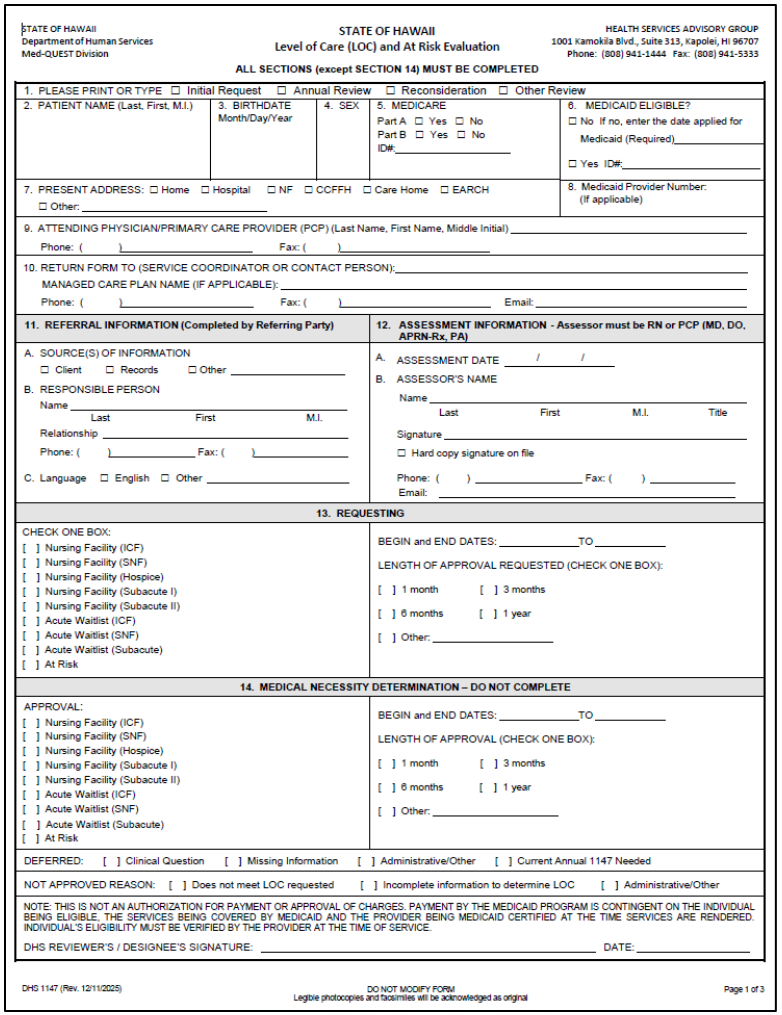
DHS Med-QUEST
Level of Care and At Risk Evaluation
1147 Form Training

Rev. 01.06.26

Types of 1147 Forms



STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

HEALTH SERVICES ADVISORY GROUP
1001 Kamokila Blvd., Suite 313, Kapolei, HI 96707
Phone: (808) 941-1444 Fax: (808) 941-5333

ALL SECTIONS (except SECTION 14) MUST BE COMPLETED

1. PLEASE PRINT OR TYPE ☐ Initial Request ☐ Annual Review ☐ Reconsideration ☐ Other Review

2. PATIENT NAME (Last, First, M.I.) | 3. BIRTHDATE Month/Day/Year | 4. SEX | 5. MEDICARE Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:_____ | 6. MEDICAID ELIGIBLE? ☐ No If no, enter the date applied for Medicaid (Required)_____ ☐ Yes ID#:_____

7. PRESENT ADDRESS: ☐ Home ☐ Hospital ☐ NF ☐ CCFFH ☐ Care Home ☐ EARCH ☐ Other: _____ | 8. Medicaid Provider Number: (If applicable)

9. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial) _____
Phone: ( )_____ Fax: ( )_____

10. RETURN FORM TO (SERVICE COORDINATOR OR CONTACT PERSON):_____
MANAGED CARE PLAN NAME (IF APPLICABLE):_____
Phone: ( )_____ Fax: ( )_____ Email:_____

11. REFERRAL INFORMATION (Completed by Referring Party)

A. SOURCE(S) OF INFORMATION
☐ Client ☐ Records ☐ Other _____

B. RESPONSIBLE PERSON
Name _____ (Last First M.I.)
Relationship _____
Phone: ( )_____ Fax: ( )_____

C. Language ☐ English ☐ Other _____

12. ASSESSMENT INFORMATION - Assessor must be RN or PCP (MD, DO, APRN-Rx, PA)

A. ASSESSMENT DATE ___/___/___

B. ASSESSOR'S NAME
Name _____ (Last First M.I. Title)
Signature _____
☐ Hard copy signature on file
Phone: ( )_____ Fax: ( )_____
Email: _____

13. REQUESTING

CHECK ONE BOX:
[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (Hospice)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)
[ ] At Risk

BEGIN and END DATES: _____TO_____

LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):
[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other: _____

14. MEDICAL NECESSITY DETERMINATION – DO NOT COMPLETE

APPROVAL:
[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (Hospice)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)
[ ] At Risk

BEGIN and END DATES: _____TO_____

LENGTH OF APPROVAL (CHECK ONE BOX):
[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other: _____

DEFERRED: [ ] Clinical Question [ ] Missing Information [ ] Administrative/Other [ ] Current Annual 1147 Needed

NOT APPROVED REASON: [ ] Does not meet LOC requested [ ] Incomplete information to determine LOC [ ] Administrative/Other

NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.

DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____

DHS 1147 (Rev. 12/11/2025) DO NOT MODIFY FORM Legible photocopies and facsimiles will be acknowledged as original Page 1 of 3

- 1147 - 3 pages (for Adults Only)
  - A comprehensive assessment of the individual
  - Initial entry into NF Level of Care (LOC) or At Risk
  - Annual Assessment
- 1147e - children, under the age of 21
- 1147a - short form for adults or children to extend or change in LOC

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1. **PATIENT NAME** (Last, First, Middle Initial)	2. **BIRTHDATE**

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):

PRIMARY: _____

_____

SECONDARY: _____

_____

II. COMATOSE ☐ No ☐ Yes If "Yes," go to **XVIII.**

III. VISION / HEARING / SPEECH:

☐ Hearing ☐ Vision ☐ Speech

[0] a. Individual has normal or minimal impairment (with / without corrective device).
[1] b. Individual has impairment (with / without corrective device).
[2] c. Individual has complete absence of hearing / vision / speech.

IV. COMMUNICATION:

[0] a. Adequately communicates needs/wants.
[1] b. Has difficulty communicating needs/wants.
[2] c. Unable to communicate needs/wants.

V. MEMORY:

[0] a. Normal or minimal impairment of memory.
[1] b. Problem with long-term or short-term memory.
[2] c. Individual has a problem with both long-term and short-term memory.

VI. MENTAL STATUS / BEHAVIOR: (Make one selection from a through c for orientation. Aggressive and/or abusive and wandering may also be checked with appropriate orientation.) *

[0] a. Oriented (mentally alert and aware of surroundings).
[1] b. Disoriented (partially or intermittently; requires supervision).
[2] c. Disoriented and/or disruptive.
[3] d. Aggressive and/or abusive. (Examples required in Section XX)
[4] e. Wanders at [ ] Day [ ] Night [ ] Both and/or [ ] in danger of self-inflicted harm or self-neglect. (Examples required in Section XX)

VII. FEEDING:

[0] a. Independent with or without an assistive device for feeding and with meal preparation.
[1] b. Needs supervision or assistance with feeding and/or meal preparation.
[2] c. Is spoon / syringe / tube fed, does not participate.

VIII. TRANSFERRING:

[0] a. Independent with or without a device.
[2] b. Transfers with minimal /stand-by help of another person, helper provides 25% or less of the work.
[3] c. Transfers with physical / moderate assistance of another person, helper provides more than 25% up to 50% of the work.
[4] d. Does not assist in transfer / requires maximum assistance / or is bedfast, helper provides more than 50% of the work.

IX. MOBILITY / AMBULATION: (Check a maximum of 2 for items b through e. If an individual is either independently mobile or unable to walk, no other selections can be made.)

[0] a. Independently mobile with or without device / self-propels wheelchair.
[1] b. Ambulates with/without device / stand-by assist / unsteady / risk for falls.
[2] c. Able to walk/be mobile with minimal assistance, helper provides 25% or less of the work.
[3] d. Able to walk/be mobile with one-person hands-on/moderate assistance, helper provides more than 25% up to 50% of the work.
[4] e. Able to walk/be mobile with more than one-person hands-on assistance, helpers provide more than 50% of the work.
[5] f. Unable to walk / immobile.

X. BOWEL FUNCTION / CONTINENCE:

[0] a. Continent or incontinent / able to independently perform bowel care.
[1] b. Continent or incontinent / requires cues / reminders to perform bowel care.
[2] c. Continent or incontinent (at least once daily) / requires help with bowel care on a regular basis.
[3] d. Continent or incontinent (more than once daily) / dependent for all bowel care.

XI. BLADDER FUNCTION / CONTINENCE:

[0] a. Continent or incontinent / able to independently perform bladder care.
[1] b. Continent or incontinent / requires cues / reminders to perform bladder care.
[2] c. Continent or incontinent (at least once daily) / requires help with bladder care on a regular basis.
[3] d. Continent or incontinent (more than once daily) / dependent for all bladder care.

XII. BATHING:

[0] a. Independent bathing.
[1] b. Unable to safely bathe without minimal assistance and supervision.
[2] c. Unable to safely bathe without moderate assistance.
[3] d. Cannot bathe without total assistance (tub, shower, whirlpool, or bed bath).

