STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110 Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

Please Print or 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 ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:________	5. MEDICAID ELIGIBLE? ☐ Yes ID # ________ ☐ No Date Applied ________

6. PRESENT ADDRESS (Specify Facility Name When Applicable) Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ Other ________

7. PROVIDER I.D. NO.

8. ATTENDING PHYSICIAN (Last Name, First Name, Middle Initial)
Phone: ( )________ Fax: ( )________

9. CONTACT PERSON (Last Name, First Name, AND Title)
Phone: ( )________ Fax: ( )________

10. RETURN FORM TO: ________ [ ] VIA FAX (Print Fax Number Below) [ ] BY MAIL (Print Address Below)

Phone ( )________ Fax ( ) ________ Mail ________

11. REFERRAL INFORMATION (Completed by Referring Party)

A. SOURCE(S) OF INFORMATION
☐ Client ☐ Records ☐ Other ________

B. RESPONSIBLE PERSON
Name ________
Last First MI
Relationship ________
PHONE ( )_ FAX ( ) _____

C. Language ☐ English ☐ Other ________

12. ASSESSMENT INFORMATION (Completed by RN or Physician)

A. ASSESSMENT DATE ___/___/___

B. ASSESSOR'S NAME
Name ________
Last First MI
Title ________
Signature ________
PHONE: ( ) ________ FAX: ( ) ________

13. REQUESTING (Check all that apply)

Expected Placement Date: ________

☐ Nursing Facility (NF) ☐ Subacute I ☐ Subacute II ☐ SNF ☐ ICF ☐ Acute Waitlist ☐ Subacute ☐ SNF ☐ ICF ☐ Hospice – NF

☐ Home & Community Based Services (HCBS) ☐ NHWW ☐ RACCP 1 ☐ RACCP 2 ☐ HCCP ☐ PACE Program

HCBS Option Counseling provided: ☐ Yes ☐ No

If NO: explain: ________

If YES, by whom: Name ________ Title: ________

Independent Living (IL) service/material provided: ☐ Yes ☐ No

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

LEVEL OF CARE APPROVAL:
[ ] Subacute Level I [ ] Subacute Level II
[ ] SNF [ ] ICF
[ ] Acute Waitlisted Subacute [ ] Acute Waitlisted SNF
[ ] Acute Waitlisted ICF [ ] Hospice - NF

EFFECTIVE DATE:________

LENGTH OF APPROVAL:
[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other – Specify:________ to________

SETTING APPROVAL:
[ ] Home and Community-Based Services
☐ Nursing Home Without Walls (NHWW)
☐ Residential Alternatives Community Care Program (RACCP)
Level I ________ Level 2 ________
☐ HIV Community Care Program (HCCP)
☐ PACE Program

[ ] Nursing Facility
[ ] Hospice - NF
[ ] Home
[ ] Extended Care ARCH
[ ] Other ________

Comments: ________

[ ] DEFERRED: [ ] New 1147 Needed. [ ] Other. Reason: ________

[ ] 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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APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (Last, First, Middle Initial)	2. **BIRTHDATE**

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. MENTAL STATUS / 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.

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
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	

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

____

____

____

____

____

DO NOT MODIFY FORM
Legible photocopies and facsimiles will be acknowledged as original

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

☐ Yes ☐ No Therapeutic Diet (Describe) ______

☐ Yes ☐ No Restorative Therapy (check therapy and submit/attach evaluation and treatment plan: ☐ PT ☐ OT ☐ 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:

Name: ______ Relationship: ______
Last, First MI

Address: ______ Phone: ( ) ______ Fax ( ) ______

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 (PRINT): ______