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	6. MEDICAID ELIGIBLE?
			Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:_____	☐ 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: _____

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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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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: _____ (Last First MI) Relationship: _____

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): _____