

Direct Admissions

EASY AS 1, 2, 3

Westminster Village Health & Rehab Skilled Nursing Direct Admit Program:
ERs, Physicians, Home Health, Independent and Assisted Living

Follow These Three Steps To Direct Admit:

1
CALL



Call for a Direct Admit
Virtual Evaluation:
(812) 242-5414

2
DOWNLOAD



Download a 'Direct Admit'
form at:
[WestminsterVillageIN.com/
Direct-Admit](http://WestminsterVillageIN.com/Direct-Admit)

3
FAX



Fax the completed form
documentation to:
(812) 242-5411

Key Triggers That May Require Skilled Nursing Care:

- Non-healing wound needing daily wound care
- New onset cancer with debilitating effects
- New onset fracture affecting mobility
- Status post-surgical within 30 days
- General weakness due to an underlying diagnosis (AFib, COPD, CHF)
- IV antibiotic therapy needed
- Exacerbation of COPD, Pneumonia, CHF

Skilled Nursing 3-Day Rule Waiver:

The SNF 3-Day Rule Waiver waives the requirement for a 3-day inpatient hospital stay prior to Medicare-covered SNF services for eligible beneficiaries.

Direct Admission Suggested Documentation:

- Demographics/Face Sheet
- Current Medication list
- H&P (less than 30 days old)
- Physician Order to "admit to skilled nursing for PT/OT"
- Current nurse/physician progress notes or notes from recent physician visit

Insurances Accepted:

- Anthem
- AARP
- Medicare
- UHC
- Humana
- Medicaid
- Aetna

Accommodations available for patients who are:

- COVID-free
- COVID-recovered
- COVID-positive

Patient First Name: _____ Last Name: _____

DOB: _____ SS#: _____

Insurance Provider: _____ Insurance Number: _____

1. Admit to: Skilled Nursing

2. PCP: _____

Phone: _____

3. Primary Diagnosis: _____

4. Allergies: _____

5. Activity:

Ad lib Bed rest

Bed rest with
bathroom privileges/assistance

Restrictions: _____

6. Diet/Nutrition:

Regular Soft Thickened

Diabetic Puree liquids

Low sodium NPO Tube feed

Other: _____

7. Advance Directives:

Full code

Do not resuscitate

8. Therapy:

PT

OT

ST

9. Wound Care:

Yes

No

Wound care orders attached:

Yes

No

Wound location: _____

Other instructions/dressing: _____

10. Copy of medications list attached:

Yes

No

To the care of a Westminster Village Health & Rehab:

Yes

No

11. Additional orders: _____

Physician Name (Please Print): _____	Date: _____
Physician Signature: _____	

