



**Nebraska Department of Health and Human Services  
Categorical Determinations and Exemptions (PASRR)**

Phone: (877) 431-1388 ext 3341  
Fax: (877) 431-9568

"CONFIDENTIAL"

**Please submit this form directly to DDM by fax.**

*Complete this form **only** if the individual is considered to have Serious Mental Illness, Mental Retardation, Related Condition, or a Dual Diagnosis based on Criteria identified on form DPI-OBRA 1.*

**SECTION I: PERSON COMPLETING FORM**

Name: \_\_\_\_\_ Facility: \_\_\_\_\_ Date: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**SECTION II: PATIENT INFORMATION**

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
*First Last*

**SECTION III: ADVANCED DEMENTIA**

**Supporting documentation to affirm the diagnosis must be submitted by fax.**

No	Yes
----	-----

Does the individual have a diagnosis of Serious Mental Illness or Mental Retardation or a Related Condition <b>and</b> have a diagnosis of Dementia, Alzheimer's Disease or related disorder?		
Is the diagnosis of Dementia, Alzheimer's Disease or related disorder considered the <b>primary</b> diagnosis?		
Is the individual considered to be in the advanced stages of this condition and no longer able to participate in or benefit from Mental Retardation/Developmental Disability or specialized services?		

**SECTION IV: EXEMPTED HOSPITAL DISCHARGE (EHD)**

This individual's physician certifies the following:

- Admission to a NF directly from a hospital after receiving *acute in-patient medical care* at the hospital; and
- Requires NF services for the medical condition he/she received care in the hospital; and
- The attending physician has certified prior to NF admission that the individual will require less than 30 days services.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician's Printed Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**SECTION V: TIME-LIMITED\* CATEGORICAL DETERMINATIONS** \*Please attach the appropriate validating documentation.

The following categories indicate the individual requires NF services and does not require specialized services for the time specified.

- Emergency Protective Service:** individual is admitted to a NF pending further assessment, in an emergency for a stay not anticipated to exceed 7 days.
- Respite:** admission to a NF is needed to care for individual to provide respite for in-home caregivers to whom the MI, MR/RC individual will return. Not to exceed 30 days.

**SECTION VI: OTHER CATEGORICAL DETERMINATIONS (non-limited)**

Records and/or physician's certification to affirm the above medical condition exists must be submitted with the request.

**Serious Medical:**  
Individual has a diagnosis/medical condition of: Coma, Ventilator Dependence, functioning at a brain stem level or a End-stage Medical Condition, which results in the inability to benefit from specialized services.

**The following documentation has been attached:**

- Additional supporting documentation is attached/submitted.
- Physician's certification stating less than 30 day nursing facility
- Physician's certification/Medical records indicating Serious Medical Condition

**Notes:** \_\_\_\_\_