XIII. DRESSING AND PERSONAL GROOMING:

[0] a. Appropriate and independent dressing, undressing, and grooming.
[1] b. Can groom / dress self with cueing (Can dress, but unable to choose or lay out clothes).
[2] c. Physical assistance needed on a regular basis.
[3] d. Requires total help in dressing, undressing, and grooming.

ONLY complete items XIV to XVII for At Risk requests:

XIV. HOUSECLEANING

[0] a. Independent.
[2] b. Needs assistance.
[3] c. Unable to safely clean the home.

XV. SHOPPING

[0] a. Independent.
[2] b. Needs assistance.
[3] c. Unable to safely go shopping.

XVI. LAUNDRY

[0] a. Independent.
[1] b. Needs assistance.
[2] c. Unable to safely do the laundry.

XVII. MEAL PREPARATION

[0] a. Independent.
[1] b. Needs assistance.
[2] c. Unable to safely prepare a meal.

XVIII. TOTAL POINTS:

Comatose = 30 points Total Points Indicated: _____

XIX. MEDICATIONS / TREATMENTS: List all significant medications, dosage, frequency, and mode or attach medication list.

	Administers Independently	Requires Supervision/ Monitoring	Requires Admin
_____	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]

XX. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS *Include examples, frequency of occurrences, and interventions for aggressive and/or abusive behaviors, wandering, and/or self-inflicted harm or self-neglect behaviors.

_____

_____

_____

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Department of Human Services
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1. **PATIENT NAME** (Last, First, Middle Initial)	2. **BIRTHDATE**

XXI. SKILLED PROCEDURES: **D** = Daily Indicate number of times per day **L** = Less than once per day **N** = Not applicable / Never

D #	L √	N √	PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:
___	[ ]	[ ]	Tracheostomy care/suctioning in ventilator dependent person.
___	[ ]	[ ]	Tracheostomy care/suctioning in non-ventilator dependent person.
___	[ ]	[ ]	Nasopharyngeal suctioning in persons with no tracheostomy.
___	[ ]	[ ]	Total Parenteral Nutrition (TPN). Specify number of hours per day: _____
___	[ ]	[ ]	Maintenance of peripheral/central IV lines.
___	[ ]	[ ]	IV Therapy. Specify agent & frequency: _____
___	[ ]	[ ]	Decubitus ulcers (Stage III and above).
___	[ ]	[ ]	Decubitus ulcers (less than Stage III); wound care. Specify nature of ulcer/wound and care prescribed: _____
___	[ ]	[ ]	Wound care. Specify nature of wound and care prescribed: ☐ Debridement ☐ Irrigation ☐ Packing ☐ Wound Vac _____
___	[ ]	[ ]	Instillation of medications via indwelling urinary catheters. Specify agent: _____
___	[ ]	[ ]	Intermittent urinary catheterization.
___	[ ]	[ ]	IM/SQ medications. Specify agent: _____
___	[ ]	[ ]	Difficulty with administration of oral medications. Explain: _____
___	[ ]	[ ]	Swallowing difficulties and/or choking.
___	[ ]	[ ]	Stable Gastrostomy/Nasogastric/Jejunostomy tube feedings; Enteral Pump? ☐ Yes ☐ No
___	[ ]	[ ]	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration. Specify reason person at risk for aspiration: _____
___	[ ]	[ ]	Initial phase of Oxygen therapy.
___	[ ]	[ ]	Nebulizer treatment.
___	[ ]	[ ]	Complicating problems of patients on: [ ] renal dialysis [ ] chemotherapy [ ] radiation therapy [ ] with orthopedic traction Check problem(s) and describe : _____
___	[ ]	[ ]	Behavioral problems related to neurological impairment. Describe: _____
___	[ ]	[ ]	Other. Specify condition and describe nursing intervention: _____
☐ Yes	☐ No		Therapeutic Diet. Describe: _____
☐ Yes	☐ No		Restorative Therapy. Check therapy and submit/attach evaluation and treatment plan: ☐ PT ☐ OT ☐ Speech
☐ Yes	☐ No		The patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XXII. SOCIAL SITUATION:

A. Person can return home? ☐ Yes ☐ No ☐ N/A Community setting can be considered as an alternative to facility? ☐ Yes ☐ No ☐ N/A
B. If person has a home, caregiving support system is willing to provide/continue care? ☐ Yes ☐ No
Caregiver requires assistance? ☐ Yes ☐ No
Assistance required by caregiver: _____
_____
C. Caregiver Name:
Name: _____ Relationship: _____
Last First MI
Address: _____ Phone: ( ) _____ Fax ( ) _____
Email: _____

XXIII. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

_____
_____

I HAVE REVIEWED AND AGREE WITH THIS ASSESSMENT.
RN or PCP (MD, DO, APRN-Rx, PA) SIGNATURE: _____ **DATE:** ____/____/____
☐ Hard copy signature on file. This plan of care has been discussed with the RN or PCP.

RN or PCP (MD, DO, APRN-Rx, PA) Name (PRINT): _____

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1147 Forms – General Information

What is it?	1147 is the State's process to evaluate level of care.
What is the purpose?	Payment is needed from the QUEST Integration Health Plans Medicaid long term applicant
Who submits it?	Hospitals, NF, community providers, and health plans. 1147 assessment must be completed by a RN or PCP (MD, DO, APRN-Rx, PA)
What is required?	Must have Medicaid or Medicaid Pending
When is it not needed?	1147 is not needed for care home level of care or acute hospital stays

1147 Forms - Submittal Process

Hawaii Level of Care

Web Application

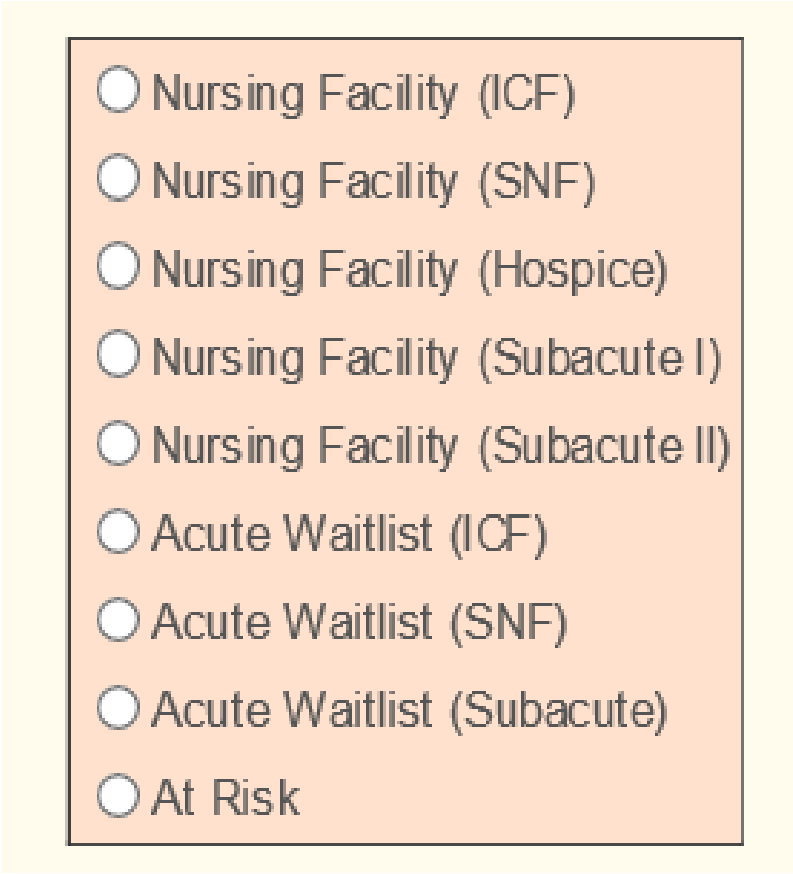
- Electronic submission of 1147 forms
- Able to track status and determination
- Must be a Medicaid provider
- Need to register for access and receive approval
- Non-HILOC users may mail or fax 1147 form

1147 Form Submittal Process

- **Assessment date:**
  - Day patient assessment was completed by a RN or PCP (MD, DO, APRN-Rx, PA)
  - Cannot be more than 60 days prior the end date of the previous 1147 approval 1147 approval
- **LOC start date:**
  - Must be on or after the assessment date (up to 60 days).
  - Cannot be before the assessment date.

