



## NURSING FACILITY LENGTH OF STAY

Client / Member Name: \_\_\_\_\_

Client / Member Social Security Number: \_\_\_\_\_

Initial Review Date: \_\_\_\_\_

Continued Stay Review Date (if applicable): \_\_\_\_\_

Case Manager: \_\_\_\_\_

Client / Member Considerations:

At least 75 years old (**'YES', score 1**): \_\_\_\_\_

Service provision in community exceeds average cost in nursing facility (**'YES', score 2**): \_\_\_\_\_

Not expected to return to pre-morbid or pre-event level of functioning (**'YES', score 3**): \_\_\_\_\_

No formal or informal support available (**'YES', score 4**): \_\_\_\_\_

Cognitively impaired and/or danger to self or others (**'YES', score 5**): \_\_\_\_\_

**TOTAL SUM OF 'YES' SCORES:** \_\_\_\_\_

Score Range / Calculated Length of Stay:

Authorized Length of Stay:

\_\_\_\_\_

\_\_\_\_\_

Brief explanation of factors that determined authorized length of stay:

\_\_\_\_\_

Service options discussed with Client / Member? \_\_\_\_\_

**\* Supervisor's signature required if "Open End Date" length of stay is authorized**

Supervisor's signature: \_\_\_\_\_