

STATE OF HAWAII
Level of Care (LOC) Evaluation

Please Type

Initial Request Annual Review Other review

1. PATIENT NAME (Last, First, M.I.)		2. BIRTHDATE Month/Day/Year	3. SEX	4. MEDICARE Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Part B <input type="checkbox"/> Yes <input type="checkbox"/> No ID#:	5. MEDICAID ELIGIBLE? <input type="checkbox"/> Yes ID # <input type="checkbox"/> No Date Applied
6. PRESENT ADDRESS (Specify Facility Name When Applicable) Present Address is <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> NF <input type="checkbox"/> Care Home <input type="checkbox"/> Other				7. PROVIDER I.D. NO.	
8. ATTENDING PHYSICIAN (Last Name, First Name, Middle Initial) Phone: (808) Fax: (808)			9. CONTACT PERSON (Last Name, First Name, AND Title) Phone: (808) Fax: (808)		
10. RETURN FORM TO: Phone: (808) Fax: (808)		<input type="checkbox"/> VIA FAX (Type Fax Number Below) <input type="checkbox"/> BY MAIL (Type Address Below) Mail:			
11. REFERRAL INFORMATION (Completed by Referring Party) A. SOURCE(S) OF INFORMATION <input type="checkbox"/> Client <input type="checkbox"/> Records <input type="checkbox"/> Other B. RESPONSIBLE PERSON'S NAME (Last, First, M.I.) Name: Relationship: Phone: (808) Fax: (808) C. Language <input type="checkbox"/> English <input type="checkbox"/> Other			12. ASSESSMENT INFORMATION (Completed by RN or Physician) A. ASSESSMENT DATE B. ASSESSOR'S NAME (Last, First, M.I.) Name: Title: Signature _____ Phone: (808) Fax: (808)		
13. REQUESTING (Check all that apply)					
Expected Placement Date: <input type="checkbox"/> Nursing Facility (NF) <input type="checkbox"/> Subacute I <input type="checkbox"/> Subacute II <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> Acute Waitlist <input type="checkbox"/> Subacute <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> Hospice - NF <input type="checkbox"/> Home & Community Based Services (HCBS) <input type="checkbox"/> NHWW <input type="checkbox"/> RACCP 1 <input type="checkbox"/> RACCP 2 <input type="checkbox"/> HCCP <input type="checkbox"/> PACE Program HCBS Option Counseling provided: <input type="checkbox"/> Yes <input type="checkbox"/> No If NO: explain: If YES, by whom: Name _____ Title: _____ Independent Living (IL) service/material provided: <input type="checkbox"/> Yes <input type="checkbox"/> No					
14. MEDICAL NECESSITY / LEVEL OF CARE ACTION - DO NOT COMPLETE					
LEVEL OF CARE APPROVAL: <input type="checkbox"/> Subacute Level I <input type="checkbox"/> Subacute Level II <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> Acute Waitlisted Subacute <input type="checkbox"/> Acute Waitlisted SNF <input type="checkbox"/> Acute Waitlisted ICF <input type="checkbox"/> Hospice - NF			EFFECTIVE DATE: _____ LENGTH OF APPROVAL: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> Other - Specify: _____ to _____		
SETTING APPROVAL: <input type="checkbox"/> Home and Community-Based Services <input type="checkbox"/> Nursing Home Without Walls (NHWW) <input type="checkbox"/> Residential Alternatives Community Care Program (RACCP) Level I _____ Level 2 _____ <input type="checkbox"/> HIV Community Care Program (HCCP) <input type="checkbox"/> PACE Program <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Hospice - NF <input type="checkbox"/> Home <input type="checkbox"/> Extended Care ARCH <input type="checkbox"/> Other _____					
Comments: _____ _____ _____					
<input type="checkbox"/> DEFERRED: <input type="checkbox"/> New 1147 Needed. <input type="checkbox"/> Other. Reason: _____					
<input type="checkbox"/> DENIED					
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 **XIV.**

III. VISION / HEARING / SPEECH:

[0] a. Individual has normal or minimal impairment (with/without corrective device) of: Hearing Vision Speech

[1] b. Individual has impairment (with/without corrective device) of:
 Hearing Vision Speech

[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. MENTALSTATUS/BEHAVIOR: (refer to instructions)

[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.

[4] e. Wanders at Day Night Both, or in danger of self-inflicted harm or self-neglect.

VII. FEEDING/MEAL PREPARATION:

[0] a. Independent with or without an assistive device.

[1] b. Feeds self but needs help with meal preparation.