1147 Form Submittal Process

Level of Care Request Types:

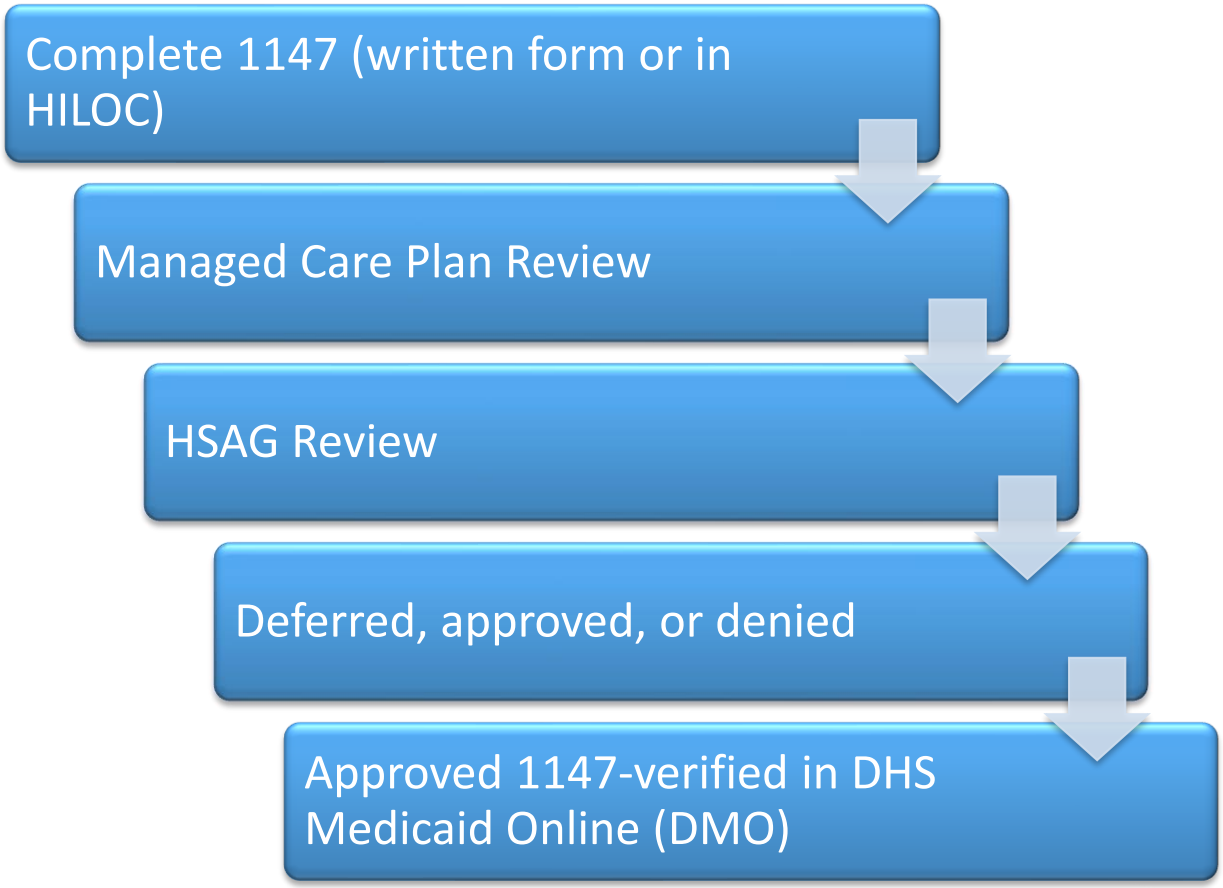


Length of approvals for end date:

- NF ICF: Up to 1 year, depending on situation
- NF SNF: 1-3 months, depending on skilled procedure
- Hospice: Up to 6 months
- NF Subacute: 1-3 months, up to 1 year depending on chronic conditions
- Acute Waitlist: Up to 1 month
- At Risk: Up to 1 year, depending on situation

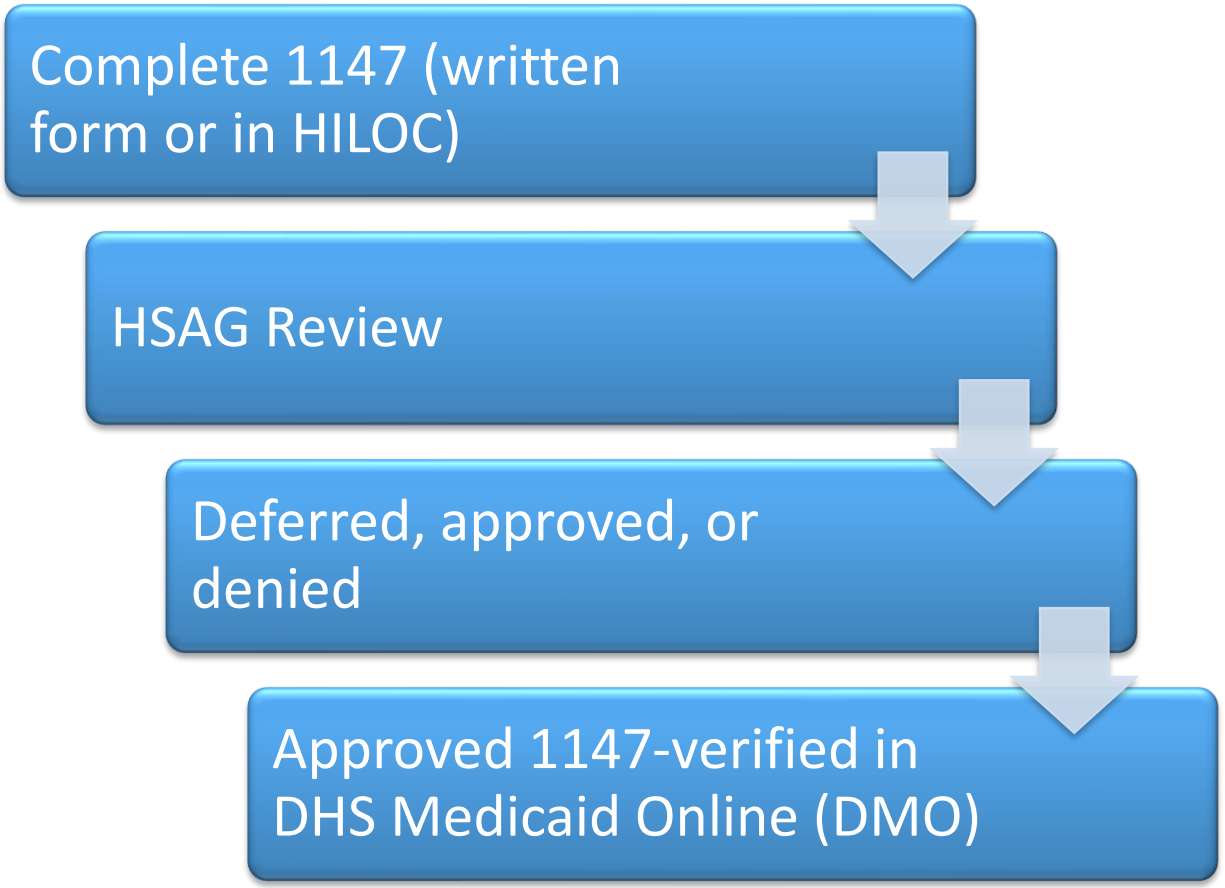
1147 Form Submittal Process

Process for Medicaid-Eligible individuals:



1147 Form Submittal Process

Process for Medicaid applicants individuals:



1147 Form Submittal Process

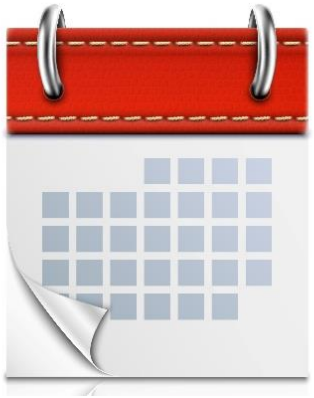
Reconsiderations:

- May ask for a reconsideration if an 1147 was not approved as meeting the level of care requested
  - Submit additional documentation to support level of care
  - Determination may not change, if this happens: Health plans communicates with provider, coordinates options, sends out denial letters, and provides appeal rights. For Medicaid applicants, the Med-QUEST Eligibility Branch sends out denial letters with appeal rights.

1147 Form Submittal Process

Retroactive Approvals:

- Twelve (12) months retroactive approvals
  - Exceptions will be given if more than 12 months
    - Medicaid eligibility issue
    - Medically necessary
    - Situation not the fault of provider and/or health plan



Level of Care Definition & Criteria

Nursing Facility Intermediate Care Facility (NF ICF)

- The patient must require intermittent skilled nursing, daily skilled nursing assessment, and 24-hour supervision for the following:

  Unstable medical condition, i.e., fragile diabetic, COPD, or renal failure; wandering posing a safety concern day and night; behavioral needs

  – Oversight by RNs and/or LPNs
  – Requires significant assistance with activities of daily living (ADL)

Level of Care Definition & Criteria

Intermittent Skilled Nursing Services are, but not limited to:

- Changing of indwelling foley catheters
- Administering IM medications three times a week, routine oral, eye gtts, and ointments
- Assistance with ADLs
- Maintenance therapies, oxygen
- General maintenance care of colostomies or ileostomies
- Changes of dressing for non-infected post – operative wounds or for chronic conditions not involving sterile/complex dressing changes
- Prophylactic and palliative skin care
- General maintenance of treating incontinence, including use of incontinent appliances (all incontinent patient are not automatically ICF. Care Home residents may have daily incontinence, but should not require attention at night or be excessively incontinent)

Level of Care Definition & Criteria

Skilled Nursing Facility (SNF):

- Daily skilled nursing or restorative therapy:
- Examples:
  - Daily IV medications or IV fluids for hydration
  - Complex wound care
  - Respiratory treatment (suctioning or nebulizer) at least 4 times per day
  - PT/OT/SP

    Able to participate in therapy at least 45 minutes per day, 5 days per week, for at least one therapy type (not combined)

    Must provide 3 goals for at least one therapy type

Refer to LOC Criteria

Level of Care Definition & Criteria

Subacute I

- Mechanical ventilation 50% or more of the time

Subacute II

Pulmonary Care:

- Mechanical ventilation less than 50% of the time
- Trach care with frequent endotracheal suctioning (every 1-2 hrs.)
- Trach, bed-bound, and receiving hemodialysis
- Trach with suctioning at least once per shift (8 hours) and the patient is morbidly obese
- Trach with suctioning at least once per shift (8 hours) and the patient requires wound care for multiple Stage II or higher wounds
- Trach care with suctioning at least once per shift (8 hours) and total skilled nursing needs are at least 4 hours per day.

