LIFE Annual Recertification Form

Name of LIFE Provider _____

Name of Participant _____ Sex _____ Age _____

Date of Enrollment _____ SS# _____

Date of Evaluation _____

Medical Summary _____

_____

_____

_____

The Participant is permanently residing in a Nursing Facility Yes ____ No _____

Prognosis (check only one) Stable ____ Improving _____ Deteriorating _____

Rehabilitation Potential (check only one) Good _____ Limited _____ Poor _____

Participant Has: Alzheimer's Disease/Dementia _____ COPD _____ ESRD _____ CHF _____

Physician's Recommendations:

On the basis of the present medical findings I have determined that the participant continues to meet Nursing Facility Level of Care

Yes _____ No _____

If No, in absence of continued coverage under this program, would the participant reasonably be expected to require Nursing Facility Level of Care within the next six months?

Yes _____ No _____

Physician Signature _____ Date _____

Physician (Printed Name) _____

For Department Use

Annual Recertification Form reviewed Yes _____ No _____

Participant's Plan of Care reviewed Yes _____ No _____

Based on predetermined eligibility criteria and review of documentation provided:

_____ Participant continues to be eligible, no further recertification necessary.

_____ Participant continues to be eligible, but requires recertification next year.

_____ Participant is not eligible, but would require NF level services within 6 months in absence of services.

_____ Participant is not eligible, refer to AAA for reassessment.

Comments _____

_____

_____

_____

_____

_____

_____

Reviewer's Signature Title Date