UTAH MEDICAID NURSING FACILITY
QUALITY IMPROVEMENT INCENTIVE (2)(iv) APPLICATION
Patient Life Enhancing Devices, Rule R414-504-4

This form and all supporting documentation must be emailed on or before May 31st of the incentive period.

Facility Name: _____

National Provider I.D. _____ Administrator: _____

Please mark all that are complete:

- ☐ This facility has purchased or enhanced patient life enhancing devices, which must be one or more of the following:
  - ☐ Telecommunication enhancements primarily for patient use. This may include land lines, wireless telephones, voice mail and push to talk devices. Overhead paging, if any, must be reduced.
  - ☐ Wander management systems and patient security enhancement devices (e.g. cameras, access control systems, access doors, etc.).
  - ☐ Computers and game consoles for patient use (includes TVs and personal music systems).
  - ☐ Garden enhancements (resident fruit/vegetable gardens - materials/tools for such - not landscaping/maintenance).
  - ☐ Furniture enhancements for patients (includes mattresses, bed spreads, comforters but not blankets or sheets).
  - ☐ Wheelchair washers.
  - ☐ Automatic doors.
  - ☐ Flooring enhancements.
  - ☐ Automatic Electronic Defibrillators (AED devices).
  - ☐ Energy efficient windows with a U-factor rating of 0.35 or less.
  - ☐ Exercise equipment for group fitness classes (e.g., weights, exercise balls, exercise bikes, etc.).
  - ☐ Environmental management programs (e.g. water management programs, disinfectant fogger, etc.); and
  - ☐ Fall-reduction beds.
- ☐ A detailed description of the patient life enhancing devices is attached.
- ☐ The patient life enhancing devices were purchased by May 31st, of the incentive period.
- ☐ The patient life enhancing devices were installed between July 1st, and May 31st, of the incentive period.

- ☐ Proof of purchase that includes receipts and invoices, is also attached. This includes proof of payment, i.e., cancelled check(s), financial debt instrument, etc. Check amounts must match receipt and invoice amounts. If the check does not match the receipt or invoice amount, an itemized list of invoices paid by the check must be provided with one entry matching the amount of the receipt or invoice for which the facility is seeking incentive payments.

Qualifying facilities may receive up to the amount posted on the website per Medicaid Certified bed under this incentive (count as of 7/1). This incentive is part of incentive (2). The maximum a facility may receive from all incentives in incentive (2) combined, is the amount posted on the website per Medicaid Certified bed (count as of 7/1). Facilities will not receive more than was expended under this incentive.

Attach Spreadsheet for detail expenditures.
Total Reimbursement Requested (should match spreadsheet): $_____

Please ensure that all the supporting documentation is included. Failure to include all of the above detailed information will prevent the facility from qualifying.

By submitting this application I certify that all of the above criteria have been met.
Administrator Signature: _____ Date: _____

Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify.

Email to: qii@utah.gov