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 Long Term Services & Supports (LTSS) 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.

SECTION A: IDENTIFYING INFORMATION FOR APPLICANT/PATIENT

Last Name	First Name	MI

Living arrangement prior to the hospital admission:

[ ] group home
[ ] own home/apt – with friend or relative
[ ] nursing facility
[ ] psychiatric hospital
[ ] homeless
[ ] other (please specify)
[ ] own home/apt - alone
[ ] prison

Street Address	City	State	Zip

SD County of Residence	Sex [ ] Male [ ] Female	Date of Birth (mm/dd/yyyy)

Social Security #	Medicaid Recipient [ ] yes [ ] no [ ] pending
Hospital Name	Hospital Phone #
Hospital Contact	Discharge from Psychiatric Unit to NF? [ ] yes [ ] no

SECTION B: DIAGNOSIS OF SERIOUS MENTAL ILLNESS or INTELLECTUAL and DEVELOPMENTAL DISABILITIES

1) If applicable, date of most recent Level II PASRR determination*_____(mm/dd/yyyy) [ ] 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 Long Term Services & Supports 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? [ ] yes [ ] no
If yes please list below.

[ ] schizophrenia
[ ] mood disorder
[ ] delusional (paranoid) disorder
[ ] panic or other severe anxiety disorder
[ ] somatoform disorder
[ ] personality disorder
[ ] other psychotic disorder
[ ] another mental disorder other than ID
If so, describe _____

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. [ ] yes [ ] 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?
[ ] yes [ ] 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 Long Term Services & Supports, 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 LTSS
Signature of Hospital staff completing this form	Date (mm/dd/yyyy) faxed to LTSS

Circle the name of the LTSS Nurse Consultant to whom you faxed this notification form.

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

Region II – Toni Rounds
Phone: 605-353-7100 x208
FAX: 605-353-6922

Region III – Cassandra Varilek
Phone: 605-882-5010 x6
FAX: 605-882-5024

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

Region V – Tricia Fjerestad
Phone: 605-367-4777 x1000421
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 LONG TERM SERVICES & SUPPORTS PRIOR TO THE 30th DAY FOLLOWING ADMISSION FROM THE HOSPITAL.