Level of Care Definition & Criteria

Subacute II

Other:

- Continuous cardiac monitoring
- Patients with complex drains or tubes, including Ommaya reservoir, fecal re-implantation, Aspira chest tube, and drains requiring monitoring and draining (i.e., JP drains)
- Other patients will be approved on a case-by-case basis provided they need at least 4 hours of skilled nursing care daily

Refer to LOC Criteria

Level of Care Definition & Criteria

Acute Waitlist (AW):

- Patient is in the hospital (acute care bed) waitlisted for either discharge to home or placement in an alternative care environment (i.e., care home, foster home)
- Care can only be provided inpatient
  - **AW ICF:**

    Receiving intermittent skilled nursing, 24-hr supervision, significant assistance with ADLs
  - **AW SNF:**

    Receiving skilled nursing or skilled restorative rehabilitative therapy
  - **AW Subacute:**

    Refer to previous slide and LOC Criteria

Level of Care Definition & Criteria

At-Risk:

- Individual is in a home, shelter, or group home and has a MCP
- The individual does not meet NF ICF LOC and is at-risk of deteriorating to an institutional LOC if certain long-term services and support are not provided.

MCP: Managed care plan (QUEST Integration health plan)

Level of Care Definition & Criteria

At Risk (cont.):

- Individual may be eligible to receive home and community-based services (HCBS):
  - Home-delivered meals
  - Personal Emergency Response System (PERS)
  - Personal assistance (levels I and II)
  - Adult day care
  - Adult day health
  - Skilled nursing services
- Must document how patient would benefit from HCBS

Level of Care Definition & Criteria

Nursing Facility Hospice

- Requires **hospice election** form signed and dated by the patient or the patient's legal representative.
  - If the patient is not able to sign, please indicate the reason.
- Requires a copy of the **certification of terminal illness (COTI):**
  - Signed and dated by two physicians.
  - Stated that the patient is terminally ill and prognosis is for a life expectancy of 6 months or less.
- Must meet nursing facility ICF level of care
- Must provide the name of the Medicaid certified NF

Level of Care Criteria

State of Hawaii LOC Criteria

Criteria for LOC Decisions

The following examples of clinical indications for the different levels of care are listed; the patient's overall medical status and functional limitations should be considered when determining the appropriate level of care.

CLINICAL INDICATIONS FOR LEVEL OF CARE

TYPE	ACUTE M.D. Daily Visits	SUBACUTE* 24-hour RN Oversight Required	SNF Professional Nurse Daily Assessment RESTORATIVE CARE	ICF** Professional Nurse Daily Assessment MAINTENANCE CARE
Ostomy care	Initial teaching of ostomy care; operative admission; irrigation initiated.	Appropriate for complications and total skilled nursing care are at least 4 hours per day.	Uncomplicated ostomy care does not qualify.	Maintenance care.
IV Therapy	Adjunct therapy.	IV Therapy (continuous): Administration of therapeutic agents or hydration thru a peripheral or central line or both and total skilled nursing care are at least 4 hours per day. IV Therapy (intermittent): Administration of therapeutic agents at least once a shift (8 hours). Therapeutic agents include antibiotics, non-vesicant oncology chemotherapy, and analgesics and total skilled nursing care are at least 4 hours per day.	IV is intermittent and given for hydration to restore fluid and electrolyte balance (potassium, vitamins, etc.) IV administration of therapeutic agents, including antibiotics, non-vesicant oncology chemotherapy, and analgesics at least once a day.	Not appropriate.
Total Parenteral Nutrition (TPN)	Initial administration; adjunct therapy.	Requires at least 4 hours of skilled nursing care per day.	Intermittent or continuous.	Not appropriate.
Chemotherapy	24 hr infusion or observation.	Infusion more than 4 hours, RN supervision for 4 hours per day.	Short term infusion less than 4 hours or PO, RN supervision.	Not appropriate.
Radiation therapy	Initial treatments (daily for 1 week) in debilitated patients.	Daily treatments in patients and total skilled nursing care are at least 4 hours per day.	Daily treatments in patients requiring RN supervision.	Occasionally appropriate.

Refer to document under HILOC - Resources & Instructions and HSAG website

Level of Care Criteria

Level of care review process:

- Clinical status of the patient and the intensity and severity:
  - Diagnoses
  - Physical and cognitive impairments
  - Care needs: Ostomy care, decubitus & wound care, tube feedings, bladder catheterization, pulmonary care, rehabilitative therapy, medications, insulin, vital signs, renal dialysis, isolation, traction, etc.
- Functional status, ADL assistance, and the intensity and severity

Level of Care Criteria

Level of care review process (cont.)

- Social Situation:
  - Does the patient have a home, can return home, can community setting be considered?
  - Has a caregiver who is willing to provide/continue care?
  - What assistance does the caregiver need?
- Other: Age, placement history, behavioral needs, etc.

Level of Care Criteria

Infant/Child level of care criteria:

- Medically fragile
- Unstable medical condition
- Requires intensive skilled procedures
- Refer to LOC criteria and Kapiolani Medical Center LOC protocol

Adult Residential Care Homes (ARCH) Department of Health

Adult Residential Care Homes/Department of Health

(Not Medicaid)

- There is a difference between Medicaid NF ICF and care home level
  - 1147 is not required for care home
  - Patient does not meet NF ICF level of care
  - Generally custodial care but includes individuals with medical needs
  - Care home level does not qualify for Medicaid coverage
- Examples:
  - Needs assistance with ADLs during the day and evening, but not at night
  - Needs supervision less than 24 hours
  - Wanders during the day and evening, not at night

Adult Residential Care Homes (ARCH) Department of Health

- Examples (cont.):
  - Stable medical conditions: Diabetics on routine insulin, kidney disease, COPD, etc.
  - Stable equipment usage: CPAP, BiPAPs, ostomies, wheelchairs, oxygen, nebulizer treatments, etc.
  - Self preserving, can exit a home with minimal assistance in an event of a fire

COPD= Chronic Obstructive Pulmonary Disease
CPAP= Continuous positive airway pressure therapy
BiPAPs= Bilevel Positive Airway Pressure

Behavioral Health Parity

Behavioral health conditions are included in the 1147 assessments:

- LOC determinations are not based solely on medical or mental health diagnosis
- 1147 form assesses behaviors:
  - Mental Status/Behavior (section VI): Aggressive and/or abusive, wandering, in danger of self-inflicted harm or self-neglect
  - Behavioral problems related to neurological impairment (section XXI)

Functional Status Assessment

Functional Status Assessment Instructions & Examples

Functional Status related to Health Conditions:

Sections III – XII are scored. These sections primarily provide information about the resident's functional status as related to his/her health conditions. A critical component to assist with planning the best environment for a person with medical and/or physical disabilities is an assessment of these areas. In general, residents will meet the medical necessity criteria for long term care services with a total score of 15 or more points in these areas:

The following provides a description of each item per category.

Score	Status	Description
30	Comatose	Unable to be aroused by external stimuli.

Vision/Hearing/Speech:

Score	Status	Description
0	Has normal or minimally impaired vision/hearing/speech with or without a device.	May wear a hearing aid, glasses, or may have minimal speech impairment.
1	Needs some assistance with hearing, being able to see, and being able to speak.	Requires some help of another because of vision/hearing/speech impairment.
2	Has absence of hearing, vision, and/or speech.	Requires help of another, resident is deaf, is legally blind, and/or has complete absence of speech.

Communication:

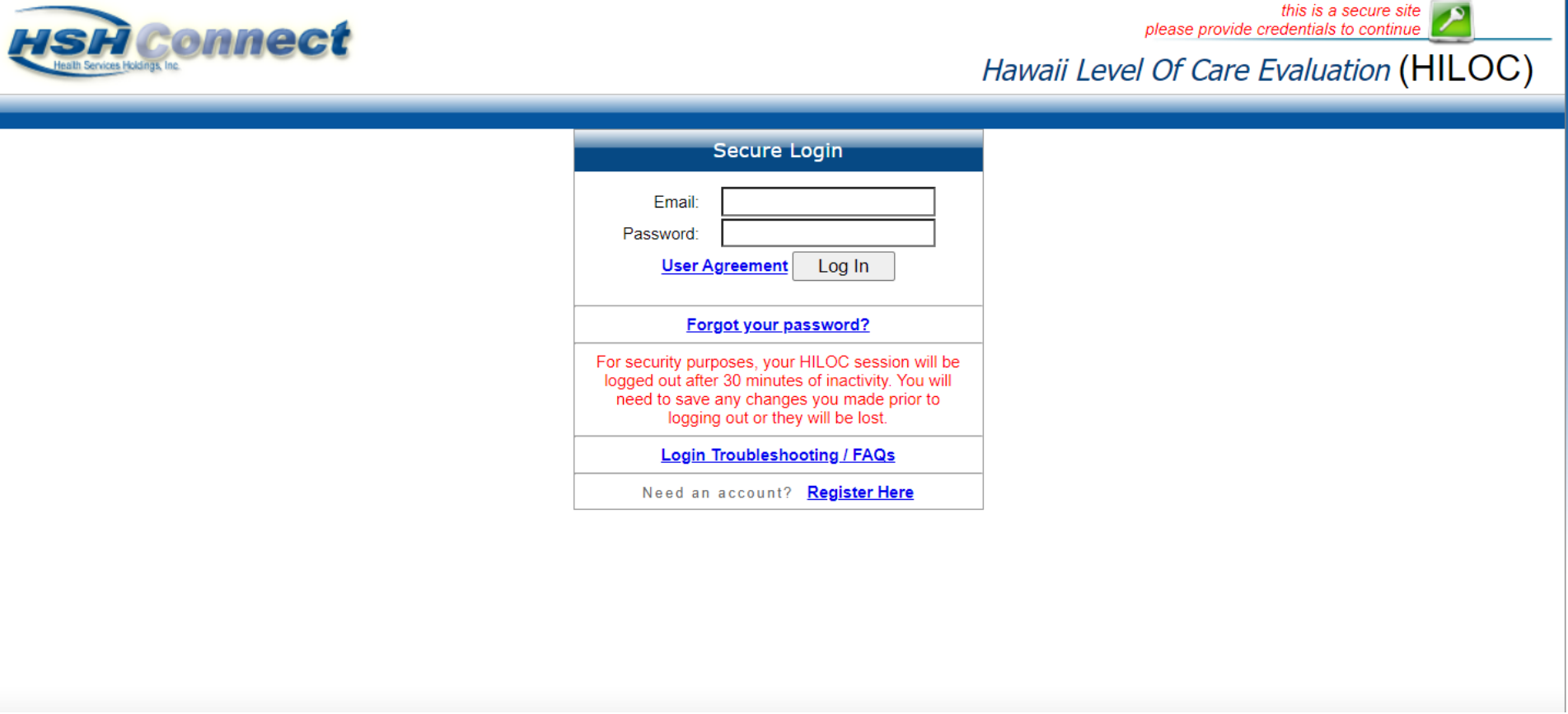
Score	Status	Description
0	Adequately communicates needs/wants with or without the assistance of communication enhancing devices or techniques (i.e. sign board; sign language).	May wear glasses or hearing aids, and/or use communication devices, but impairment does not restrict self-care of communication.
1	Needs some assistance to communicate needs/wants.	Requires some help of another because of communication impairment.
2	Requires complete assistance in areas of communication.	Unable to communicate without help of another person.

