



Long Term Care Reconsideration of Administrative Day (back to full rate) Request Form

Date Request Submitted	
Client Name	
Client DOB	
Facility Name	
Admission Date	
Discharge Date (if applicable)	
Start Date of Administrative Days	
Requested Start Date to Return to LTC Days (Full rate)	
The Client has sustained decompensation for at least 2 weeks and a lower level of care is not viable within the next 45 days (Note: Please attach clinical documentation that describe the decompensation or exception.)	☐ Yes. Provide a brief explanation: ☐ No (Attach a completed Long Term Care Exception Request Form)
Date of most recent psychiatric hospitalization (if occurred within the last 2 weeks of the request to return to LTC Days (Full rate))	☐ Dates: ☐ N/A
Name of Requestor	
Phone of Requestor	
Fax Number of Requestor	
Email of Requestor	