DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE

Retro Eligibility Attestation Form for Long Term Care Services and Supports

This retro attestation form must be completed **(all sections are required)** and sent to D.C Economic Security Administration (ESA) by uploading into District Direct/District Direct Provider Portal or Mailed.

Section I: BENEFICIARY INFORMATION	
Name: _____	
Medicaid #: _____	Date of birth: _____
Current Medicaid Certification Period From: _____	To: _____
CURRENT INTERRAI ASSESSMENT INFORMATION	
Functional Score Without Medication Management:	
Functional Score with Medication Management:	
Current Assessment Level of Care (LOC) Effective Date From:	To:

Section II: LONG TERM CARE INSTITUTION INFORMATION	
Facility Name:	
Facility Address:	
Phone Number:	Fax Number:

Section III: SUMMARY OF BENEFICIARY's RETRO ATTESTATION NEEDS		
Retro Start Date From:	To:	
Answer the following assessment questions based on beneficiary needs during the retro period indicated above		
FUNCTIONAL NEEDS (need assistance/care)	Yes	No
Bathing	☐	☐
Dressing	☐	☐
Eating/Feeding	☐	☐
Transfer	☐	☐
Mobility	☐	☐
Medication	☐	☐
Toileting	☐	☐
SKILLED CARE NEEDS	Required	Not Required
Skilled nursing required by the beneficiary	☐	☐
Therapy required by the beneficiary	☐	☐
COGNITIVE/BEHAVIORAL NEEDS	Present	Not Present
Previously identified Serious Mental Illness/Intellectual Disability/Developmental Disability	☐	☐
Receptive and expressive communication issues	☐	☐
Behavior and Behavioral Symptoms	☐	☐

Section IV: PHYSICIAN ATTESTATION FOR APPROVAL OF RETRO ASSESSMENT		
	Met	**Unmet**
Retro Assessment Level of Care	☐	☐
Physician Name:		
I have examined this beneficiary and/or records and attest that the beneficiary retro level of care assessment is met or unmet for the above retro certification date.		
Physician Signature:	Date:	