# Exempted Hospital Discharge (EHD) Form

## Physician Certification of Need for Nursing Facility Services

| **Applicant Information** | | |
|---|---|---|
| First Name: | Last Name: | M.I.: |
| Date of Birth: | | |
| Name of Hospital Discharging From: | | |

| **Exempted Hospital Discharge** | | |
|---|---|---|
| Exempted discharge means: | | |
| 1. The applicant is being admitted to a nursing facility after receiving acute inpatient care at the hospital; **AND** | ☐ Yes ☐ No | |
| 2. The applicant requires nursing facility care for the condition for which they received care in the hospital; **AND** | ☐ Yes ☐ No | |
| 3. The attending physician, upon signing this document has certified to the nursing facility that the applicant is likely to require **less** than thirty (30) days of nursing facility services. | ☐ Yes ☐ No | |
| **Note:** If you answered **"No"** to **any of the above** questions, the individual is **not eligible** for an Exempted Hospital Discharge according to 42 CFR 483.106(b)(2). Please continue with the Level I screen and Level II Evaluation if needed. | | |
| Attending Physician Signature: | | Date: |

Upload this **signed certification** of eligibility for Exempted Hospital Discharge into the Telligen Qualitrac system at the time of your Level I submission.