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, INC.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

COMPLETE ALL SECTIONS OF THE FORM EXCEPT SECTION 14

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	6. MEDICAID ELIGIBLE?
			Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:_____	☐ Yes ID # _____ ☐ No If no, date applied for Medicaid (Required)_____

7. PRESENT ADDRESS: Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ 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 MI
Relationship _____
PHONE ( )_____ FAX ( )_____

C. Language ☐ English ☐ Other _____

12. ASSESSMENT INFORMATION (Completed by RN, Physician, PCP)

A. ASSESSMENT DATE ____/____/____

B. ASSESSOR'S NAME
Name _____
Last First MI
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: [ ] Current 1147 Version Needed [ ] Missing Information [ ] Clinical Question

NOT APPROVED:

[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] DOES NOT MEET AT RISK CRITERIA [ ] INCOMPLETE INFORMATION TO MAKE DETERMINATION

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: _____

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APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **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:
[0] a. Individual has normal or minimal impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[1] b. Individual has impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[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: (only one selection for orientation – items a through c. 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.
[1] b. Needs supervision or assistance with feeding.
[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.
[3] c. Transfers with physical / moderate assistance of another person.
[4] d. Does not assist in transfer / requires maximum assist / or is bedfast.

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.
[3] d. Able to walk/be mobile with one-person hands-on/moderate assistance.
[4] e. Able to walk/be mobile with more than one-person hands-on assistance.
[5] f. Unable to walk / immobile.

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

XI. BLADDER FUNCTION / CONTINENCE:
[0] a. Continent / able to independently perform bladder care.
[1] b. Continent with cues / requires reminders to perform bladder care.
[2] c. Incontinent (at least once daily) / requires help with bladder care on a regular basis.
[3] d. 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.

Complete questions XIV to XVII for At Risk requests only:

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) Attach additional sheet if necessary	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____

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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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 (___) _____

XXIII. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

_____
_____

I HAVE REVIEWED AND AGREE WITH THIS ASSESSMENT.
PHYSICIAN/PCP/RN SIGNATURE: _____
☐ Hard copy signature on file. This plan of care has been discussed with the MD/PCP/RN. **DATE:** ___/___/___
Physician/PCP/RN Name (PRINT): _____