- Nine pages functional status assessment description and examples

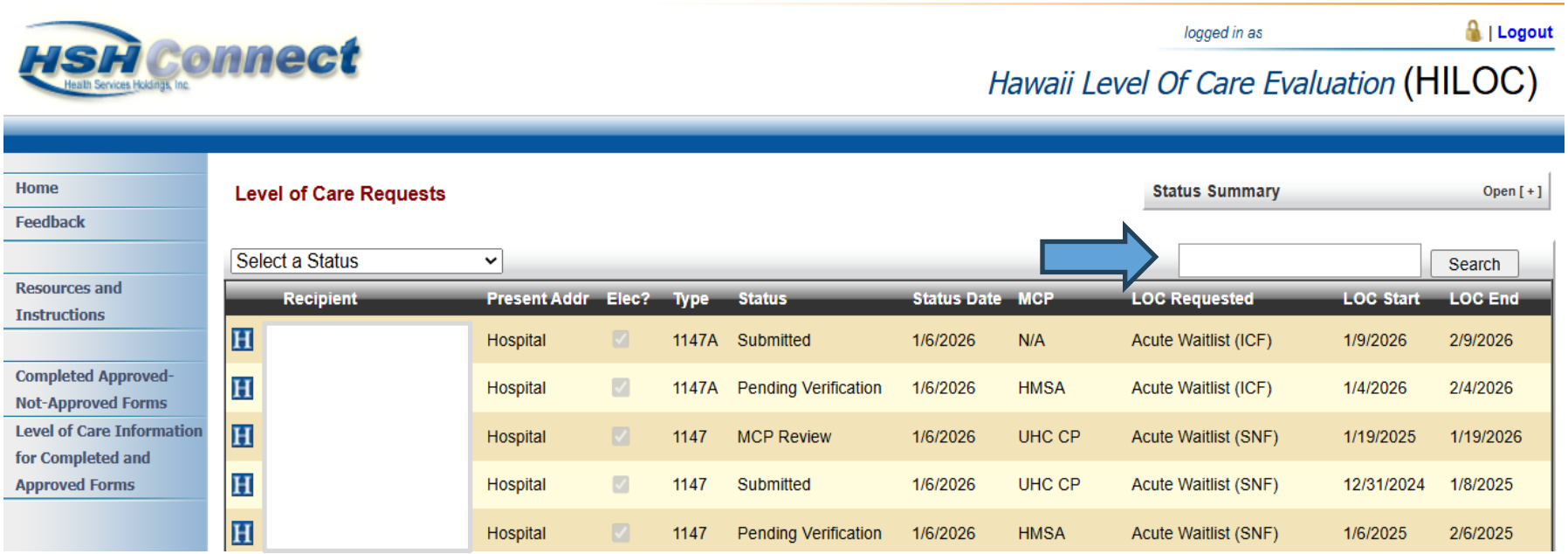
Refer to document under HILOC - Resources & Instructions and HSAG website

HILOC
Hawaii Level of Care

Web Application

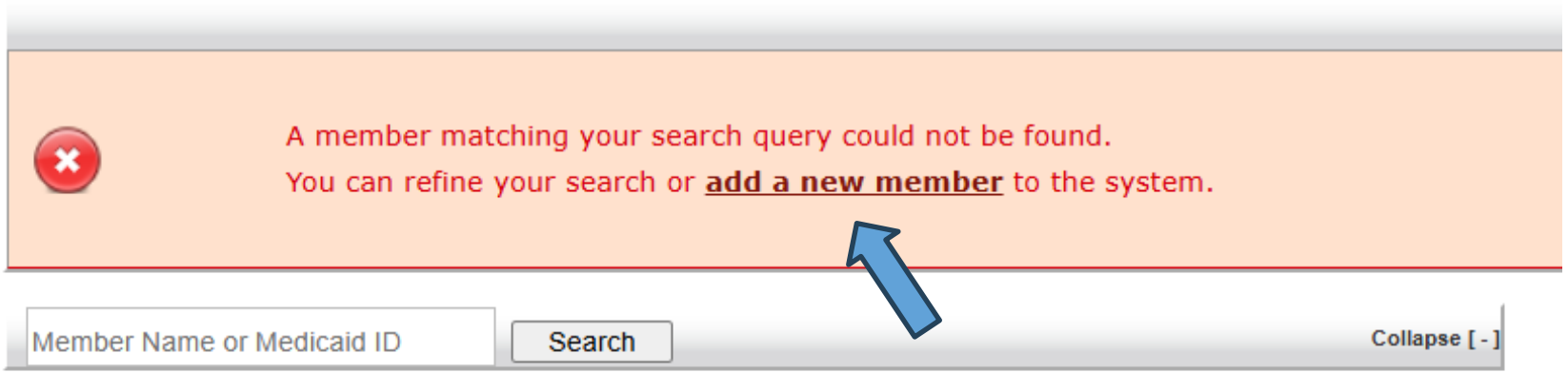


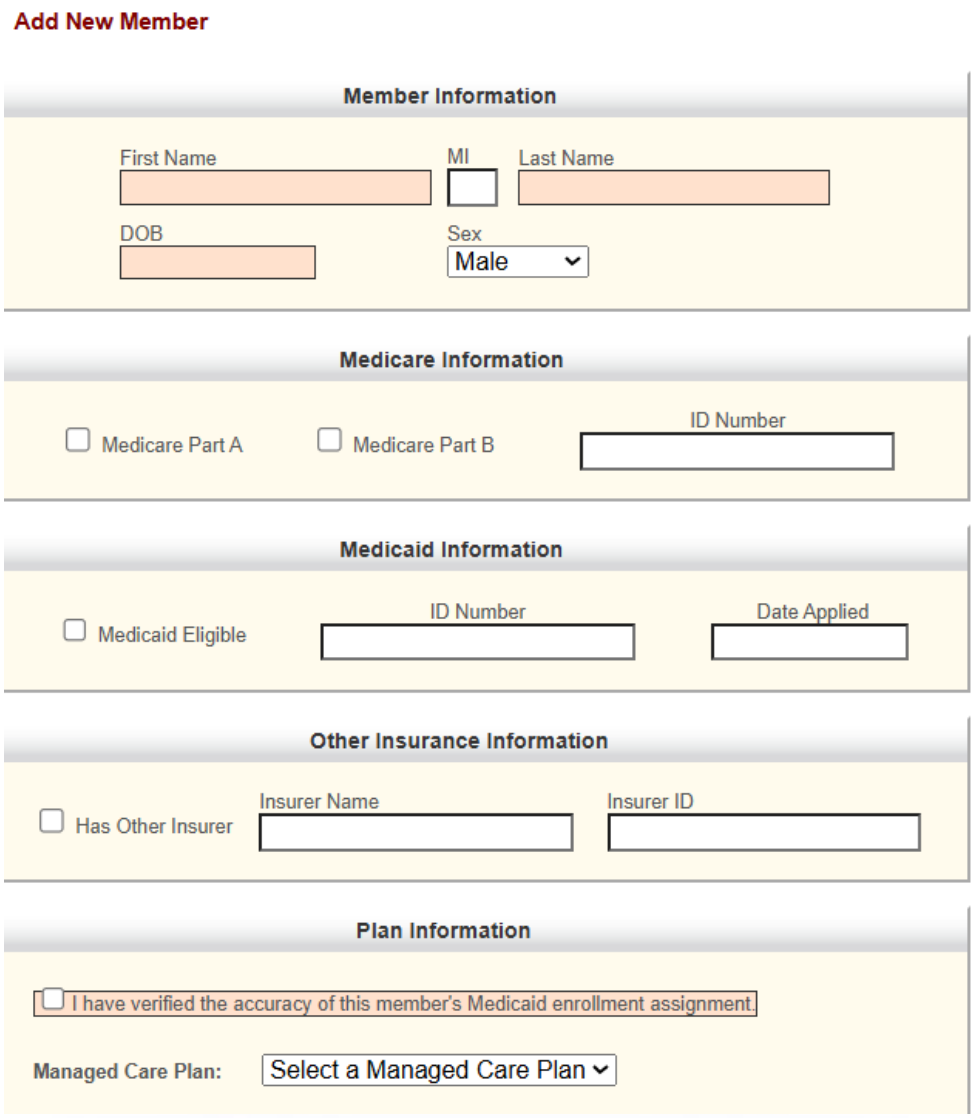
HSAG HEALTH SERVICES ADVISORY GROUP



Search member thoroughly. If searching by Medicaid ID number is not successful, please try searching by the member's last name, or even a part of the last name, before trying to enter a new member. Search partial name in case of a misspelling.

