

STATE OF HAWAII
Children/Youth EPSDT Level of Care (LOC)
Services Request/Authorization

Please Print or Type Initial Request 6-Month Review Annual Review Other Review

1. NAME (Last, First, Middle Initial)	2. MEDICAID ID NO.	3. BIRTHDATE Month/Day/Year	4. SEX	5. OTHER INSURANCE <input type="checkbox"/> Yes Insurer _____ <input type="checkbox"/> No
6. PRESENT ADDRESS (Specify Facility Name When Applicable) Address is <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> NF <input type="checkbox"/> Foster Home <input type="checkbox"/> Other _____				7. PROVIDER I.D. NO.
8. ATTENDING PHYSICIAN (PRINT Last, First, M.I.)	9. PROVIDER NO.	10. CONTACT PERSON (Last Name, First Name, AND Title)/DATE		

11. RETURN FORM TO: _____ VIA FAX (Print Fax Number Below) BY MAIL (Print Address Below)
Phone () _____ Fax () _____ (Mail) _____

12. REFERRAL INFORMATION (Completed by Referring Party) A. SOURCE(S) OF INFORMATION <input type="checkbox"/> CLIENT <input type="checkbox"/> RECORDS <input type="checkbox"/> OTHER _____ B. <input type="checkbox"/> PARENT/LEGAL GUARDIAN Name _____ Last First MI Relationship _____ Phone () _____ Fax () _____ C. Language <input type="checkbox"/> English <input type="checkbox"/> Other _____	13. ASSESSMENT INFORMATION (Completed by RN or Physician) A. LAST ASSESSMENT DATE ____/____/____ B. ASSESSOR'S NAME Name _____ Last First MI Title: _____ Signature: _____ Phone: () _____ Fax: () _____
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14. REQUESTING (Check all that apply)

Initial Level of Care Determination (LOC) Re-eval LOC Provider: _____ TO/FROM: _____

Nursing Facility (NF) (complete page 2) Provider: _____ TO/FROM: _____

Hospice in NF (complete page 2 and attach hospice election form) Provider: _____ TO/FROM: _____

EPSDT Case Management (complete pages 2, 3). Attach service plan ONLY if service plan is new or has changed. Code: T1016-_____. Agency: _____ TO/FROM: _____

Skilled Nursing (complete pages 2, 3). Agency(ies): _____ Hrs/Mo _____ TO/FROM: _____

Home and Community-Based Services (HCBS) (complete pages 2, 3)
 Medically Fragile Community Care (MFCC) Nursing Home without Walls (NHWW) HIV Community Care (HCC)
 HCBS Option Counseling provided: Yes No
 If NO: explain: _____
 If YES, by whom: Name _____ Title: _____

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

LEVEL OF CARE APPROVAL:
 Acute Waitlist Subacute I Subacute II SNF ICF Hospice

16. SERVICE AUTHORIZATION					
SERVICE	HOURS	CODE	PROVIDER NAME	PROVIDER #	EFFECTIVE DATES (TO/FROM)
<input type="checkbox"/> Facility					
<input type="checkbox"/> EPSDT Case Mgmt		T1016			
<input type="checkbox"/> EPSDT Skilled Nursing		T1030			
<input type="checkbox"/> EPSDT Skilled Nursing		T1030			
<input type="checkbox"/> EPSDT Personal Care		T1021			

DEFERRED: New form 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: _____

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. NAME (PRINT Last Name, First Name, Middle Initial)		2. BIRTHDATE			
3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS		4. Nursing Intervention		Frequency/Complexity	Points
A. LIST CURRENT SIGNIFICANT DIAGNOSIS(ES): PRIMARY: _____ _____ _____ ACTIVE: _____ _____ _____ _____ B. MEDICATIONS/TREATMENTS: List all Significant Medications, Dosage and Frequency (As an option, attach treatment sheet with same information)		<input type="checkbox"/> Ventilator <input type="checkbox"/> <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Oxygen therapy <input type="checkbox"/> <input type="checkbox"/> Nebulized Medications <input type="checkbox"/> <input type="checkbox"/> Vascular access catheter <input type="checkbox"/> Parenteral nutrition <input type="checkbox"/> <input type="checkbox"/> Gastrostomy/jejunostomy nasogastric tube <input type="checkbox"/> <input type="checkbox"/> Ileostomy/colostomy <input type="checkbox"/> Urinary bladder catheterization <input type="checkbox"/> Orthopedic appliance <input type="checkbox"/> <input type="checkbox"/> Isolation/reverse isolation <input type="checkbox"/> Enteral Medications <input type="checkbox"/> <input type="checkbox"/> IM/SQ medications <input type="checkbox"/> <input type="checkbox"/> IV medications <input type="checkbox"/> <input type="checkbox"/> Oral medications <input type="checkbox"/> <input type="checkbox"/> Monitor (Apnea, Pulse Oximeter, C-R) <input type="checkbox"/> Special Skin Care (Burn, decubiti) <input type="checkbox"/> <input type="checkbox"/> Wound Care (describe) <input type="checkbox"/> Restorative therapy (PT, OT, Speech) <input type="checkbox"/> Initial Discharge from hospital <input type="checkbox"/> Readmission for exacerbation of existing medical condition or new diagnosis <input type="checkbox"/> Acute, episodic illness requiring physician or emergency room visits <input type="checkbox"/> Other specialized nurse interventions (explain on page 3) <input type="checkbox"/> Comatose (Rancho Los Amigos Scale of I. No Response or II. Generalized Response.		Continuous Intermittent Intermittent Continuous Intermittent TID or less >TID Continuous Intermittent Gravity feedings Pump feedings Intermittent or continuous Splint/cast Complex (describe) 8 doses/day or less >8 doses/day 4 doses/day or less >4 doses/day 4 doses/day or less >4 doses/day Less than 12 doses/day 12 or more doses/day Localized Extensive (describe) 50 40 20 _____ 30	50 30 30 20 10 10 20 40 40 30 20 30 10 10 5 10 30 05 10 15 15 20 2 5 20 5 10 10 5 50 40 20 _____ 30
C. ACTIVITIES OF DAILY LIVING: Identify only assistance required due to developmental delays: <input type="checkbox"/> Feeding <input type="checkbox"/> Transferring <input type="checkbox"/> Mobility/Ambulation <input type="checkbox"/> Toileting <input type="checkbox"/> Bathing <input type="checkbox"/> Dressing/Grooming Provide comments or explanation on page 3.					
D. NON-VENT/NON-TRACH CASE MANAGEMENT: <input type="checkbox"/> Yes <input type="checkbox"/> No Provide comments or explanation on Page 3.					
E. CARE PLAN <input type="checkbox"/> No Changes <input type="checkbox"/> Changes (plan attached)					
				Total Nursing Points	

