Complex Care Request Form

Please select (X) all that apply:	
DSW add-on request	
Nursing add-on request	
Equipment add-on request	

SECTION 1: CLIENT INFORMATION

Name of Recipient: _____ Facility: _____

Current Level of care (41, 42, 43, 44): _____

Medicaid Number: _____ Medicare Number (if applicable): _____

Person completing this form: _____ Contact number: _____

SECTION 2: DIRECT SUPPORT WORKER ADD-ON REQUEST

The direct support worker (DSW) add-on is only available when staffing is being provided above the minimum Title XIX staffing requirements (for example, 1:4 in the day and 1:8 at night). If the client is already receiving Pervasive Plus, the client would not qualify for the DSW add-on. This limitation includes instances where Pervasive Plus is added after the approval of a DSW add-on for complex care.

In the list below, please indicate the level of assistance that the client needs with certain activities. Full support means that the client cannot perform any aspect of the activity for themselves and needs total assistance from the DSW. Partial assistance means that the individual needs the DSW to physically provide some aspect of the activity. No or minimal assistance means that the client may need a reminder, but can otherwise physically perform most of the activity for themselves.

To qualify for the DSW add-on, a client must require full assistance with 4 or more activities.

Activity	Full assistance needed	Partial assistance needed	No/minimal assistance needed
Transferring (e.g., moving from a chair to bed)	❑	❑	❑
Mobility (e.g., getting from one room to another—propelling wheelchair, walking)	❑	❑	❑
Turning and repositioning (e.g., while in bed or wheelchair)	❑	❑	❑
Eating	❑	❑	❑
Bathing/showering	❑	❑	❑
Grooming (e.g., nail care and oral hygiene)	❑	❑	❑
Dressing (physically dressing and undressing the individual)	❑	❑	❑
Continence and toileting	❑	❑	❑

For clients who do not require full assistance for at least 4 activities, exceptions can be made when complicating factors are present and supported by medical documentation. Please complete the below table of complicating factors.

Complicating factor	Description
Documented history of falls	
Skin breakdown	
Sensitivity to touch or combative/agitated behavior	
Dementia with confusion or disorientation	
More than one person required to safely lift, transfer, reposition, bathe, dress	
Contractures	
Dysphagia which requires supervision	

Documentation must be provided to substantiate the above needs, per the Documentation Checklist below.

Duration of the request:

Please indicate below the duration of the DSW add-on request. Medical documentation provided must provide evidence that the client's condition will require the enhanced services for the duration requested. If documentation does not support that the client's condition will require enhanced services for the requested duration, the approved duration may be reduced at the sole discretion of LDH. Requests are limited to a maximum of 1 year at a time.

Duration of DSW request: _____

SECTION 3: SKILLED NURSING ADD-ON REQUEST

Skilled nursing refers to care that can only be provided by a clinically trained and licensed nurse. The skilled nursing add-on is only available if there is a nurse on the home for at least 16 hours per day. In the list below, please indicate the client's skilled nursing needs.

To qualify for the skilled nursing add-on, a client must have 3 or more of the below skilled nursing needs.

Skilled nursing need	Check all that apply

Nasopharyngeal, tracheal, tracheostomy, or oral suctioning	❑
Enteral feeding (tube feeding) with complications such as reflux, combative/agitated behavior, or contractures	❑
Urinary or vesicostomy catheterization and care	❑
Colostomy care	❑
Nebulization treatments and nebulizer care	❑
Ventilator or positive airway pressure device care	❑
Diabetes care with injectable medications	❑
Administration of intravenous, intramuscular, or subcutaneous injections other than diabetes medications	❑
Wound care involving prescription medications and dressings with aseptic technique	❑
Administration of five (5) or more different medications per day (can be a combination of oral and topical)	❑
Three (3) or more skilled nursing assessments per day (e.g., neurological checks, glucose measurements)	❑

Documentation must be provided to substantiate the above needs, per the Documentation Checklist below. The presence of an "as needed" order alone is not sufficient to demonstrate need and documentation must show that the service is actually being delivered routinely. In addition, nursing documentation must show that the services indicated above are being provided by a nurse.

Duration of the request:

Please indicate below the duration of the skilled nursing add-on request. Medical documentation provided must provide evidence that the client's condition will require the enhanced services for the duration requested. If documentation does not support that the client's condition will require enhanced services for the requested duration, the approved duration may be reduced at the sole discretion of LDH. Requests are limited to a maximum of 1 year at a time.