Search Results




Add New Member
Member Information
First Name
MI
Last Name
DOB
Sex
Male
Medicare Information
Medicare Part A
Medicare Part B
ID Number
Medicaid Information
Medicaid Eligible
ID Number
Date Applied
Other Insurance Information
Has Other Insurer
Insurer Name
Insurer ID
Plan Information
I have verified the accuracy of this member's Medicaid enrollment assignment.
Managed Care Plan:
Select a Managed Care Plan

Member Details

Member Name:		**Date of Birth:**		**Sex:**	
Medicaid ID:		**Date Applied:**		**Is Eligible:**	Yes
Medicare ID:		**Part A:**	Yes	**Part B:**	Yes
Other Ins. Name:		**Other Ins. ID:**			
Managed Care Plan:	UHC CP				

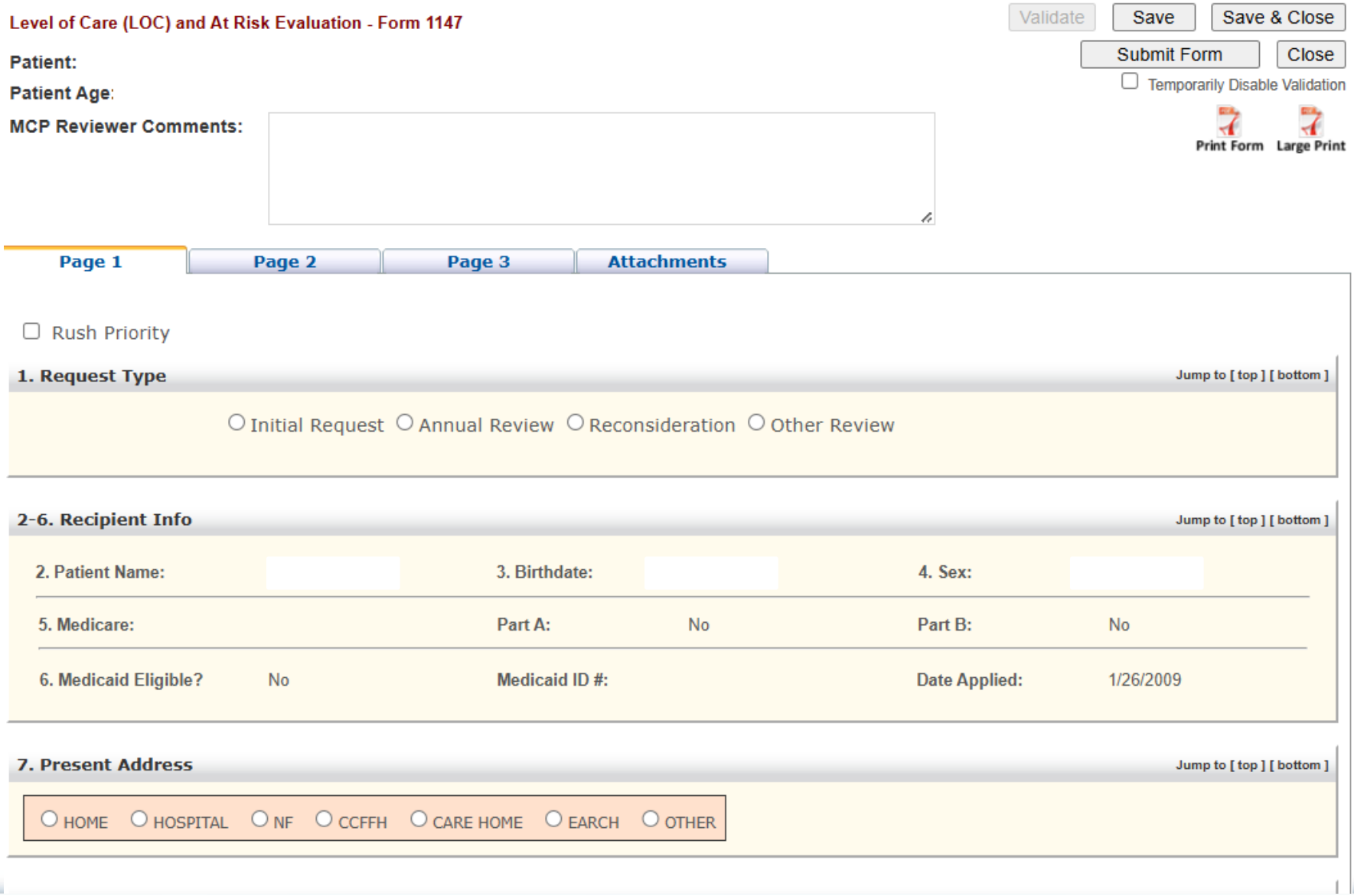
Assign Member to a Managed Care Plan

Edit

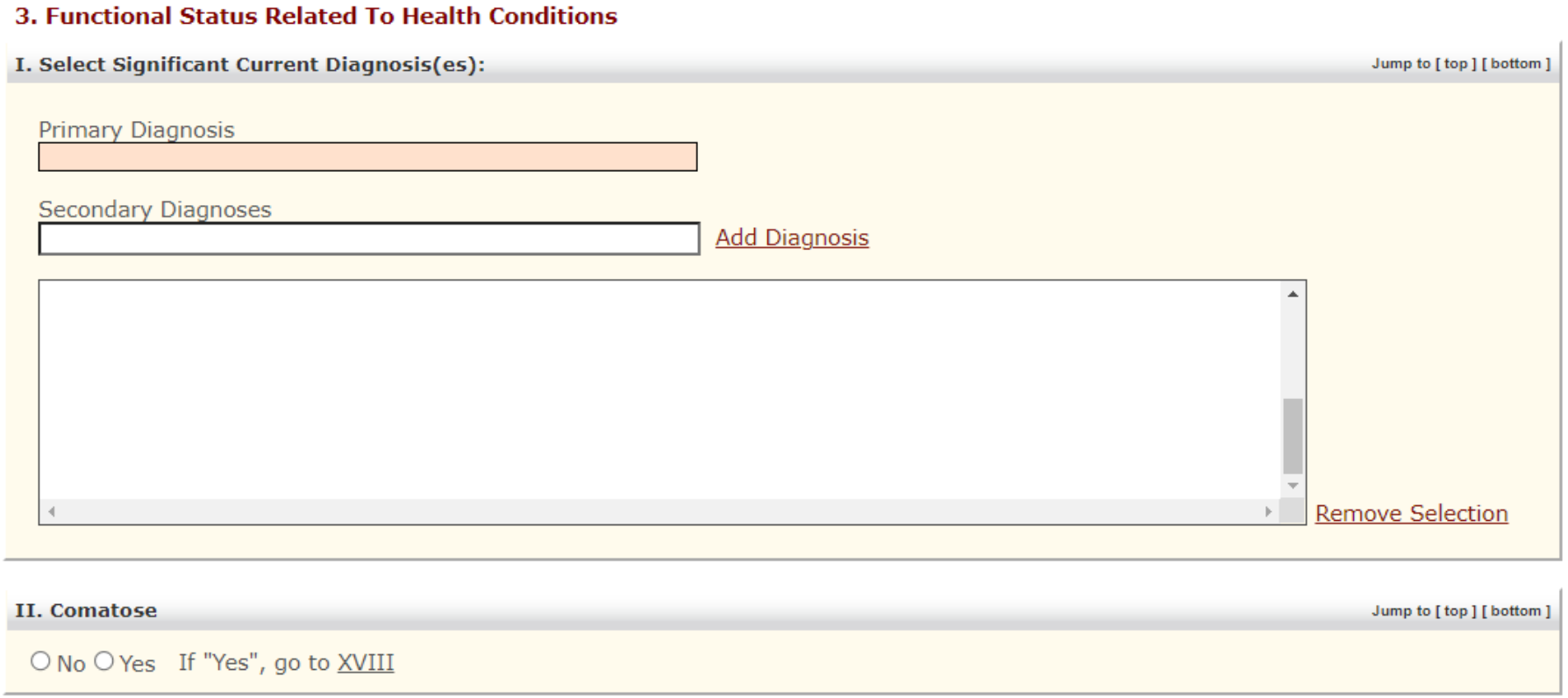
Create Evaluation Request (1147/1147e)

Create Re-Evaluation Request (1147a)

Type	Elec?	Status	Status Date	MCP	LOC Requested	LOC Start	LOC End	LOC Approved	LOC Start	LOC End	Copy
	☑	Complete	10/22/2021	N/A	Nursing Facility (ICF)	6/1/2021	6/1/2022	Nursing Facility (ICF)	6/1/2021	6/1/2022	
	☑	Complete	5/4/2022	UHC CP	Nursing Facility (ICF)	6/1/2022	6/1/2023	Nursing Facility (ICF)	6/1/2022	6/1/2023	
	☑	Submitted	5/25/2023	UHC CP	Nursing Facility (ICF)	6/1/2023	6/1/2024	NONE			


