



Hospital EARC Application

Application Date	Application Type	Confirmation Number
	EARC	N/A

Application Disclaimer

The Hospital Enhanced At-Risk Criteria (EARC) screening tool is to be used **only** for those acute care or long-term acute care (LTAC) hospital patients who meet the target criteria and are being discharged to a Medicaid certified Nursing Facility (NF) or ventilator SCNF with the expectation of billing Medicaid for all or part of their stay. Only discharge planners who have undergone training and who have been certified by the Department of Human Services can complete and submit this tool.

The Hospital EARC Screening Tool, once authorized, is valid for 10 days and authorizes up to 90 days of NF Services, which is contingent upon full clinical and financial Medicaid eligibility within 90 days of admission to the NF as per N.J.A.C. 8:85-1.8(b.1). If the patient is not discharged to a NF within 10 days of the authorization date as identified through OCCO authorization, the EARC is then invalid, and a NEW EARC must be submitted when the patient is ready for discharge. The admitting NF is responsible to submit the Notice of NF Admission (LTC-2) within two business days of admission as per N.J.A.C. 8:85-1.8(c).

The Hospital EARC Screening Tool and all PASRR documents must accompany the patient to the NF to be permanently filed in their NF medical record.

By proceeding with this screening tool, you acknowledge that all requirements are met.

Hospital Admission Information

Date of Hospital Admission	Hospital - Hospital Branch	Branch County

Request Type:

NF

Vent SCNF

Patient Information

Patient Name	Date of Birth	Gender	SSN
		M / F	

Address Information

Residency Type at Admission	Facility
<input type="checkbox"/> Private Home/Apartment	
<input type="checkbox"/> Private Home/Apartment, with care	
<input type="checkbox"/> Facility (Specify)	
<input type="checkbox"/> Homeless	

Address	County of Residency

Hospital EARC Eligibility Information

Questions	Answers
Is Medicaid expected to pay for any of the cost of the nursing facility stay?	YES / NO
Did patient apply for Medicaid and is application pending?	YES / NO
Date of Medicaid Application	
Will the patient's funds last less than six (6) months in a nursing facility?	YES / NO

Financial Information

Questions	Answers
Income	Check One
Patient's monthly income is at, or below, the current NJ Care Special Medicaid Program's maximum monthly income limit of \$1,064	<input type="checkbox"/>
Patient's monthly income is at, or below, the current Medicaid institutional cap of \$2,349	<input type="checkbox"/>
Patient's monthly income above \$2,349, potential eligibility for Medicaid Qualified Income Trust	<input type="checkbox"/>
Assets	Check one
Patient has no spouse in the community and resources no greater than \$4,000 (plus \$1,500 burial fund)	<input type="checkbox"/>
Patient has no spouse in the community and resources at or below \$64,000 (plus \$1,500 burial fund)	<input type="checkbox"/>
Patient has a spouse in the community with combined countable resources at or below \$128,640 (plus \$1,500 burial fund)	<input type="checkbox"/>

Medical - PASRR Information

Questions	Answers
1. Does the patient have catastrophic illness, a debilitating and/or a chronic illness affecting functional status that may require long term nursing facility stay?	YES / NO
2. Diagnoses (minimum of one):	
3. Is this Patient Ventilator dependent?	YES / NO

PRE-ADMISSION SCREENING RESIDENT REVIEW (PASRR)

Questions	Answers
1. Date of Level I PASRR Screen	
1a. Level I Screen Outcome	Circle one Negative Positive MI Positive ID/DD/RC Positive Both MI and ID/DD/RC
1b. PASRR Not Applicable - Returning to same NF - PASRR on file at NF	<input type="checkbox"/>
2. Did physician certify NF placement as 30-day exempted hospital discharge?	YES / NO
2a. Date positive Level I PASRR referred to Level II Authority	

MI PASRR Level II

Questions	Answers
Date of MI Level II Determination	
MI Level II Determination	Circle one No specialized services (Negative) Requires Specialized Services (Positive) MI Primary Dementia Exclusion Categorical Determination
MI Level II Categorical Determination (if applicable)	Circle one Terminal Illness Severe Physical Illness Respite Care Adult Protective Services

ID/DD/RC PASRR Level II

Questions	Answers
Date of ID/DD/RC Level II Determination	
ID/DD/RC Level II Determination	Circle one No specialized services (Negative) Requires Specialized Services (Positive) Categorical Determination
ID/DD/RC Level II Categorical Determination (if applicable)	Circle one Terminal Illness Severe Physical Illness Respite Care Adult Protective Services DDD Dementia

