STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
CHILDREN/YOUTH UNDER AGE 21
Level of Care Evaluation

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

1. PLEASE PRINT OR TYPE ☐ Initial Request ☐ Six Months ☐ Annual Review ☐ Reconsideration ☐ Other Review

2. PATIENT NAME (Last, First, M.I.)	3. BIRTHDATE Month/Day/Year	4. SEX	5. Private/Other Insurance ☐ Yes ☐ No Ins. Co.:_____ ID#: _____	6. MEDICAID ELIGIBLE? ☐ 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. PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY:
Name _____
Last First MI
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 LEVEL OF CARE

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)

BEGIN and END DATES: _____TO _____

LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):
[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other: _____

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

LEVEL OF CARE 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)

BEGIN and END DATES: : _____TO _____

LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):
[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other: _____

DEFERRED: [ ] Clinical Question [ ] Missing Information [ ] Administrative/Other [ ] Current Annual 1147E 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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1. **NAME** (Last Name, First Name, Middle Initial)

2. **BIRTHDATE**

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

A. LIST CURRENT SIGNIFICANT DIAGNOSIS(ES):

PRIMARY:

SECONDARY:

B. MEDICATION/TREATMENTS: List all significant medications, dosage, frequency, and mode or attach medication list.

C. ACTIVITIES OF DAILY LIVING: Identify assistance required due to developmental delays only.

☐ Feeding ☐ Transferring ☐ Mobility/Ambulation

☐ Toileting ☐ Bathing ☐ Grooming

D. FAMILY/SOCIAL CONSIDERATIONS:

1. Child can return home? ☐ Yes ☐ No ☐ NA
2. Community setting can be considered as an alternative to facility? ☐ Yes ☐ No ☐ NA
3. If child has a home, caregiving support system is willing to provide/continue care? ☐ Yes ☐ No
   a. Assistance required by caregiver: _____
   b. Caregiver Name: _____
   Relationship: _____
   Address: _____
   Phone: ( ) _____ Fax: ( ) _____
   Email: _____

E. Additional information concerning functional status and justification for LOC (i.e. apnea events, transitioning from tube feeds, isolette, parent teaching/training, behavior, communication, vision):

4. Nursing Intervention		**Frequency/Complexity**
☐	Ventilator	Continuous
☐		Intermittent, specify time on ventilator:
☐	Tracheostomy	
☐	Oxygen Therapy	Continuous
☐		Intermittent
☐	Nebulized Medications	TID or less
☐		> TID
☐	Vascular Access Catheter	
☐	Parenteral Nutrition	Continuous
☐		Intermittent
☐	Gastrostomy/jejunostomy/ nasogastric tube	Gravity Feedings
☐		Pump Feedings
☐	Ileostomy/Colostomy	
☐	Urinary Bladder Catheterization	Intermittent or Continuous
☐	Orthopedic Appliance	Splint/cast (each)
☐		Complex (describe):
☐	Isolation/Reverse Isolation	
☐	Enteral Medications	8 Doses/Day or Less
☐		> 8 Doses/Day
☐	IM/SQ Medications	4 Doses/Day or Less
☐		> 4 Doses/Day
☐	IV Medications	4 Doses/Day or Less
☐		> 4 Doses/Day
☐	Oral Medications	12 Doses/Day or Less
☐		> 12 Doses/Day
☐	Monitor (Apnea, Pulse Oximeter, C-R)	
☐	Special Skin Care (Burn, Decubiti)	Localized
☐		Extensive (describe):
☐	Wound Care (describe):	
☐	Restorative Therapy (PT,OT, Speech – Include Treatment Plan)	
☐	Initial discharge from hospital	
☐	Readmission for exacerbation of existing medical condition or new diagnosis	
☐	Acute episodic illness requiring physician or emergency room visits	
☐	Other specialized nurse intervention (explain):	
☐	Comatose	

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): _____