CommCare Corporation
the caring company

142 FACTS

GOOD FOR 30 DAYS

Once approval has been obtained, the individual must be admitted to the facility within 30 calendar days of the date of the approval notice.

BREAK IN CARE

Whenever a patient leaves an acute care setting or moves across state lines, this counts as a break in care. The state line rule may only apply in non-emergency instances.

EXAMPLES:

An individual moves from a Louisiana certified facility to a facility in Texas and wants to admit back.
A new 142 is required.

An individual is a current nursing home resident and has a LTAC stay for over 30 days.
A new 142 is not required.

A DISCHARGE HAS CHANGED ITS MIND

An individual has left the facility to return home. Once there they decide it may not have been the best decision. A direct admit back to the facility may be possible if a 148 has not been issued and home leave days are available. This is at the discretion of the facility.

142s EXPIRE

Continued stay request are needed. Required documents are needed in order for OAAS to determine the need for continued services in a nursing facility.

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Print Form

BHSF Form 142
Rev. 07/12
Prior Issue Obsolete

Louisiana Department of Health and Hospitals
Medicaid Program
Notice of Medical Certification

SSN: 123-45-6789 Date of Birth: 01/01/2000 Medicaid No: _____

To: John Smith

Home Address: 123 State Street, New Orleans, LA 12345

Facility/Provider/Support Coordinator Name: _____ Vendor No: _____

Facility Address: _____ Parish: _____

Nursing Facility or Intermediate Care Facility

- Eligibility must be approved prior to admission to Nursing Facility. Prior approval is valid for 30 days for Nursing Facility Admission. If admitted within 30 days, decision is valid until discharged. If not admitted within 30 days of decision, a new decision is needed.
- This decision relates to medical eligibility only and is separate from a decision on financial eligibility for Medicaid.

I.

☐ A. Approved for Medicaid/Private medical eligibility services effective _____.
☐ Level II decision pending. Level of Care: _____

☑ B. Approved for Medicaid medical eligibility services for a temporary period effective 06/03/2021 through 09/11/2021. Level of Care: _____

Please check:

☐ MD/Physician involvement
☑ Treatment/Conditions
☐ Skilled Therapies
☐ Hospital Exemption
☐ TDC
☐ NRTP
☐ Other: _____

☐ C. Not Approved/Denied – Does not meet Medicaid medical eligibility requirement.

☐ D. ICF/DD decision pending-additional information needed: _____

Agency Representative Amber Dabney Date: 06/03/2021

OCDD/OAAS Office Address _____

II. If item F, G, or H is marked, disregard Section I decision.

☐ E. Level II decision is not required.

☐ F. Approved for admission by Level II Authority effective _____.

☐ G. Approved for admission by Level II Authority for a temporary period effective _____ through _____.

☑ H. Not Approved – Admission Denied by Level II Authority.

Agency Representative Gloria Thompson, LCSW LDH/OBH Date: 06/17/2021

OCDD/OBH Office Address _____

III. WAIVER/PACE

☐ A. Approved Medicaid waiver criteria for _____ Waiver services effective _____.

☐ B. Not Approved - Does not meet Medicaid medical eligibility.

☐ C. Vendor Payment May Begin Date: _____

Agency Representative/Support Coordinator: _____ Date: _____

OAAS or OCDD Regional Office or OBH State Office: _____

OAAS or OCDD Regional Office or OBH State Office Address: _____

CC: ☑ Facility/Provider ☐ Office of Behavioral Health ☑ OAAS ☐ OCDD
☑ Medicaid Long Term Care Unit (specify Parish): _____
☐ Other (specify): _____