ICF/ID Special Rate Leave Of Absence

Reimbursement Request Form

Participant Name_____ MID#_____

Facility Name_____ Date of request_____

Number of days requested for L.O.A._____ Date range for LOA_____

Total number of days already taken within calendar year prior to this request _____

As per IDAPA 16.03.10 Section 620; ICF/ID: PAYMENTS FOR PERIODS OF TEMPORARY ABSENCE. Payments may be made for reserving beds in ICFs/ID for participants during their temporary absence if the facility charges private paying participants for reserve bed days, subject to the following limitations: (3-19-07)

01. Prior Approval for Absence. Therapeutic home visits for ICF/ID residents of up to thirty-six (36) days per calendar year so long as the days are part of a written treatment plan ordered by the attending physician. Prior approval from the RMS must be obtained for any home visits exceeding fourteen (14) consecutive days. (3-19-07)

Treatment plan outlining Leave(s) of Absence is signed by physician and enclosed with request? ○Yes ○No

In submitting this completed request, you agree that the reimbursed bed held during the participant's LOA will not be used for any other reimbursable circumstance; such as relocation or crisis during that time. ○Yes ○No

Requester Signature_____ Date_____

Care Manager Signature_____ Date_____

Please submit complete request form to BDDSR6CMDocs@dhw.idaho.gov