



# SNF/Acute Rehab Request for Continued Stay

FCHP case manager: \_\_\_\_\_

Member: \_\_\_\_\_ Authorization number: \_\_\_\_\_

Facility: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Admission date: \_\_\_\_\_ Current authorization expires: \_\_\_\_\_

Date of request: \_\_\_\_\_ Discharge date, if applicable: \_\_\_\_\_

QUALIFIERS	
Ongoing:	
New:	Start date:
Discontinued:	End date:
SHORT-TERM GOALS	
Progress made toward short-term goals:	<input type="checkbox"/> On target <input type="checkbox"/> Date revised: _____
LONG-TERM GOALS	
Progress made toward long-term goals:	<input type="checkbox"/> On target <input type="checkbox"/> Date revised: _____
Additional pertinent clinical information necessary to make level of care determination:	
DISCHARGE PLANNING	
Barriers to discharge:	Approved discharge date:
Family meeting date:	Home evaluation date:
Training needs:	Training date:
Patient to be d/c to: <input type="checkbox"/> Home <input type="checkbox"/> LTC <input type="checkbox"/> Assisted living <input type="checkbox"/> Rest home <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with: _____	
Anticipated services needed at home:	
Services to be provided by:	
<b>Attach:</b> <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> Nursing notes/med sheets (if skilled nursing) <input type="checkbox"/> Care management/social work notes (family meetings, discharge planning) <input type="checkbox"/> New skilled MD orders <input type="checkbox"/> Discontinuation of skilled MD orders	

\_\_\_\_\_  
Signature and title of *licensed* staff member completing this form