Application ID:_____

MICHIGAN MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATION (LOCD)

Provider's Name : _____

Provider's ID/NPI: _____

Applicant's Name: _____

Date of Birth : _____ LOCD Created-on Date: _____

Representative(if any): _____

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 SectionIII)

_____ _____ _____

Signature of healthcare professional completing or adopting LOCD | Healthcare profession title | Date

SECTION II-FREEDOM OF CHOICE

I have been advised that I meet LOCD medical/functional criteria and I am eligible for any of the LTC programs listed below. I have received information about all LTC programs available in my area. I choose to receive services and supports from:

☐ MI Choice Waiver Program.

☐ Nursing Facility.

☐ PACE program.

☐ MI Health Link.

Other service option(s) and local referral(s) that do not require Nursing Facility Level of Care:

_____

_____ _____ _____

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