South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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PIERRE, SD 57501-2291

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LONG TERM ACUTE CARE (LTAC) AND OUT-OF-STATE REHAB PRIOR AUTHORIZATION REQUEST FORM

Form **must be** submitted with medical records to support services.
Please include the admission H&P and most recent progress notes amongst other supporting records.

Date:		
RECIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
Acute Hospital Admission Date:	**LTAC Estimated Length of Stay:**	
Primary Diagnosis Code(s):		
Anticipated Care Needs (Ex: 6 weeks IV antibiotics, vent weaning, etc.):		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
Note: *The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed Point of Contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
ACCEPTING/SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

RECIPIENT BACKGROUND
Prior level of function:
Previous living environment:

Activity	Evaluation:	Discharge Goal:	Date:	Date:	Date:	Date:	Date:
Bed Mobility							
Sit to Stand							
Supine to Sit							
Ambulation - Feet							
Type of Assistive Device							
Stairs							
Weight Bearing Status							
Dressing-Upper							
Dressing-Lower							
Transfers							
Bowel Continence							
Bladder Continence							
Toileting (Level of Assistance)							
Additional Clinical Info							

Please Enter: Independent (I), Mod Indep. (MI), Supervision (S), Min Assist (MinA), Mod Assist (ModA), Total Assist (TA) or Not Applicable (NA)

(Y/N)	Date:	Date:	Date:	Date:	Date:
Additional rehab therapy required					
Participates in therapy					

NEUROLOGICAL						
5 Dates Must Be Tracked	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Motor Response						
Obeys Commands Fully						
Obeys Commands Partially						
Withdraws to Noxious Stimuli						
No Response						
Verbal Response						
Alert & Orientated						
Confused Yet Coherent Speech						
Inappropriate Words or Jumbled Phrases						
Incomprehensible Sounds						
No Sounds						
Eye Opening						
Spontaneous						
To Speech						
To Pain						
No Eye Opening						

RESPIRATORY STATUS & TREATMENT
Does the individual have an ongoing need for mechanical ventilation after 3 weeks, with 3 or more weaning failures in an acute hospital setting during the same 3 week period? Yes ☐ No ☐
If this was not completed, please provide further information/rationale:
Does the individual have a: ☐ Trach ☐ Chest Tube
Does the individual require ventilator and respiratory management at least every 4 hours? Yes ☐ No ☐
Current vent settings:
Current oxygen requirements:
Nebulizer treatments:
Has there been improvement or decline in recent days? Yes ☐ No ☐ Please describe the individual's recent improvement or decline in detail:

WOUNDS
Extensive wounds requiring daily assessment, drain management, debridement or complex wound care:
Describe dressings/drains/wound vac/frequency:
Wound Care – types of wound(s):
Location and description of wound(s):
Stage and measurements of wound(s):
History of the wound(s):(e.g. when acquired, non-healing, failed flaps, etc.)
Has there been improvement or decline in recent days? Yes ☐ No ☐ Please describe the individual's recent improvement or decline in detail:

DIET
Diet: Oral ☐ NG Tube ☐ Thickened Liquids ☐ Soft/Mechanical ☐ Gastric Tube ☐
If Tube Fed-Provide details:
Feed Swallowing Concerns:
Protein/calorie deficit:
Bariatric:
Has there been improvement or decline in recent days? Yes ☐ No ☐ Please describe the individual's recent improvement or decline in detail:

OTHER
Fluids/TPN:
IV Medication plan:
Dialysis needs:
PO Medication plan:
Anticipated procedures:
Ongoing lab needs:
Co-morbid conditions complicating care:
Mental Health, behavioral, substance abuse, or non-compliance issues impacting care? Yes ☐ No ☐ If yes, please describe..
Has there been improvement or decline in recent days? Yes ☐ No ☐ Please describe the individual's recent improvement or decline in detail

DISCHARGE PLAN
Home Alone ☐ Home with DME ☐ Home with Home Health ☐ Rehab ☐ Skilled Nursing Facility ☐ Possible barriers to discharge? (e.g. supervision needs, care giver resources, criminal record)