



EXCEPTIONAL CARE PROGRAM DESK OR WAIVED QUARTERLY REVIEW FACILITY ROSTER

FACILITY: _____ PROVIDER NUMBER: _____

DATE OF REVIEW: _____ DATE OF LAST REVIEW: _____

INDIVIDUALS ENROLLED IN EXCEPTIONAL CARE (Attach a labor cost analysis if minutes have increased or decreased by 15% or more)

INDIVIDUAL NAME	RIN	ADMIT DATE	15% INCREASE		15% DECREASE		INDIVIDUAL CONDITION/COMMENTS
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Printed Executive Director or Designee Name: _____ PHONE NUMBER: _____

Executive Director or Designee Signature: _____ Date: _____



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Guidelines

- 1) Facility: Record name of the SNF/Ped as it is recorded with the Illinois Secretary of State.
- 2) Provider Number: Record SNF/Ped number that is assigned by the State of Illinois.
- 3) Date of Review: Record the date of this review (i.e., new admit or quarterly).
- 4) Date of Last Review: Record date when the last quarterly review occurred.
- 5) Executive Director or Designee (Print Only): Print legible name of facility Executive Director or designee.
- 6) Phone Number: Enter current telephone number with area code for facility.
- 7) Individual Name: Record official name of individual as recorded in Medicaid system.
- 8) RIN: Record each individual's nine digit Recipient Identification Number (RIN) assigned by Medicaid.
- 9) Admit Date: Record date individual was officially admitted to the SNF/Ped noted above.
- 10) 15% Increase Yes or No box: Mark one box as applies to individual's current Exceptional Care nursing minutes.
- 11) 15% Decrease Yes or No box: Mark as applies to individual's current Exceptional Care nursing minutes.
- 12) Individual condition/comments: Record a short, concise statement about the individual's current or changing health status.
- 13) Executive Director or Designee Signature: Record signature of Executive Director or designee.
- 14) Date: Record date of signature.