INSTRUCTIONS
DHS 1147A (Rev. 12/11/2025)

LEVEL OF CARE (LOC) Re-EVALUATION

PURPOSE:

A Medicaid Provider or QUEST Integration Health Plan shall use the DHS 1147A "Level of Care (LOC) Re-Evaluation" form to extend of change the level of care of a Medicaid beneficiary. This form serves as documentation to support requests for Medicaid long-term services and supports.

SPECIFIC INSTRUCTIONS:

1. ***Patient Name***: Enter the full legal name of the patient.

2. ***Birthdate***: Self-explanatory

3. ***Sex***: Indicate whether the patient is "M" for male or "F" for female.

4. ***Medicaid I.D. Number***: Enter Medicaid I.D. number assigned by the Department of Human Services. If the I.D. number is unknown, use one of the available eligibility verification systems to find the I.D. number of the patient. If the patient has applied for Medicaid but has not yet been deemed eligible, write "pending."

5. ***Present Address:*** Indicate patient's present address, i.e., Home, Hospital, Nursing Facility (NF), Care Home, Extended Adult Residential Care Home (EARCH – Type I & Type II), Community Care Family Foster Home (CCFFH), or other.

   Home: Patient is at his or her residential home. This includes a shelter.
   Hospital: Patient is currently residing in an Acute Care Hospital. The patient is at an acute waitlisted level of care.
   Nursing Facility (NF): Patient is currently residing in a nursing facility
   Care Home: Patient is currently residing in a care home – not at nursing facility level of care.
   Extended Adult Resident Care Home (EARCH): Patient is currently residing in a Department of Health—licensed care home or a shared home arrangement under the Department of Human Services. This residential type includes patients at a care home and nursing facility level of care.
   Community Care Foster Family Home (CCFFH): Patient is currently residing in a Department of Human Services—licensed Community Care Foster Family Home. This residential type includes patients at a nursing facility level of care.
   Other: Check this box if the patient's present address is not listed among the options above. Provide a brief description of the location.
   Note: Choose this option if the individual is homeless and not residing in a shelter.

6. ***Medicaid Provider Number.***: Enter only if applicable. Patient must be pending Medicaid and currently NOT a patient in a managed care health plan.

7. ***Attending Physician/Primary Care Provider (PCP)***: Print last name, first name, and middle initial, telephone and fax number.

8. ***Return Form to***: Enter the name of the service coordinator or the contact person. Indicate the managed care plan name if applicable, telephone, fax number and email address of the person able to provide additional information about the patient.

9. ***Reasons for LOC Re-Evaluation***: Indicate whether the request is for:

    a. Change in LOC. The change in LOC should be a minor change in functional or skilled nursing status, i.e., waitlisted skilled level of care (IV therapy) to nursing facility intermediate care (discontinued IV therapy –no change in functional status).
    b. Extension of Current LOC, i.e., continues in hospital stay as acute waitlisted.
    c. At home and waitlisted for Long-Term Care Services. If a patient is waitlisted for a Long-Term Care Service and is at home, check this box.
    d. No longer meeting LOC <u>(NOT meeting an Acute, NF ICF, NF SNF, NF Hospice, NF Subacute I or II, Acute Waitlisted ICF or SNF or Subacute LOC).</u>

    <u>If "No longer meeting LOC" is selected, indicate date when the patient no longer met the LOC. Must fill out #10 "Date Span" and enter the current date span of this patient's LOC from the most current APPROVED form.</u>

10. ***Approved LOC on Most Current Form***: Enter the date span on most current approved 1147/1147a/1147e form and check the LOC.

11. ***LOC Being Requested***: Enter the begin and end dates of the request.

12. ***Current Status***: Specify current primary diagnosis(es). Check if there are additional diagnosis(es), list the most significant diagnosis first. Specify changes in functional capabilities (increases/decreases in ADLs, behavioral and cognitive functioning) and/or nursing needs.

    Document Need at Requested LOC: If the answers to "current status" are sufficient to the document the need, enter "see above." Use this space to provide additional information as to the reasons for the continuation of the requested level of care.

    RN or PCP (MD, DO, APRN-Rx, or PA) Signature: Provide signature. Electronic submittal of form(s) will be accepted with the box checked that the RN or PCP

(MD, DO, APRN-Rx, or PA) has signed a hard copy of the form(s) and that the plan of care has been discussed with the RN or PCP. The hard copy of the form(s) must be kept in the patient's file.

Date: Enter the date or the RN's or PCP's (MD, DO, APRN-Rx, or PA) signature.

RN or PCP (MD, DO, APRN-Rx, or PA) Name (Print): Print name.

13. ***Medical Necessity/Level of Care Determination***: Completed by DHS reviewer or designee. Leave Blank. DO NOT COMPLETE.

FILING/DISTRIBUTION:

Submit the DHS 1147 form electronically via the Hawaii Level of Care (HILOC) web application. For access information, contact Health Services Advisory Group (HSAG) at 808-941-1444.

You may mail or fax the completed form to:

Health Services Advisory Group
1001 Kamokila Blvd., Suite 313
Kapolei, HI 96707
Phone: (808) 941-1444
Fax: (808) 941-5333z