

STATE OF HAWAII
Level of Care (LOC) Reevaluation

Please Print or 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 (PRINT Last Name, First Name, M.I.) 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. REASON(S) FOR LOC RE-EVALUATION (Check all that apply) | | | | |
| <input type="checkbox"/> 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: _____ <input type="checkbox"/> Transfer from NF to NF (name) _____ Date: _____ <input type="checkbox"/> Change in LOC <input type="checkbox"/> Extension of Acute Waitlist NF status (date of initial determination) _____ (period requested) From: _____ To _____ <input type="checkbox"/> At home, <input type="checkbox"/> waitlisted for NF or <input type="checkbox"/> waitlisted for HCBS program <input type="checkbox"/> In NF, and discharge options offered. Complete disposition below: <input type="checkbox"/> 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 1 <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) | | | | |
| <input type="checkbox"/> No change in diagnoses (Specify Primary Diagnoses) _____ <input type="checkbox"/> Additional Diagnoses (list diagnoses) _____ <input type="checkbox"/> Functional Capabilities () No Change () Change(s) {Specify} _____ <input type="checkbox"/> Nursing needs () No Change () Change(s) {Specify} _____ <input type="checkbox"/> Change in LOC () No Change () Change(s) {Specify} _____ DOCUMENT NEED AT REQUESTED LOC: _____ _____ _____ | | | | |
| PHYSICIAN'S SIGNATURE: _____ | | DATE: _____ | | |
| Physician's Name (PRINT): _____ | | | | |
| 15. MEDICAL NECESSITY/LEVEL OF CARE ACTION – DO NOT COMPLETE | | | | |
| APPROVED FOR: <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 | | EFFECTIVE DATE: _____ LENGTH OF APPROVAL <input type="checkbox"/> 1 year <input type="checkbox"/> 6 months <input type="checkbox"/> Other – Specify: _____ To _____ | | |
| DEFERRED: [] New 1147 Needed. [] Other. Reason: _____ | | | | |
| DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ | | DATE: _____ | | |