Acumentra HEALTH

Fax Cover Sheet

Request for Medicaid 1915 (i) Plan Qualification Determination

To: Acumentra Health **Date:_____**

Fax: 503-432-2095 **Total Pages:_____**

From: _____
Name of Sender **Phone**

Residential Facility Name: _____

Address: _____Phone: _____

Contact Person: _____Fax:_____

Mental Health Provider/Agency: _____

Address: _____Phone: _____

Contact Person: _____Fax:_____

The facility must supply all information Acumentra Health needs for determining if the resident meets the qualifying criteria.

Please check that the information listed below is provided in this fax prior to sending:

Resident Name: _____

Resident Medicaid Number: _____

Admission Assessment (including AXIS 1 diagnosis and LOCUS score if available)

Most recent Mental Health Assessment and Treatment Plan

Most recent Care Plan for ADLs if different from Treatment Plan.

Documentation of daily care provided/one week of direct care notes