Ohio Department of Medicaid

REQUEST TO PARTICIPATE IN THE ODM NURSING FACILITY VENTILATOR PROGRAM

Please complete the following information and email to: NFPolicy@medicaid.ohio.gov

Facility Name:		
City:	Zip Code:	County:
Tax Identification Number:	Medicaid Number:	
Room/Bed Numbers in Vent Unit:		

Check "Yes" or "No" if the facility can meet the following requirements:	Yes	No
Ventilators are connected to emergency outlets connected to a backup generator in an amount sufficient to meet the needs of ventilator dependent individuals	☐	☐
Respiratory care professional (RCP) is on-site at least 5 hours per week	☐	☐
Registered Nurse (RN) with 1-year experience working with ventilator dependent individuals is in the facility at least 5 hours per week	☐	☐
If ordered by a physician, initial therapy assessments can be done within 48 hours of receipt of order	☐	☐
If ordered by a physician, therapy is available for up to 2 hours per day, 6 days per week for each ventilator dependent individual	☐	☐
Stat laboratory services are available 24 hours per day, 7 days per week with results within 4 hours	☐	☐
For new admissions, pain medications can be administered within two hours from receipt of physician order	☐	☐

Complete the following section to request approval to participate in the vent weaning part of the program.

Check "Yes" or "No" if the facility can meet the following requirements:	Yes	No
A weaning protocol is in place established by a physician trained in pulmonary medicine who is available by phone 24 hours per day 7 days per week while weaning services are provided	☐	☐
A respiratory care professional (RCP) with training in basic life support is on-site 8 hours per day 7 days per week and available by phone during the remaining hours of the day while weaning services are provided	☐	☐
A registered nurse (RN) with training in basic life support is on-site 24 hours per day 7 days per week while weaning services are provided	☐	☐

Complete the following only if you are a provider who is requesting participation in the NF Ventilator Program subsequent to a change in operator (CHOP) when the previous operator was approved for participation in the NF Ventilator Program.

Check "Yes" or "No":	Yes	No
Program requirements were met as of the date of a CHOP	☐	☐
If no, please indicate the date program requirements were met		

Name of Person Completing Form:	Title:
Email Address:	Phone:
Requested Effective Date for Participation:	
Signature:	Date: