Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Skilled nursing facility assessment form

For attaching to the case in the e-referral system

For Blue Cross commercial and BCN commercial members

March 2021

Facility and provider must participate with their local Blue Cross Blue Shield plan or the member may incur higher costs. Complete every field unless otherwise noted. Authorization is not a guarantee of payment.

Complete the form and attach it to the request in the e-referral system. Incomplete submissions may cause a delay or a denial. Allow 24-72 hours for processing authorization requests.

☐ **Initial admission: Include hospital admission H&P and any additional notes** ☐ **Continuing stay**

Person submitting the request – Name:	**Phone:**
Attestations	
SNF benefits are verified: ☐ No ☐ Yes – Number of days available:	
All therapy notes are within 24-48 hours of admission date or last covered date: ☐ No ☐ Yes	
Member is receiving at least 1 hour of therapy 5 days a week: ☐ No ☐ Yes ☐ NA	
Member demographic information	
Member name:	**Date of birth** / **Enrollee ID:**
Admission information	
Height: / **Weight:** / **Estimated length of stay:**	
Prior level of function (home):	
Cognition	
Cognition – A&O: x_____ or Other:	
Vital signs	**Bowel / bladder**
Vital signs: T P R BP	**Bowel:** ☐ Continent ☐ Incontinent
Diet	**Bladder:** ☐ Continent ☐ Incontinent
Type: ☐ NPO ☐ TPN ☐ Tube feeding —	**Catheter:** ☐ No ☐ Yes -- Type:
Calories / day _____ CCs / day: _____	**Ostomy:** ☐ No ☐ Yes
	Post-op complications of ostomy: ☐ No ☐ Yes
Oxygen delivery	
Delivery mechanism: ☐ None ☐ Type: Flow rate: Saturation:	
Vent: ☐ No ☐ Yes – Saturation: Vent settings:	
Suction per 24 hours	
☐ **None** ☐ **Frequency:**	
Respiratory treatment	
☐ **No** ☐ **Yes — Frequency:** **Type:**	
Tracheostomy	
☐ **No** ☐ **Yes — Type:**	
Pain	
Pain: ☐ No ☐ Yes — Location:	
Medication: ☐ No ☐ Yes — Drug: Route: Dose: Frequency:	
Pain scale — Before management: After management:	
Significant medication changes at reassessment that affect functioning:	
List the changes:	

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IV medications				
IV / PICC line: ☐ No ☐ Yes — Complete the medication information below:				
Medication name:	Dose:	Frequency	Start date:	End date:

Skin status
☐ **Skin is intact** ☐ **Skin is not intact —** Complete the fields below:
#1 wound or incision: ☐ No ☐ Yes — Size: L x W x D (cm): Location and stage: Treatment (type, frequency):
#2 wound or incision: ☐ No ☐ Yes — Size: L x W x D (cm): Location and stage: Treatment (type, frequency):

Mobility: current functioning	
PT / OT — Date of notes:	Focus goal:
Bed mobility / assist needed	☐ Total assist ☐ Max assist ☐ Mod assist ☐ Min assist ☐ CGA ☐ SBA ☐ Mod ind ☐ Ind
Transfers	☐ Total assist ☐ Max assist ☐ Mod assist ☐ Min assist ☐ CGA ☐ SBA ☐ Mod ind ☐ Ind
Gait / assist needed	☐ Total assist ☐ Max assist ☐ Mod assist ☐ Min assist ☐ CGA ☐ SBA ☐ Mod ind ☐ Ind
Gait / distance —	**Gait / assistive device —** ☐ None ☐ Type:
Stairs — Current number of stairs patient can climb:	Number of stairs in home:
Stairs / assist needed	☐ Total assist ☐ Max assist ☐ Mod assist ☐ Min assist ☐ CGA ☐ SBA ☐ Mod ind ☐ Ind
Comments:	

Self-care: current functioning	
Occupational therapy — focus goal:	
Bathing / UE:	☐ Total assist ☐ Max assist ☐ Mod assist ☐ Min assist ☐ CGA ☐ SBA ☐ Mod ind ☐ Ind
Bathing / LE:	☐ Total assist ☐ Max assist ☐ Mod assist ☐ Min assist ☐ CGA ☐ SBA ☐ Mod ind ☐ Ind
Dressing / UE:	☐ Total assist ☐ Max assist ☐ Mod assist ☐ Min assist ☐ CGA ☐ SBA ☐ Mod ind ☐ Ind
Dressing / LE:	☐ Total assist ☐ Max assist ☐ Mod assist ☐ Min assist ☐ CGA ☐ SBA ☐ Mod ind ☐ Ind
Toileting / hygiene management:	☐ Total assist ☐ Max assist ☐ Mod assist ☐ Min assist ☐ CGA ☐ SBA ☐ Mod ind ☐ Ind
ADL transfers	☐ Total assist ☐ Max assist ☐ Mod assist ☐ Min assist ☐ CGA ☐ SBA ☐ Mod ind ☐ Ind

Speech therapy: current status
☐ **No speech therapy needed** ☐ **Dysphagia evaluation / modified barium swallow assessment needed**
Result / aspiration risk / recommendations:

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Discharge plans (must be initiated at admission)
Discharge date (tentative): **Discharge goal:**
Discharge location — ☐ Assisted living ☐ Long-term care ☐ Foster care ☐ Home alone ☐ Home with HHC ☐ Home with family support ☐ Other:
Home evaluation date:
Home – number of levels — ☐ 1 level ☐ 2 levels ☐ 3 levels ☐ Other:
Home – number of steps— At entry: At bed / bath:
Lives with:
Supervision needs at discharge:
Equipment needs at discharge:
Discharge barriers:
Additional notes

Note: **For BCN members:** For DME and P&O, contact Northwood, Inc., at 1-800-393-6432. For diabetes supplies, contact J&B Medical Supply at 1-888-896-6233. **For Blue Cross commercial members:** For information about DME and diabetes supplies, contact Provider Inquiry at 1-800-249-5103 to determine benefits.