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

CHILDREN/YOUTH Under Age 21 LEVEL OF CARE (LOC) EVALUATION

PURPOSE:

A Medicaid Provider shall use the DHS 1147E "Children/Youth Under Age 21 Level of Care" form to assess a child or youth under age 21 level of care. This form serves as documentation to support requests for Medicaid services.

SPECIFIC INSTRUCTIONS:

1. ***Check the appropriate box for the evaluation***: Check type of request – Initial, Six Months, Annual, or Other Review (i.e., 3-month review to determine continued stay).

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

3. ***Birthdate***: Self-explanatory

4. ***Sex***: Enter the patient's date of birth in MM/DD/YYYY format.

5. **Private/Other Insurance**: Check the appropriate box indicating whether patient has private or other insurance. Indicate the insurer's company name and ID number.

6. ***Medicaid Eligible***: Check "Yes" or "No" to indicate whether the patient is currently Medicaid eligible. Enter Medicaid I.D. number assigned by the Department of Human Services, if eligible.

   If the patient has applied for Medicaid but has not yet been deemed eligible, print or type in "pending" for I.D. # and print or type in date applied for Medicaid. Forms will be processed only if patient has a Medicaid number or has the date of the Medicaid application.

7. ***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 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—license 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.

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

9. ***Attending Physician/Primary Care Provider (PCP)***: Enter the name of the attending physician or primary care provider, telephone and fax number.

10. ***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.

11. ***Referral Information***: Complete all sections for an initial request. Skip this section, if this is an annual or "other" review.

    a. **Source(s) of Information**: Identify the source(s) of patient information received.

    b. **Parent/Legal Guardian/Responsible Party**: Provide the name, relationship, phone number, and fax number of the Parent/Legal Guardian/Responsible Party who will be making decisions for the patient.

    c. **Language**: Check the box of the primary language spoken by the patient. If selecting "Other," enter the language spoken. This information is used to obtain interpreters.

12. ***Assessment Information***: Complete all sections.

    A. Assessment Date: Enter the date of the most current assessment.

    B. Assessor's Name: The assessment must be performed by a registered nurse (RN) or primary care provider (PCP), which includes a medical doctor (MD), doctor of osteopathic medicine (DO), advanced practice registered nurse with prescriptive authority (APRN-Rx), or physician assistant (PA). Enter the name, title, telephone number, fax number, and email address of the assessor. The assessor must sign the form. Electronic submittal of form(s) will be accepted with the box checked that a signature of the RN or PCP (MD, DO, APRN-Rx, or PA) has signed a hard copy of this form and the hard copy of the form(s) can be found in the patient's file.

    For a concurrent request, the assessment must be conducted face-to-face (in-person).

13. ***Requesting Level of Care***: Check the appropriate box to indicate the level of care being requested. Enter the begin and end dates of the request.

    If hospice services have been elected by the patient AND the services will be provided in a nursing facility, attach the Hospice Election and Certification of Terminal Illness form signed by two different physicians. Hospice services in other settings do not require an 1147 form.

    Indicate the length of approval requested. Check one box.

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

PAGE 2 – APPLICANT/PATIENT BACKGROUND INFORMATION

1. ***Name***: Enter the full legal name of the individual.

2. ***Birthdate***: Enter the individual's date of birth in MM/DD/YYYY format.

3. ***Functional Status Related to Health Conditions***: Complete all sections.

    A. **List current significant diagnosis(es)**: List the primary and secondary diagnosis(es) or medical conditions related to the person's need for long-term care.

    B. **Medications/Treatments**: List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than five (6) significant medications, attach orders or treatment sheet. As an option to completing this section, the most current prescription listing can be attached. If using this option, please enter "attached" in this area.

    C. **Activities of Daily Living**: Check all of the areas that the individual requires assistance on a regular basis, considering developmental age. If the patient is a newborn, he/she is not expected to toilet, feed, transfer and dress him/herself. Therefore, these areas would NOT be checked. However, in the case of a 3-year-old, the developmentally appropriate child would be expected to walk, toilet and feed himself. If the child requires assistance in those areas, the appropriate boxes should be checked.

    D. **Family/Social Considerations**:

        1. **Child can return home**: Indicate whether the patient can return home. A home may include the patient's own home or a family member's home (i.e., grandparents, aunt, uncle, etc.). Check "NA" if the patient is already in a

home environment.

2. **Community Setting:** If the individual does not have a home, indicate whether the patient can be placed in a community setting. Check "NA" if the patient is already in a community setting.

3. **Caregiving support**: If the patient has a home, indicate whether the caregiving support is willing/able to provide care. If caregiver requires assistance, specify the type of assistance required.

4. **Caregiver name**. Provide the caregiver's name, relationship, address, phone number, fax number, and email address.

E. **Additional Information:** Provide any additional information, comments, or explanations regarding the child's functional assessment and nursing intervention requirements.

4. **Nursing Interventions**: Check the nursing intervention(s) that apply. Include frequency and complexity as applicable.

RN or PCP (MD, DO, APRN-Rx, or PA) Signature: Provide signature.
Electronic submittal of the 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 of 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.

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) 941-5333