**GOVERNMENT OF THE DISTRICT OF COLUMBIA**
**Department of Health Care Finance**
**Long Term Care Administration**

## Attachment A- Recertification Checklist for Individuals in ICF/IID

**Note:** ***For the Department of Health Care Finance to process a recertification request, all information below must be included in the order of the checklist. Submissions without a completed and signed checklist and/or that do not include the required information will not be reviewed. Incomplete submissions will be returned to the ICF/IID provider agency for finalization and resubmission.***

****Recertification of an individual's need for continued ICF/IID service is required, at minimum, twelve (12) months following the date of previous certification.***

**The requests shall include the following:**

- **The Continued Stay Recertification Form-completed in its entirety;**
- **The Physician's Certification and Recertification for Intermediate Care Form-dated with the physician's original signature; the date of certification/recertification cannot exceed one year from the date of physician's signature;**
- **A copy of the ISP for the requested recertification period;**
- **A copy of the most recent physician's order sheet and laboratory results including psychotropic and/or therapeutic drug levels and Hepatitis B status. The results should coincide with the physician's orders;**
- **A copy of the current physical examination;**
- **Results of TB testing: Annual tuberculin purified protein derivative (PPD) skin test, Chest X-ray report, or QuantiFeron TB Gold (QFT-G);**
- **A copy of the emergency room visit reports and/or hospitalizations/incident reports, if any for the previous year;**
- **Any other documentation necessary to evaluate the status of an individual who has experienced adverse events.**

| | |
|---|---|
| ***Name of Preparer:*** | ***Phone Number:*** |
| ***Signature:*** | ***Email Address:*** |

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## RECERTIFICATION FOR CONTINUED STAY

## IN INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABLITIES (ICF/IID)

_____ _____
Facility Name Individual's Name

_____ _____
Address Medicaid Number

_____ _____
City, State Zip Code Date of Admission

Attending Physician: _____

### Section I. (Nurse to Complete)

**Name of Nurse: _____ Signature: _____ Date: _____**

Current Diagnosis (Axis I-Axis IV):
_____

_____

_____

_____

Date of Most Recent ISP: _____

Active Treatment Program: _____

Medications: (**Please attach a copy of the physician's orders to document/medications**)

Name of Individual Medicaid ID Name of Provider

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Allergies:
_____

Diet:
_____

Weight: _____

Date of current Nursing Quarterly Assessment: _____

Services Ordered, Initiated and Reason ( Current physician order sheet, Laboratory test results, *please attach copies of reports, CBC, SMAC, Drug levels):

_____

_____

_____

Hospitalization/Discharge Dates (attach copies of emergency room/hospital discharges documentation):

_____

_____

Prognosis: _____

*Is individual Free of Infections Tuberculosis ( ) Yes ( ) No ( ) N/A ( )

Tuberculin Test: Date Placed_____ Date Read_____ Mfr._____ Lot #_____
_____ mm induration

Chest X-Ray: Yes ( ) No ( ) N/A ( )
Date: _____ Result: _____

QuantiFERON-TB (QFT): Yes ( ) No ( ) N/A ( )

Date: _____ Result: _____

*Hepatitis B Test Results: _____ Date:_____
(provide supporting documentation of Hepatitis screening/test)

Name of Individual Medicaid ID Name of Provider

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***-Required***

**PHYSICIAN CERTIFICATION AND RECERTIFICATION FOR INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES.**

Individual Name: _____

Medicaid Number: _____

**Recertification:** I certify that the above named individual requires level of care provided in an intermediate care facility for individuals with intellectual disabilities (ICF/IID). This individual's condition and diagnosis have not changed; therefore, there is a demonstrated need for continuing services in the ICF/IID.

Physician's Name (please print): _____

Physician's Signature: _____ Date: _____

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## For DHCF Use Only

Recertification Period: From: _____ To: _____

DHCF Staff (please print): _____ Title: _____

DHCF Staff Signature: _____ Date: _____