

STATE OF HAWAII
Level of Care (LOC) Reevaluation

Please Type

1. PATIENT NAME (Last, First, M.I.)	2. MEDICAID ID NO.	3. BIRTHDATE Month/Day/Year	4. SEX	5. ADMIT DATE Month/Day/Year
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 (TYPE Last Name, First Name, M.I.) Phone (808) _____ Fax (808) _____		9. CONTACT PERSON (Last Name, First Name, AND Title) Phone (808) _____ Fax (808) _____		
10. RETURN FORM TO: _____ VIA <input type="checkbox"/> FAX (Type Fax Number Below) <input type="checkbox"/> BY MAIL (Type Address Below) Phone (808) _____ Fax (808) _____ (Mail)				

11. REASON(S) FOR LOC RE-EVALUATION (Check all that apply)

Admission/Readmission after acute hospitalization to: _____ Date: _____
 NF(name)
 Home & Community-based Services (HCBS) Program:
 Nursing Home Without Walls (NHWW) HIV Community Care Program (HCCP)
 PACE Program Other (name) _____
 Residential Alternatives Community Care Program (RACCP) (Case Management Agency)
 Transfer from NF to NF (name) _____ Date: _____
 Change in LOC
 Extension of Acute Waitlist NF status (date of initial determination) _____ (period requested) From: _____ To _____
 At home, waitlisted for NF or waitlisted for HCBS program
 In NF, and discharge options offered. Complete disposition below:
 Disposition (check all that apply):
 Returned Home Extended Care ARCH Hospice - NF Other:
 Placed in HCBS Waiver Program NHWW RACCP 1 RACCP 2 HCCP PACE
 Inappropriate for HCBS No waiver "slot" available No willing provider No willing caregiver

12. APPROVED LOC ON MOST CURRENT FORM (Date)	13. LOC BEING REQUESTED (Effective Date)
<input type="checkbox"/> Subacute Level I <input type="checkbox"/> Subacute Level II <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> Acute Waitlist Subacute <input type="checkbox"/> Acute Waitlist SNF <input type="checkbox"/> Acute Waitlist ICF <input type="checkbox"/> Hospice - NF	Anticipated time: From _____ to _____ <input type="checkbox"/> Subacute Level I <input type="checkbox"/> Subacute Level 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

14. CURRENT STATUS (Check all that apply)

No change in diagnoses (Specify Primary Diagnoses)
 Additional Diagnoses (list diagnoses)
 Functional Capabilities No Change Change(s) {Specify}
 Nursing needs No Change Change(s) {Specify}
 Change in LOC No Change Change(s) {Specify}

DOCUMENT NEED AT REQUESTED LOC:

PHYSICIAN'S SIGNATURE: _____ DATE: _____
 Physician's Name (TYPE): _____

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

APPROVED FOR: <input type="checkbox"/> Subacute I <input type="checkbox"/> Subacute II <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> Acute Waitlist Subacute <input type="checkbox"/> Acute Waitlist SNF <input type="checkbox"/> Acute Waitlist ICF <input type="checkbox"/> Hospice - NF	EFFECTIVE DATE: _____ LENGTH OF APPROVAL <input type="checkbox"/> 1 year <input type="checkbox"/> 6 months <input type="checkbox"/> Other – Specify: _____ To _____
DEFERRED: <input type="checkbox"/> New 1147 Needed. <input type="checkbox"/> Other. Reason: _____	
DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____	