DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES 700
GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605-773-3495
WEB: dss.sd.gov
Email: DSSMedicaidPA@state.sd.us

South Dakota Department of Social Services

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

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

Date: _____

GENERAL INFORMATION		
Acute Hospital Admission Date:	LTAC ELOS:	
Primary Diagnosis Code:	Secondary Diagnosis Code(s):	
Anticipated Care Needs (For example; 6 weeks IV antibiotics, vent weaning, etc.):		
RECIPIENT INFORMATION		
Medicaid ID:	Date of Birth:	Sex: ☐M ☐F
Last Name:	First Name:	
PROVIDER INFORMATION		
Referring Provider Name:		
Referring Provider NPI:	Referring Provider Taxonomy:	
Fax:	Phone:	
Accepting/Servicing Provider Name:		
Address:		
Accepting/Servicing NPI:	Accepting/Servicing Taxonomy:	
Fax:	Phone:	

REFERRING PROVIDER INFORMATION	
Referring Acute Care Physician:	Accepting Acute Care Physician:
Referring Acute Care Physician NPI:	Accepting Acute Care Physician NPI:

RECIPIENT BACKGROUND
Prior level of function:
Previous living environment:

Activity	EVAL	DC Goal level	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 continent							
Bladder continent							
Toileting level of assist							
Additional clinical info							

Please Enter Supervision, Min assist, mod assist, Total assist (S/Min/Mod/TA/indep (I), Mod. Independent (mi).
May use N/A for items that are not applicable

(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 and orientated						
Confused yet coherent speech						
Inappropriate words or jumbled phrases						
Incomprehensible sounds						
No Sounds						
Eye Opening						
Spontaneous						
To speech						
To pain						
No eye opening						

RESPITORY STATUS/TREATMENT

Individual needs continued requirement of mechanical ventilation after 3 weeks, with 3 or more weaning failures during that period, in acute hospital? ☐ No ☐ Yes

If no, why? _____

Individual Has:

☐ Trach ☐ Chest Tube ☐ Requires ventilator and respiratory management at least every 4 hours

Vent Settings: _____

O2 Requirements _____

Nebulizer tx's: _____

Has there been improvement or decline in recent days? ☐ No ☐ Yes.

please indicate improvement or decline and describe in detail: _____

_____

WOUNDS

Extensive wounds requiring daily assessment, drain management, debridement or complex wound care:

_____

Drains/ wound vac/ describe dressings and frequency: _____

_____

Wound Care – type 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? ☐ No ☐ Yes

Please indicate improvement or decline and describe details: _____

_____

DIET

Diet: ☐ Oral ☐ NG Tube ☐ Thickened liquid ☐ 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? ☐ No ☐ Yes

Please indicate improvement or decline and describe details: _____

_____

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, describe_____

_____

Has there been improvement or decline in recent days? ☐No ☐Yes.

Please indicate improvement or decline and describe details: _____

_____

DISCHARGE PLAN

☐ Home alone ☐ Rehab ☐ Home with home health ☐ Skilled Nursing Facility

☐ Home with DME ☐ Nursing Home

Possible barriers to discharge? (e.g. supervision needs, care giver resources, criminal record)

_____

_____

_____

_____

POINT OF CONTACT	
Point of Contact Name and Title:	
Fax:	Phone:
Note: The point of contact is the individual to be the contact for questions SD Medicaid may have.	