Duration of skilled nursing request: _____

SECTION 4: EQUIPMENT ADD-ON REQUEST

The equipment add-on is available when clients need certain types of supplies. This add-on is only applicable to clients with Medicaid only and no other insurance. For example, clients with both Medicaid and Medicare are not eligible.

Equipment	Check all that apply
Enteral nutrition (tube feeding) supplies, does not include supplemental feeding	❑
Ostomy supplies	❑
Tracheostomy supplies	❑

Documentation must be provided to substantiate the above needs, per the Documentation Checklist below.

Duration of the request:

Please indicate below the duration of the equipment add-on request. Medical documentation provided must provide evidence that the client's condition will require the enhanced services for the duration requested. If documentation does not support that the client's condition will require enhanced services for the requested duration, the approved duration may be reduced at the sole discretion of LDH. Requests are limited to a maximum of 1 year at a time.

Duration of equipment request: _____

SECTION 5: ATTESTATIONS

Two attestations must be completed for this form. The first attestation must be completed by a licensed clinician operating within their scope of practice who has reviewed this form. If only the DSW add-on, the equipment add-on, or both are requested, the attestation may be signed by a physician, advance practice registered nurse, physician assistant, or an occupational, physical, or speech therapist. If the skilled nursing add-on is requested alone or in combination with any other add-on, the attestation must be signed by a physician, advance practice registered nurse, or a physician assistant.

I attest that this form is a true, accurate, and complete description of this client's needs and the rationale for the DSW add-on, the skilled nursing add-on, the equipment add-on, or a combination of the three.

Name: _____ Date: _____

Signature: _____

Profession: _____ License number: _____

The second attestation must be completed by the executive director of the facility:

I understand and will adhere to the rules and regulations for the add-on(s) requested in this form. I attest that the increased payments made will be used for the direct benefit of the individual and to meet the needs described in this form. I am aware of and agree that funds received as a result of attestation are subject to the Direct Care Floor process as described in the Louisiana Register, Title 50 Public Health Medical Assistance, Part VII Long Term Care, Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities, Chapter 329 Reimbursement Methodology, Subchapter A. Non State Facilities, ss 32901 Cost Reports, (C) Direct Care Floor.

I attest that all staff will operate within the scope of practice of their license and supervisors of unlicensed personnel will ensure that all persons operating under their license are properly trained and demonstrate competency in the skills needed.

I acknowledge that we will abide by all LDH rules and policies including but not limited to, any additional requirements in the annual survey, fiscal analysis and reporting, etc.

Executive Director Name: _____ Date: _____

Executive Director Signature: _____

SECTION 6: DOCUMENTATION CHECKLIST

Requests for the DSW add-on, the skilled nursing add-on, the equipment add-on, or a combination of the three must include all of the following documentation. Request forms submitted without the required documentation will be returned without review by LDH.

❑ A letter of medical necessity is required for all add-on requests. It must describe the client's needs as listed in this request form and be signed by a licensed clinician. If only the DSW add-on, the equipment add-on, or both are requested, the letter of medical necessity may be signed by a physician, advance practice registered nurse, physician assistant, or an occupational, physical, or speech therapist. If the skilled nursing add-on is requested alone or in combination with any other add-on, the letter of medical necessity must be signed by a physician, advance practice registered nurse, or a physician assistant.

DSW add-on:

Note: If the client is already receiving Pervasive Plus, the client would not qualify for the DSW add-on. This limitation includes instances where Pervasive Plus is added after the approval of a DSW add-on for complex care.

❑ DSW staffing schedule for the previous 2-week period showing staffing above the minimum

❑ Functional assessment by a licensed physical or occupational therapist, within the last 90 days, with specific instructions for DSWs

❑ Assessment by a licensed speech language pathologist, within the last 90 days, for individuals with swallowing disorders needing mealtime guidelines or communication instructions, with specific instructions for DSWs

Skilled nursing add-on:

❑ Nursing staffing schedule for the previous two-week period

❑ Nursing documentation for the prior 2 weeks demonstrating the skilled nursing needs and activities performed by a nurse

Equipment add-on:

❑ Documentation of the client's equipment needs, which may be included in the letter of medical necessity, functional assessment (if applicable), or nursing documentation (if applicable)