STATE OF HAWAII
Department of Human Services
Med-QUEST Division

# STATE OF HAWAII
## Level of Care (LOC) Re-Evaluation

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

| 1. PATIENT NAME (Last, First, M.I.) | 2. BIRTHDATE Month/Day/Year | 3. SEX | 4. MEDICAID ID NUMBER |
|---|---|---|---|
| | | | |

5. PRESENT ADDRESS: ☐ Home ☐ Hospital ☐ NF ☐ CCFFH ☐ Care Home ☐ EARCH
☐ Other _____

6. Medicaid Provider Number: (If applicable)

7. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial) _____

Phone: ( )_____ Fax: ( )_____

8. RETURN FORM TO (SERVICE COORDINATOR OR CONTACT PERSON): _____

MANAGED CARE PLAN NAME (IF APPLICABLE): _____

VIA [ ] FAX (Print Fax Number Below)
Phone: ( )_____ Fax: ( )_____ Email:_____

**9. REASON(S) FOR LOC RE-EVALUATION**

[ ] Change in LOC
[ ] Extension of current LOC
[ ] At home and waitlisted for Long Term Care Services: ☐ NF or ☐ Home and Community Based Services
[ ] No longer meeting LOC (NOT in Acute, NF ICF, NF SNF, NF Hospice, NF Subacute I or II, Acute waitlisted ICF or SNF or Subacute) as of date:_____. Fill out #10, then do not proceed.

| **10. APPROVED LOC ON MOST CURRENT FORM (Date Span) From: _____TO _____** | **11. LOC BEING REQUESTED LOC BEGIN and END DATES: _____ TO _____** |
|---|---|
| [ ] Nursing Facility (ICF) | [ ] Nursing Facility (ICF) |
| [ ] Nursing Facility (SNF) | [ ] Nursing Facility (SNF) |
| [ ] Nursing Facility (Hospice) | [ ] Nursing Facility (Hospice) |
| [ ] Nursing Facility (Subacute I) | [ ] Nursing Facility (Subacute I) |
| [ ] Nursing Facility (Subacute II) | [ ] Nursing Facility (Subacute II) |
| [ ] Acute Waitlist (ICF) | [ ] Acute Waitlist (ICF) |
| [ ] Acute Waitlist (SNF) | [ ] Acute Waitlist (SNF) |
| [ ] Acute Waitlist (Subacute) | [ ] Acute Waitlist (Subacute) |

**12. CURRENT STATUS**

Specify Current Primary Diagnosis: _____

[ ] Additional Diagnoses (list diagnoses): _____

[ ] Functional Capabilities ( ) No Change ( ) Change(s) {Specify} _____

[ ] Nursing needs ( ) No Change ( ) Change(s) {Specify} _____

DOCUMENT NEED AT REQUESTED LOC: _____

_____

**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): _____

**13. MEDICAL NECESSITY/LEVEL OF CARE DETERMINATION – DO NOT COMPLETE**

| LEVEL OF CARE APPROVAL: | LOC BEGIN AND END DATES: _____TO _____ |
|---|---|
| [ ] Nursing Facility (ICF) | LENGTH OF APPROVAL (CHECK ONE BOX): |
| [ ] Nursing Facility (SNF) | [ ] 1 month [ ] 3 months |
| [ ] Nursing Facility (Hospice) | [ ] 6 months [ ] 1 year |
| [ ] Nursing Facility (Subacute I) | [ ] Other: _____ |
| [ ] Nursing Facility (Subacute II) | |
| [ ] Acute Waitlist (ICF) | |
| [ ] Acute Waitlist (SNF) | |
| [ ] Acute Waitlist (Subacute) | |

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

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