COMMUNITY HEALTHCARE SYSTEM®
Community Healthcare Partners
Accountable Care Organization, Inc.

Community Healthcare Partners' ACO 3-Day Waiver Initiation Form

Patient Name: _____ DOB: _____
Medicare ID Number: _____
Admitting Diagnosis: _____
Admitting Provider and Contact Information: _____

Please provide the following information:

- Was beneficiary eligibility verified? Is prospectively assigned to my ACO for the performance year in which the beneficiary is admitted to the SNF affiliate. ACO will confirm upon receipt of form.
  - ☐ Yes
  - ☐ No
  - ☐ Other _____
- Is clinical documentation and need for skilled care attached?
  - ☐ Yes
  - ☐ No
  - ☐ Other _____
- Were patient education and rights on SNF 3-Day Waiver rules provided to the patient and/ or family?
  - ☐ Yes
  - ☐ No
  - ☐ Other _____
- Does the beneficiary reside in a SNF or other long-term care setting?
  - ☐ Yes
  - ☐ No
  - ☐ Other _____
- Is the beneficiary stable and not requiring an inpatient stay or further inpatient hospital evaluation or treatment?
  - ☐ Yes
  - ☐ No
  - ☐ Other _____

*The ACO Provider certifies that the patient meets the need for skilled care. The ACO Provider verifies the beneficiary meets the SNF 3-Day Wavier eligibility requirements.

ACO Affiliate/ Provider Approving and Certifying SNF 3-Day Waiver Admission:

_____ _____

Printed Name and Phone Number Signature

*I certify that the beneficiary meets the requirements to receive covered SNF services under the waiver.

SNF Affiliate Requesting Admission:

_____ _____

Printed Name and Phone Number Signature

*Please attach all supporting documentation with this request form and email to sgrayrapacz@comhs.org. All requesting questionnaires will be reviewed and responded to by the ACO on the same day. If you have any questions regarding this request, please contact the Manager of Care Navigation at 219-392-7106.

ACO Response to Admission:

- ☐ Yes
- ☐ No
- ☐ Other: _____

_____ _____

Printed Name and Phone Number Signature