Government of the District of Columbia
Department of Health Care Finance

Proof-of-Contact In-State Nursing Facility

SECTION A: BENEFICIARY FOR WHOM OUT-OF STATE PLACEMENT SOUGHT			
Last Name:	First:	MI:	Date of Request:

SECTION B: NURSING FACILITIES			
Facility Name 1:	Person Contacted:	Date Contacted:	Admission Approved? ❑ Yes ❑ No
Comments:			
Facility Name 2:	Person Contacted:	Date Contacted:	Admission Approved? ❑ Yes ❑ No
Comments:			
Facility Name 3:	Person Contacted:	Date Contacted:	Admission Approved? ❑ Yes ❑ No
Comments:			

Upload this form via the Qualis Health Provider Portal at www.qualishealth.org. In the Healthcare Professional Drop-Down Menu select DC Medicaid-> Provider Resources-> Qualis Health Provider Portal. You may obtain assistance in registering for the Qualis Health Provider Portal by contacting providerportalhelp@qualishealth.org