[2] c. Needs supervision or assistance with feeding.

[4] d. 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.

[3] c. Transfers with supervision and physical assistance of another person.

[4] d. Does not assist in transfer or is bedfast.

XVI. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS:
 Attach additional sheet if more space is needed.

IX. MOBILITY / AMBULATION: (refer to instructions)

[0] a. Independently mobile with or without device

[1] b. Ambulates with or without device but unsteady / subject to falls.

[2] c. Able to walk/be mobile with minimal assistance

[3] d. Able to walk/be mobile with one assist.

[4] e. Able to walk/be mobile with more than one assist.

[5] f. Unable to walk.

X. BOWEL FUNCTION / CONTINENCE:

[0] a. Continent

[1] b. Continent with cues.

[2] c. Incontinent (at least once daily).

[3] d. Incontinent (more than once daily, # of times _____).

XI. BLADDER FUNCTION / CONTINENCE:

[0] a. Continent

[1] b. Continent with cues.

[2] c. Incontinent (at least once daily).

[3] d. Incontinent (more than once daily, # of times _____).

XII. BATHING:

[0] a. Independent bathing.

[1] b. Unable to safely bathe without minimal assistance and supervision.

[3] c. 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.

XIV. TOTAL POINTS:

Comatose = 30 points

Total Points Indicated: _____

XV. MEDICATIONS/TREATMENTS:

(List all Significant Medications, Dosage, Frequency, and mode)
 Attach additional sheet if necessary

	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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XVII. 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:
___	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy care/suctioning in ventilator dependent person.
___	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy care/suctioning in non-ventilator dependent person.
___	<input type="checkbox"/>	<input type="checkbox"/>	Nasopharyngeal suctioning in persons with no tracheostomy.
___	<input type="checkbox"/>	<input type="checkbox"/>	Total Parenteral Nutrition (TPN) {Specify number of hours per day.}
___	<input type="checkbox"/>	<input type="checkbox"/>	Maintenance of peripheral/central IV lines.
___	<input type="checkbox"/>	<input type="checkbox"/>	IV Therapy {Specify agent & frequency.}
___	<input type="checkbox"/>	<input type="checkbox"/>	Decubitus ulcers (Stage III and above).
___	<input type="checkbox"/>	<input type="checkbox"/>	Decubitus ulcers (less than Stage III); wound care {Specify nature of ulcer/wound and care prescribed.}
___	<input type="checkbox"/>	<input type="checkbox"/>	Instillation of medications via indwelling urinary catheters {Specify agent.}
___	<input type="checkbox"/>	<input type="checkbox"/>	Intermittent urinary catheterization.
___	<input type="checkbox"/>	<input type="checkbox"/>	IM/SQ Medications {Specify agent.}
___	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with administration of oral medications {Explain}
___	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing difficulties and/or choking.
___	<input type="checkbox"/>	<input type="checkbox"/>	Stable Gastrostomy/Nasogastric/Jejunostomy tube feedings; Enteral Pump? <input type="checkbox"/> Yes <input type="checkbox"/> No
___	<input type="checkbox"/>	<input type="checkbox"/>	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration. {Specify reason person at risk for aspiration.}
___	<input type="checkbox"/>	<input type="checkbox"/>	Initial phase of Oxygen therapy; Oxygen therapy requiring bronchodilators.
___	<input type="checkbox"/>	<input type="checkbox"/>	Complicating problems of patients on <input type="checkbox"/> renal dialysis, <input type="checkbox"/> chemotherapy, <input type="checkbox"/> radiation therapy, <input type="checkbox"/> with orthopedic traction. (Check problem(s) and describe)
___	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral problems related to neurological impairment. (Describe)
___	<input type="checkbox"/>	<input type="checkbox"/>	Other {Specify condition and describe nursing intervention.}
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Therapeutic Diet (Describe)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No Restorative Therapy (check therapy and submit/attach evaluation and treatment plan: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech

XVIII. SOCIAL SITUATION:

A. Person can return home Yes No Residential setting can be considered as an alternative to facility? Yes No

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 (PRINT Last, First, Middle Initial):

Name: _____ Relationship: _____
Address: _____ Phone: (808) _____ Fax: (808) _____

XIX. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

I HAVE REVIEWED AND AGREE WITH THE LEVEL OF CARE ASSESSMENT, ANTICIPATED PLACEMENT DATE AND REQUESTED PLACEMENT OF THE PATIENT.

PHYSICIAN'S SIGNATURE: _____ **DATE:** ____/____/____

Physician's Name (TYPE): _____