



Exempted Hospital Discharge (EHD) Form

Physician Certification of Need for Nursing Facility Services

Applicant Information		
First Name:	Last Name:	M.I.:
Date of Birth:		
Name of Hospital Discharging From:		

Exempted Hospital Discharge	
Exempted discharge means:	
1. The applicant is being admitted to a nursing facility after receiving acute inpatient care at the hospital; AND	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The applicant requires nursing facility care for the condition for which they received care in the hospital; AND	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. The attending physician, upon signing this document has certified to the nursing facility that the applicant is likely to require less than thirty (30) days of nursing facility services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Note: If you answered “No” to any of the above questions, the individual is not eligible for an Exempted Hospital Discharge according to 42 CFR 483.106(b)(2). Please continue with the Level I screen and Level II Evaluation if needed.</p>	
Attending Physician Signature:	Date:

Upload this **signed certification** of eligibility for Exempted Hospital Discharge into the Telligen Qualitrac system at the time of your Level I submission.

Note: Use of this form is not required, however if your organization has created a similar form, it **must** include all of the above information.