PHYSICIAN CERTIFICATION
▶ Instructions on reverse

DHS-1503-ENG 9-08

1

PROVIDER INFORMATION

2 LTC Provider's Name

2a LTC MA Provider Phone #

3 NPI

4 Own Reference #

5 Today's Date

6 Street Address

7 Attending Physician's Name

8 Physician's NPI

9 City/State/Zip

10 Date Physician Signed Order

11 Date of this Admission

11a Anticipated Discharge Date (See back)

RECIPIENT INFORMATION

12 Recipient Name (Last, First, Initial)

13 Recipient Medical Assistance Number

If applying, place X in box → 13A ☐

14 Birthdate

15 Sex

16 Primary Diagnosis/Reason for Admission

17 DIAG Code

18 Secondary Diagnosis

19 DIAG Code

PREADMISSION SCREENING FOR SNFs and NFs

20. Was person screened prior to this admission? ☐ Yes ☐ No

a. If yes, date screened _____ and name of agency that did screening _____

b. No screening required: ☐ transfer from another MN SNF/NF or certified MN Board and Care Home (BCH)
☐ admit from hospital <30 day stay expected
☐ other reason, (explain) _____

c. Screening after admit: ☐ stay exceeded 30 days ☐ emergency admit
☐ other reason (explain) _____

ICF-MR SCREENING ONLY

21. Date person screened _____ Was it prior to this admission? ☐ Yes ☐ No If no, attach reason why.

ADMISSION INFORMATION

22 Date of First Admission

Recommended Level of Care: (“X” one) ..... SNF ☐ 23 NF Only ☐ 24 ICF-MR ☐ 25 RTC Psychiatric ☐ 26

Length of Stay: (“X” one) ..... 30 days or less ☐ 27 31 to 90 days ☐ 28 91 to180 days ☐ 29 over 180 days ☐ 30

Admitted from: (“X” one) ..... Acute-Care Hospital ☐ 31 Home ☐ 32 RTC ☐ 33 Other SNF or NF ☐ 34 ICF/MR ☐ 35

31a If Box 31 is checked indicate: Name of hospital _____

Date of hospital admission _____ Date of hospital discharge _____

PHYSICIAN'S SIGNATURE

I certify (or I certify that a physician has certified) that the recipient named above requires long term care services and that the services are being provided under a written plan of care.

x _____

35. AUTHORIZED SIGNATURE AND DATE

LOCAL COUNTY AGENCY USE ONLY

36. Date this form received by Local County Agency

36a. Name of county

37. LOCAL COUNTY AGENCY SIGNATURE AND DATE

38. DATE FORM RETURNED TO LTC FACILITY

▶ NOTICE: Anyone who misrepresents essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal and State law.

INSTRUCTIONS

This form must be completed by the LTC facility within 72 hours (not including weekends or holidays) after the admission of a Medical Assistance (MA) recipient or MA applicant.

Type or print all items except numbers 35 and 37.

1. Leave blank.
2., 2a, 6., 9. Long-term care (LTC) facility name, telephone and address.
3. Long-term care facility's NPI.
4. Optional – may use medical record number or other number.
5. Date the form is being completed.
7. Name of attending physician.
8. Physician's NPI, if available.
10. Date physician signed orders for this admission or if physician signed DHS-1503, date physician signed line 35. For an MA recipient, date must be prior or equal to the date in box 11.
11. Enter the date of admission or readmission to the facility.

11a. Enter the date the physician anticipates resident will be discharaged from this (current) admission. This box is for use by the local county agency worker to determine budgeting method.

12. Recipient's name.
13. Recipient's Medical Assistance identification number. If an MA applicant leave blank, the Local County Agency will complete.

13a. If a MN Health Care Programs (MHCP) applicant, place an X in this box. If an MHCP recipient, leave blank.

14. Recipient's birth date.
15. Recipient's sex – use F for female and M for male.
16. Primary diagnosis or reason for admission.
17. Enter ICD-9-CM code for primary diagnosis.
18. Secondary diagnosis for admission; if none, leave blank.
19. Optional – if used, enter ICD-9-CM code for secondary diagnosis.
20. If yes, complete 20a. If yes, but the date of screening listed here is more than 60 days before this admission, the person must be screened again. Contact your county screener. If no, check most appropriate reason in 20b or 20c. For use of "other," please refer to Chapter 27 of MHCP Manual.
21. Must be completed for each admission, including admissions from a RTC (Regional Treatment Center) to a community ICF-MR, or transfer from one community ICF-MR to another ICF-MR or readmission of person previously discharged. If not screened prior to admission, attach reason or reasons why.
22. Enter date the individual first entered the facility either as a recipient, applicant or as private pay (including Medicare eligibles).

23 - 26. Check one box only. Note: SNF refers to a Medicare certified level of care (skilled nursing care), NF-Only refers to a Medicaid-only certified level of care (i.e. such as a certified Board and Care Home-BCH), and RTC psychiatric is only used in Regional Treatment Centers for certified psychiatric beds.

27 - 30. Check one. Length of stay means the anticipated amount of time the person will be at the facility. This is to be estimated from the date in box 11.

31 - 35. Check one box only. Note: Use home option when other choices do not apply. RTC refers to any previous RTC stay, regardless of bed type or level of care in an RTC.

31a. Complete ***only*** if person was hospitalized.

35. Signature of physician or authorized person and date signed (authorized person attests to the fact that facility maintains documentation of physician signature on file in resident's record).
36. Enter the date form is received by the Local County Agency or date stamp upon receipt.

36a. Enter the county name.

37. Signature of Local County Agency representative and date signed.
38. Enter the date DHS-1503 is completed, signed and returned to the LTC facility.

Distribution: LTC facility sends the completed form to the Local County Agency and retains a photocopy. Local County Agency retains a photocopy and returns original signed/dated copy to the LTC facility for the resident's record.