



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: _____