

471-000-228 Instructions for Completing Form DPI-OBRA6. "Assurances"

Use: Form DPI-OBRA6 is used by the mental health reviewer or QMRP to document that the individual or his/her legal representative receives a clear and concise explanation of the following:

1. Requirements of the Omnibus Budget Reconciliation Act of 1987;
2. Recommendations for care in a nursing facility or for alternative placement;
3. Plans for a safe and orderly placement into the alternative placement;
4. Provision of services while waiting to be placed into the alternative placement; and
5. The requirement that if the individual has resided in the facility for more than 30 months, s/he has the right to choose to stay in the facility and receive the necessary active treatment, and that this decision is based on a full explanation of his/her institutional and non-institutional Medicaid-approved alternatives and the effects on his/her eligibility for Medicaid.

Number Prepared: Form DPI-OBRA6 is completed in triplicate.

Completion: Form DPI-OBRA6 is completed by the mental health reviewer or the QMRP with the individual or the individual's legal representative as follows.

Heading: Complete the required blanks.

Parts A-C: Check the appropriate box.

Signature: The individual or his/her legal representative signs and dates the form. The mental health reviewer or QMRP also signs and dates the form.

Distribution: The original of Form DPI-OBRA6 is given to the individual or his/her legal representative. A copy is sent to the nursing facility for inclusion in the permanent nursing facility record and to the DPI-OBRA Unit.

Retention: Form DPI-OBRA6 is retained for four years.

Nebraska Department of Public Institutions

Assurances

Name	DOB/Age	Social Security Number
Name of Facility, if appropriate	Date	

PART A

I certify that the requirements of the Preadmission Screening and Annual Resident Review Process have been explained to me. I understand that the State of Nebraska is required to review all individuals requesting admission to and current residents of nursing facilities who have an indication or diagnosis of mental illness, mental retardation or a related condition, and that based on an assessment of my treatment needs, a determination has been made that my needs (can/can not) be appropriately met in the nursing facility.

I certify that I have received a clear and concise explanation of my treatment needs and that I understand which placement is being recommended to meet my needs.

PART B

I understand that the Nebraska Department of Public Institutions and the Nebraska Department of Social Services will ensure that my placement in the alternative setting will be safe and orderly, and that at all times, I will be fully informed of the plans for placement.

I also understand that while I am waiting to be discharged from the nursing facility, I will continue to receive any services determined appropriate to meet my treatment needs.

PART C

I understand that since I have resided continuously in the nursing facility for 30 months or more, and that even though I do not require nursing facility services but do require mental health or mental retardation/developmental disability services, I can choose to stay in the nursing facility. I certify that I have been given a full explanation of my institutional and non-institutional Medicaid-approved alternatives.

I certify that I was offered the choice of remaining in the nursing facility or receiving covered services in an alternative institutional or non-institutional setting and that I clearly understand the effects on my eligibility for Medicaid should I choose to leave the nursing facility, including the effects on my readmission to the same facility.

Based on this information, I (do/do not) choose to remain in the nursing facility and receive any necessary services to meet my treatment needs.

Signature of Individual or Legal Representative

Signature of OMAP/Mental Health Reviewer

Date

Date