attributable to a condition other than intellectual disability (ID), but is closely related to ID because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with ID and requires treatment or services similar to those required for persons with ID? <input type="checkbox"/> yes <input type="checkbox"/> no      If yes, please specify:			

### SECTION C: CERTIFICATION FOR HOSPITAL EXEMPTION

As the individual's physician, I certify that the individual:

\*is discharging to a nursing facility or swing bed directly from a hospital after receiving acute inpatient hospital care; and

\*requires nursing facility services for the condition for which he/she received care in the hospital; and

\*as the physician, I certify, no later than the date of discharge, that the individual requires less than 30 days of nursing facility or swing bed services.

Physician's Printed Name

Physician's Signature

Date (mm/dd/yyyy)

*Please note:* The individual cannot be admitted to the nursing facility through the hospital exemption if all three criteria are not met. If the individual does not meet the three criteria for exemption, the individual may still seek nursing facility or swing bed admission through a pre-admission screen via completion of the "SCREENING FOR ADMISSIONS TO THE NURSING FACILITY OR SWING BED FOR MENTAL ILLNESS or INTELLECTUAL and DEVELOPMENTAL DISABILITIES" and referral to Adult Services & Aging, if applicable.

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

Facility Name

Facility Contact

Street Address

City

State

Zip

Date of Expected Admission (mm/dd/yyyy)

Phone #

Fax #

Printed Name of Hospital Staff completing this form

Time faxed to ASA

Signature of Hospital staff completing this form

Date (mm/dd/yyyy) faxed to ASA

Circle the name of the Adult Services & Aging (ASA) Nurse Consultant to whom you faxed this notification form.

Region I – Crystal Hamann  
Phone: 605-394-2525 x309  
FAX: 605-394-2363

Region II – Lana Glanzer  
Phone: 605-353-7100 x208  
FAX: 605-353-7103

Region III – Cassandra Varilek  
Phone: 605-882-5000 x213  
FAX: 605-882-5024

Region IV – Lori Baltzer  
Phone: 605-387-4219 x203  
FAX: 605-387-2438

Region V – Tricia Fjerestad  
Phone: 605-367-5444 x421  
FAX: 605-367-4272

**THIS NOTIFICATION FORM MUST BE KEPT IN THE NURSING FACILITY OR SWING BED RESIDENT'S ACTIVE FILE. BY ACCEPTING ADMISSION, THE NURSING FACILITY OR SWING BED CONFIRMS THAT THE HOSPITAL EXEMPTION CRITERIA AND ALL APPLICABLE REQUIREMENTS OF SOUTH DAKOTA'S PASRR PROGRAM ARE MET. THE NURSING FACILITY OR SWING BED ACCEPTS THE ADMISSION ONLY AFTER RECEIPT AND REVIEW OF THIS NOTIFICATION FORM FOR 100% ACCURACY AND COMPLETION. THE NURSING FACILITY OR SWING BED ACCEPTS RESPONSIBILITY FOR REQUESTING A RESIDENT REVIEW (IF REQUIRED) FROM ADULT SERVICES & AGING PRIOR TO THE 30<sup>th</sup> DAY FOLLOWING ADMISSION FROM THE HOSPITAL.**