Department of Health and Human Services
Division of Medicaid and Long Term Care
NURSING FACILITY LEVEL OF CARE DETERMINATION

Nursing Facility Name:	
Address:	
City, State and Zip:	
Client/Resident Name:	
Medicaid status: ☐ Pending Date:___________________________	☐ Open Date:________________________________
Social Security Number:	Date of Birth : (mm/dd/yyyy)
Name of Person and Agency Making Referral:	Phone Number and Fax Number of Person Making Referral:
Date NF Level of Care Referral received: (mm/dd/yyyy)	Date PASRR completed: (mm/dd/yyyy)
Date Medicare Days ended: (mm/dd/yyyy)	Date NF Level of Care Referral Completed: (mm/dd/yyyy)
	Other Applicable Date Considerations: Specify below
Level of Care Determination	
Level of Care ☐ Met ☐ Not Met	Short Term Stay: ☐ Yes End Date:____________________ ☐ No
Notes:	
Title and Signature of Person Making Determination:	
Agency/Office of Person Making Determination:	
Date Determination Provided to NF:	

INSTRUCTIONS: This replaces DHHS Form MC-9NF, Prior Authorization for Nursing Facility Care, which is no longer generated by Senior Care Options. This document is also used for NF Level of Care determination for individuals aged 64 and younger. This determination is provided to the NF following receipt of referral and the evaluation. THE NF retains this determination in the resident's record, to be provided to DHHS only upon request.