MICHIGAN MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATION (LOCD)

Provider's Name:	____________________	Provider's ID/NPI:	__________
Applicant's Name:	____________________	Date of Birth:	__________
Representative (if any):	____________________	LOCD Created-on Date:	__________

SECTION I – MEDICAL/FUNCTIONAL ELIGIBILITY

Based on an LOCD medical/functional assessment of LTC needs conducted on ______________ (*date*), the applicant indicated above:

☐ **Does** meet the LOCD medical/functional criteria for Medicaid NF Level of Care by scoring in Door ________.

☐ **Does Not** meet the LOCD medical/functional criteria for Medicaid NF Level of Care (please proceed to Section III).

Signature of healthcare professional completing LOCD	Healthcare profession title	Date

SECTION II - FREEDOM OF CHOICE

I have been advised that I meet LOCD medical/functional criteria and I choose to receive services and supports from the following:

☐ MI Choice Program. I have received information about MI Choice program services in my area.

☐ Nursing Facility. I have received information about nursing facility services in my area.

☐ PACE Program. I have received information about PACE program services in my area.

☐ MI Health Link. I have received information about MI Health Link services in my area.

Local Referral(s): ______________________________

Signature of applicant	Signature of applicant's representative	Date

SECTION III - APPEAL RIGHTS

I have received a copy of a denial of Medicaid NF Level of Care service based on the LOCD and understand my right to appeal.

Signature of applicant	Signature of applicant's representative	Date

UPHP FOC July18