State of Illinois
Department of Healthcare and Family Services

# Nursing Facility Ventilator Notification

Completion and submission of this HFS 106 form is required to start or discontinue enhanced care rate payment to nursing facilities for ventilator services under SECTION 147.335 ENHANCED CARE RATES. This form must be fully completed, signed, dated and emailed together with all required documentation to HFS.DMP.BLTC@illinois.gov within 45 calendar days of the requested start date or within 15 days of the requested discontinue date

Facility Name: _____ Address & City: _____

Provider Number: _____ National Provider Identifier: _____

Resident Name: _____

Recipient Identification Number: _____ Birth Date: _____

Original Admit Date: _____ Date of Most Recent Admission: _____

**Start Date (begin the enhanced care rate for ventilator services):** _____

- Average hours daily on eligible ventilator services per Section 147.335: _____
- Average hours daily on weaning ventilator services per Section 147.335: _____

*The following documents must be submitted with this form before the enhanced care rate can be authorized:*

- ☐ Physician orders (POS) identifying the effective date, ventilation mode, settings and parameters.
- ☐ Vent weaning orders (including vent weaning mode, parameters & hours per day) must also be submitted.
- ☐ Signed and dated Respiratory Therapy (RT) flow sheets for a minimum of 3 to 5 days (am and pm shifts)
- ☐ RT admission assessment or most recent weekly RT assessment for the requested start date.
  per week.
- ☐ Current history and physical, along with progress notes from a pulmonologist or specialist in ventilator care.

**Discontinue Date (end the enhanced care rate for ventilator services):** _____

*NOTE: Discontinue date is always the last date on eligible ventilator services while in the facility.*

*Facility must choose one reason for discontinuing COS 038 rate below:*

☐ Weaned off ventilator, remains resident in the facility-

- Date weaning started: _____ Date weaning ended: _____
- Must include POS identifying weaning directives-POS date: _____
- Must include RT daily flow sheets (am and pm shifts) five days prior to and including last day weaning on ventilator-RT dates: _____

☐ Discharged from facility (not returning) - date: _____

☐ Died in facility - date of death: _____

☐ Other: _____

I certify that all entries on this form are accurate and meet all the requirements of the Illinois Department of Healthcare and Family Services.

_____ _____
Print RT Director Name & Email Print Name & Title of Staff Completing Form

_____ _____ _____ _____
RT Director's Signature Date Staff Signature Date

Submit by Email Print Form