Level of Care (LOC) and At Risk Evaluation - Form 1147
Validate
Save
Save & Close
Submit Form
Close
Temporarily Disable Validation
Print Form
Large Print
Patient:
Patient Age:
MCP Reviewer Comments:
Page 1
Page 2
Page 3
Attachments
Rush Priority
1. Request Type
Jump to [top] [bottom]
Initial Request
Annual Review
Reconsideration
Other Review
2-6. Recipient Info
Jump to [top] [bottom]
2. Patient Name:
3. Birthdate:
4. Sex:
5. Medicare:
Part A:
No
Part B:
No
6. Medicaid Eligible?
No
Medicaid ID #:
Date Applied:
1/26/2009
7. Present Address
Jump to [top] [bottom]
HOME
HOSPITAL
NF
CCFFH
CARE HOME
EARCH
OTHER

1147 Form Page 2: Functional Status Related to Health Conditions



III. Vision / Hearing/ Speech

☐ Vision ☐ Hearing ☐ Speech

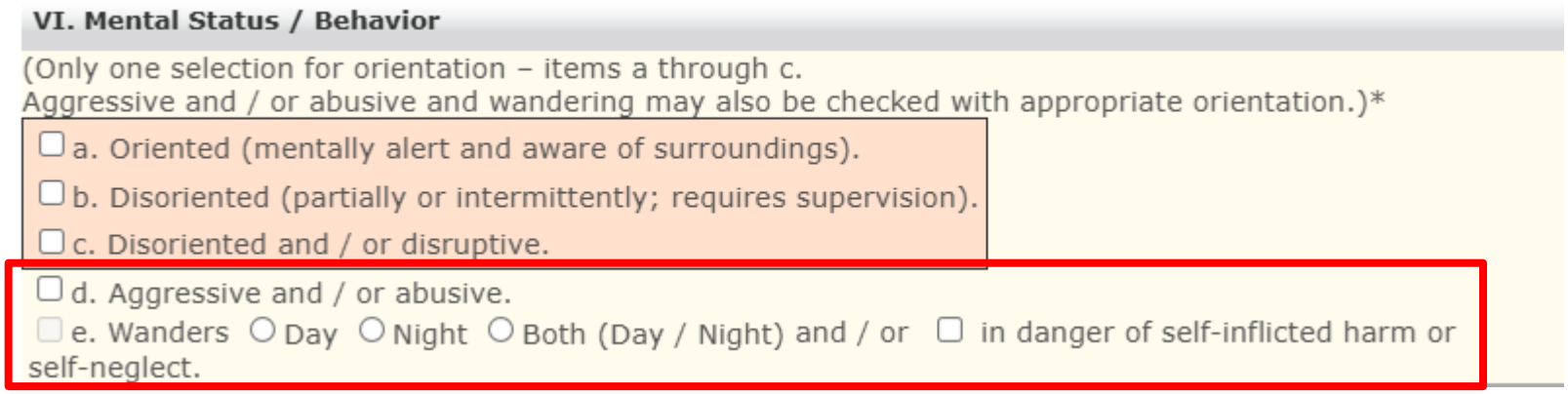
- ○ a. Individual has normal or minimal impairment (with/without corrective device)
- ○ b. Individual has impairment (with/without corrective device)
- ○ c. Individual has complete absence of hearing/vision/speech

IV. Communication

- ○ a. Adequately communicates needs/wants
- ○ b. Has difficulty communicating needs/wants
- ○ c. Unable to communicate needs/wants

V. Memory

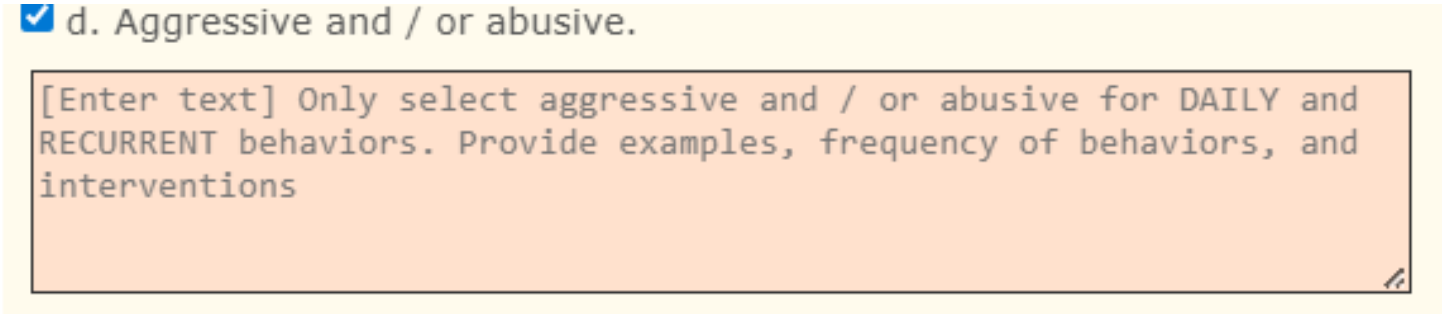
- ○ a. Normal or minimal impairment of memory
- ○ b. Problem with long-term or short-term memory.
- ○ c. Individual has a problem with both long-term and short-term memory



VI. Mental Status/Behavior

Aggressive and/or abusive

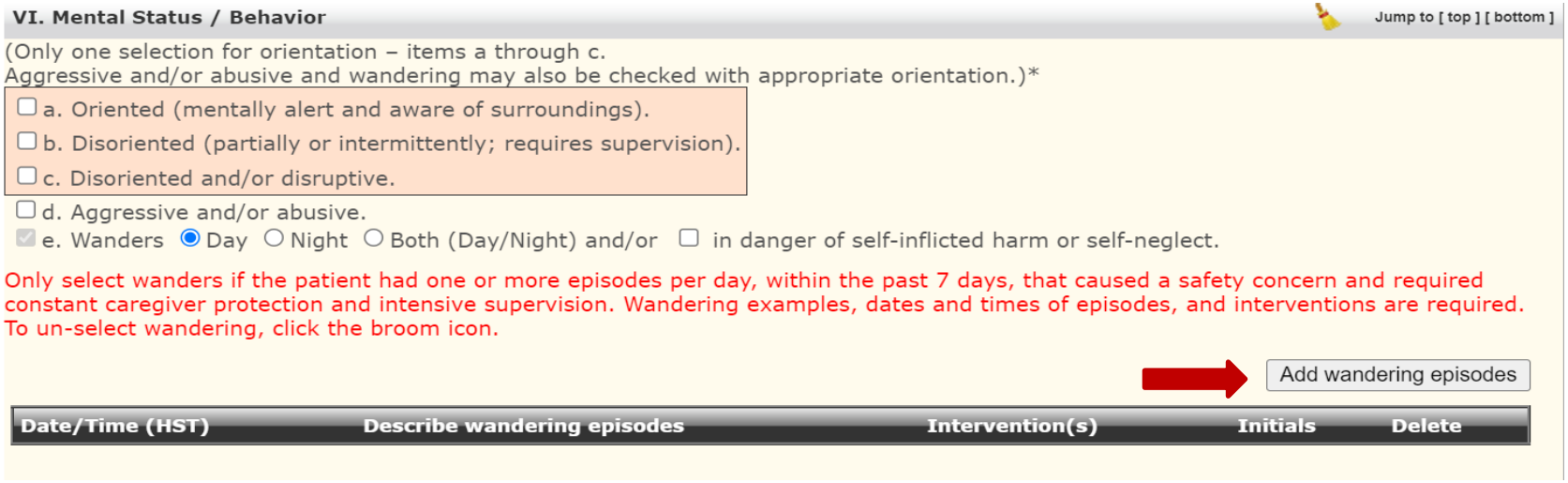
- Should be recurrent episodes (1–3 times a day), requiring intensive supervision **and** physical/mechanical/medication interventions to manage behaviors



VI. Mental Status/Behavior (continued):

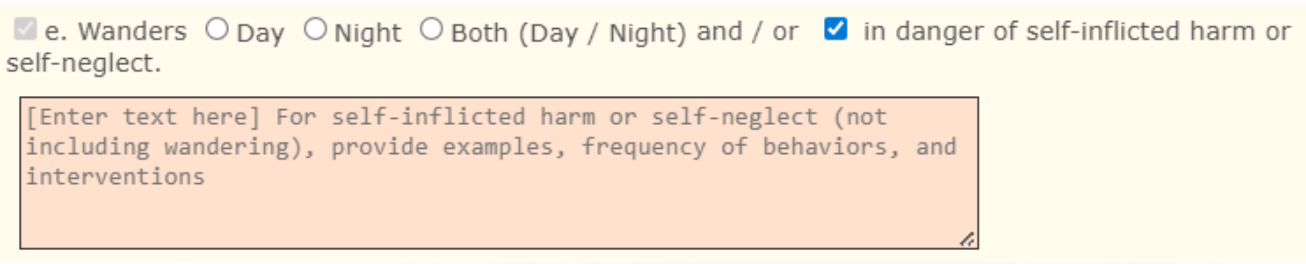
Wanders Day, Night, or Both (day and night):

- Should be occurring at least daily and causing a safety concern requiring intensive supervision. Wandering log will be required to complete in HILOC:



In danger of self-inflicted harm or self-neglect:

- Should be examples that are beyond what is already captured in the functional assessment (i.e., "not able to do ADLs" is already reflected in assessment).