Cognition and ADLs Self Performance Information

Questions	Answers
Cognitive Status	
1. Daily Decision Making: How well does patient make decisions about organizing the day (e.g. when to eat, choose clothes, when to go out)?	Circle one Independent Modified Independence Minimally Impaired Moderately Impaired Severely Impaired
2. Short-term Memory: Can patient recall 3 items from memory after 5 minutes?	YES / NO
3. Making Self Understood: How well does patient express or make self understood (expressing information content, however able)?	Circle one Understood Usually Understood Often Understood Sometimes Understood Rarely/Never Understood
4. ADL Self Performance (score over past 3 days)	
4a. Bed Mobility	Circle one for each Independent Set Up Supervision Limited Assistance Extensive Assistance Maximal Assistance Total Dependence Did Not Occur

4b. Transfer	Independent Set Up Supervision Limited Assistance Extensive Assistance Maximal Assistance Total Dependence Did Not Occur
4c. Locomotion (indoor/outdoor)	Independent Set Up Supervision Limited Assistance Extensive Assistance Maximal Assistance Total Dependence Did Not Occur
4d. Dressing (Upper and/or Lower Body)	Independent Set Up Supervision Limited Assistance Extensive Assistance Maximal Assistance Total Dependence Did Not Occur
4e. Eating	Independent Set Up Supervision Limited Assistance Extensive Assistance Maximal Assistance Total Dependence Did Not Occur
4f. Toileting (toilet use and/or toilet transfer)	Independent Set Up Supervision Limited Assistance Extensive Assistance Maximal Assistance Total Dependence Did Not Occur
4g. Bathing (over past 7 days)	Independent Set Up Supervision Limited Assistance Extensive Assistance Maximal Assistance Total Dependence Did Not Occur

Options Counseling Information

Patient and/or patient’s family or authorized representative(s) has been provided with information and counseling about:	Check all that apply
Long-term care supportive services including discharge to community with supportive services, referral to ADRC/AAA and placement in Nursing Facility/Sub-Acute	<input type="checkbox"/>
How to submit an application to determine financial eligibility for Medicaid benefits	<input type="checkbox"/>
Medicaid eligibility dependent upon both clinical and financial eligibility. NF Preadmission Screening (PAS) utilized to determine clinical eligibility following NF admission	<input type="checkbox"/>
Patient Choice of Setting	Check one
Nursing Facility – Long Term	<input type="checkbox"/>
Sub-Acute Nursing Facility Placement – Short Term	<input type="checkbox"/>

Sub-Acute Nursing Facility Placement – Short Term

Questions	Answers
Provider feels there is a potential for discharge of the patient to the Community in the future?	YES / NO
Patient/family expresses an interest in returning to Community?	YES / NO
Was a referral made to County ADRC/AAA?	YES / NO

Options Counseling

Date of Options Counseling	Name of Patient / Authorized Representative who received Options Counseling	Check One:
		<input type="checkbox"/> Patient <input type="checkbox"/> Authorized Representative

Attestation Information

By submitting this Hospital EARC Screening Tool, I attest that the information represented is accurate to the best of my knowledge. I have provided counseling to the individual and/or their legal representative on the need to seek Medicaid eligibility at the CWA and discussed discharge options. I also understand that if discharge occurs prior to OCCO authorization date, then the Hospital EARC is not valid.

Name of Certified Hospital EARC Screener	Certified Hospital EARC Assessor Certification No.	Hospital EARC Screener Phone Number

Discharge Location (if known):

Attestation Comments:

OCCO Determination (FOR OCCO USE ONLY)

IMPORTANT: THIS AUTHORIZATION IS NOT A GUARANTEE OF MEDICAID PAYMENT. MEDICAID PAYMENT IS CONTINGENT UPON FULL AND FINANCIAL ELIGIBILITY WITHIN 90 DAYS OF ADMISSION TO THE NF AS PER N.J.A.C. 8:85-1.8(b).

OCCO Determination	Choose one
Authorized	<input type="checkbox"/> NF <input type="checkbox"/> Vent SCNF Valid Through: <i>Valid for this Hospital Admission only.</i>
Not Authorized NF	<input type="checkbox"/> Requires on-site PAS in Hospital. OCCO Regional Office will schedule on-site PAS assessment.
Referral Dismissed	<input type="checkbox"/> PASRR Level I <input type="checkbox"/> PASRR Level II <input type="checkbox"/> RFI not responded to <input type="checkbox"/> Other
Inappropriate Referral	<input type="checkbox"/> Valid Clinical Assessment on File <input type="checkbox"/> MCO Enrolled <input type="checkbox"/> Incorrect Data <input type="checkbox"/> Other

OCCO Determination Comments:

Name of OCCO Reviewer	Signature of OCCO Reviewer	Date of Review