COLORADO
Department of Health Care Policy & Financing

Physician Certification of Eligibility for the Exempted Hospital Discharge (EHD) or Convalescent Care Categorical

This **signed certification** of eligibility can be uploaded into AssessmentPro at the time of Level I submission for Maximus' consideration of an EHD or Convalescent Care Categorical applicability. *This form only applies to nursing facility applicants, on a preadmission basis, who have a known or suspected mental illness, intellectual disability, and/or related condition.* Your organization may create and use a similar form for either option requested, if it includes the criteria identified below.

Nursing Facility Applicant Information		
First Name:	Last Name:	M.I.:
Date of Birth:		
Name of Discharging Hospital:		

Exempted Hospital Discharge (30 days)	
An Exempted Hospital Discharge (per 42 CFR 483.106(b)(2)) means the nursing facility applicant:	
1. Is being admitted to a nursing facility after receiving acute inpatient care at the hospital; AND	☐ Yes ☐ No
2. Requires nursing facility care for the condition for which they received care in the hospital; AND	☐ Yes ☐ No
3. Are likely to require **less than thirty (30) days of nursing facility services.**	☐ Yes ☐ No
Note: The attending physician, upon signing below, certifies that the nursing facility applicant meets eligibility. If "No" was answered to any of the above questions, the individual is not eligible. The Level I screen must still be submitted so Maximus can determine if a preadmission Level II Evaluation is needed.	
Attending Physician Signature:	**Date:**
Attending Physician Name (printed):	**License No:**

Convalescent Care Categorical (60 days)	
A Convalescent Categorical (per 42 CFR 483.130(d)(1)) means the nursing facility applicant:	
1. Requires convalescent care from an acute physical illness, AND	☐ Yes ☐ No
2. The acute physical illness required [inpatient] hospitalization, AND	☐ Yes ☐ No
3. They do not meet all criteria for an Exempted Hospital Discharge, AND	☐ Yes ☐ No
4. Are likely to require **less than sixty (60) days of nursing facility services.**	☐ Yes ☐ No
Note: The attending physician, upon signing below, certifies that the nursing facility applicant meets eligibility. If "No" was answered to any of the above questions, the individual is not eligible. The Level I screen must still be submitted so Maximus can determine if a preadmission Level II Evaluation is needed.	
Attending Physician Signature:	**Date:**
Attending Physician Name (printed):	**License No:**