VII. Feeding Jump to [top] [botto

- ○ a. Independent with or without an assistive device for feeding and with meal preparation.
- ○ b. Needs supervision or assistance with feeding and / or meal preparation.
- ○ c. Is spoon / syringe / tube fed, does not participate.

VIII. Transferring Jump to [top] [botto

- ○ a. Independent with or without a device.
- ○ b. Transfers with minimal / stand-by help of another person, helper provides 25% or less of the work.
- ○ c. Transfers with physical / moderate assistance of another person, helper provides more than 25% up to 50% of the work.
- ○ d. Does not assist in transfer / requires maximum assistance / or is bedfast, helper provides more than 50% of the work.

IX. Mobility / Ambulation Jump to [top] [botto

(Check a maximum of 2 for items b through e.
If an individual is either independently mobile or unable to walk, no other selections can be made.)

- ☐ a. Independently mobile with or without device / self-propels wheelchair.
- ☐ b. Ambulates with / without device / stand-by assist / unsteady / risk for falls.
- ☐ c. Able to walk / be mobile with minimal assistance, helper provides 25% or less of the work.
- ☐ d. Able to walk / be mobile with one-person hands-on/moderate assistance, helper provides more than 25% up to 50% of the work.
- ☐ e. Able to walk / be mobile with more than one-person hands-on assistance, helpers provide more than 50% of the work.
- ☐ f. Unable to walk / immobile.

X. Bowel Function / Continence

- ○ a. Continent or incontinent / able to independently perform bowel care.
- ○ b. Continent or incontinent / requires cues / reminders to perform bowel care.
- ○ c. Continent or incontinent (at least once daily) / requires help with bowel care on a regular basis.
- ○ d. Continent or incontinent (more than once daily) / dependent for all bowel care.

XI. Bladder Function / Continence

- ○ a. Continent or incontinent / able to independently perform bladder care.
- ○ b. Continent or incontinent / requires cues / reminders to perform bladder care.
- ○ c. Continent or incontinent (at least once daily) / requires help with bladder care on a regular basis.
- ○ d. Continent or incontinent (more than once daily) / dependent for all bladder care.

XII. Bathing

- ○ a. Independent bathing.
- ○ b. Unable to safely bathe without minimal assistance and supervision.
- ○ c. Unable to safely bathe without moderate assistance.
- ○ d. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).

XIII. Dressing and Personal Grooming

- ○ a. Appropriate and independent dressing, undressing and grooming.
- ○ b. Can groom / dress self with cueing. (Can dress, but unable to choose or lay out clothes).
- ○ c. Physical assistance needed on a regular basis.
- ○ d. Requires total help in dressing, undressing, and grooming.

Additional Questions for At-Risk

Complete questions XIV to XVII for At Risk only:

XIV. House Cleaning

- ○ a. Independent.
- ○ b. Needs Assistance.
- ○ c. Unable to safely clean the home.

XV. Shopping

- ○ a. Independent.
- ○ b. Needs Assistance.
- ○ c. Unable to safely go shopping.

XVI. Laundry

- ○ a. Independent.
- ○ b. Needs Assistance.
- ○ c. Unable to safely do the laundry.

XVII. Meal Preparation

- ○ a. Independent.
- ○ b. Needs Assistance.
- ○ c. Unable to safely prepare a meal.

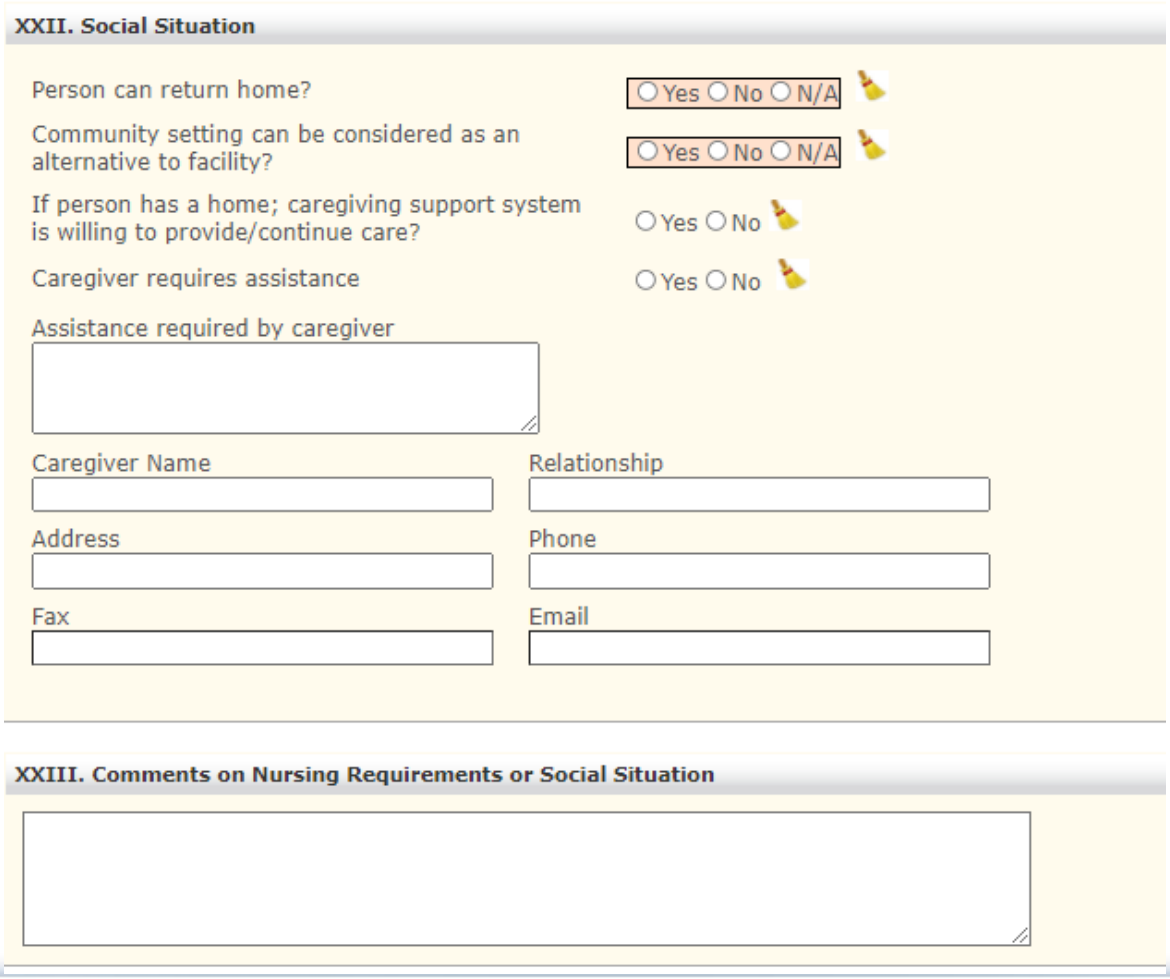
Skilled Procedures

1147 form Page 3: Skilled Procedures:

- Tracheostomy care/suctioning in ventilator or
- non-ventilator dependent person
- Nasopharyngeal suctioning in persons with no tracheostomy
- Total parenteral nutrition (TPN)
- Maintenance of peripheral/central IV lines
- IV therapy
- Decubitus ulcers
- Wound care
- Instillation of medications via indwelling urinary catheters
- Intermittent urinary catheterization
- IM/SQ medications
- Difficulty with administration of oral medications
- Swallowing difficulties and/or choking.
- Stable Gastrostomy/Nasogastric/ Jejunostomy tube feedings; enteral pump
- Initial phase of oxygen therapy
- Nebulizer treatment
- Renal dialysis, chemotherapy, radiation therapy, orthopedic traction
- Behavioral problems related to neurological impairment
- Therapeutic diet
- Restorative therapy

Social Situation

1147 Form Page 3 (cont.)- Social Situation



XXII. Social Situation

Person can return home? ○ Yes ○ No ○ N/A

Community setting can be considered as an alternative to facility? ○ Yes ○ No ○ N/A

If person has a home; caregiving support system is willing to provide/continue care? ○ Yes ○ No

Caregiver requires assistance ○ Yes ○ No

Assistance required by caregiver

Caregiver Name

Relationship

Address

Phone

Fax

Email

XXIII. Comments on Nursing Requirements or Social Situation


HSH Connect
Health Services Holdings, Inc.
Home
Feedback
Resources and Instructions
Completed Approved-Not-Approved Forms
Level of Care Information for Completed and Approved Forms
Resources and Instructions
Documents
Criteria for At Risk Population (effective 5-14).pdf
CTR-1401 Memo-1147 Mental Illness.pdf
DHS 1147 Form_Rev.06.2023.pdf
DHS 1147 Instructions_Rev.06.2023.pdf
DHS 1147A Form_Rev.06.2023.pdf
DHS 1147A Instructions_Rev.06.2023.pdf
DHS 1147E Form_Rev.06.2023.pdf
DHS 1147E Instructions_Rev.06.2023.pdf
Frequently Asked Questions.pdf
Functional Status Instructions and Examples_Rev.12.2025.pdf
Page 1 of 2 (20 items) [1] 2

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HSAG Hawaii Office: 808.941.1444
(office hours 7:45 A.M. – 4:30 P.M. HST)
HSAG Help Desk (after hours):
1.866.316.6974

DHS Med-QUEST
Kathy Ishihara, Nurse Consultant: kishihara@dhs.hawaii.gov
Phone: 808.692.8159

Managed Care Plans Contacts:
Available in HILOC Resources & Instructions and website, www.hsag.com/myhawaiieqro

Questions?

HSAG HEALTH SERVICES ADVISORY GROUP

Thank you!