

STATE OF HAWAII
CHILDREN/YOUTH UNDER AGE 21
Level of Care Evaluation

1. PLEASE PRINT OR TYPE <input type="checkbox"/> Initial Request <input type="checkbox"/> Six Months <input type="checkbox"/> Annual Review <input type="checkbox"/> Other review					
2. PATIENT NAME (Last, First, M.I.)		3. BIRTHDATE Month/Day/Year	4. SEX	5. Private/Other Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No Ins. Co.: _____ ID#: _____	6. MEDICAID ELIGIBLE? <input type="checkbox"/> Yes ID # _____ <input type="checkbox"/> No Date Applied _____
7. 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"/> EARCH <input type="checkbox"/> CCFFH <input type="checkbox"/> Other: _____				8. Medicaid Provider Number: (If applicable)	
9. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial) Phone: () _____ Fax: () _____					
10. RETURN FORM TO (SERVICE COORDINATOR/CONTACT PERSON): _____ MANAGED CARE PLAN NAME (IF APPLICABLE): _____ [] VIA FAX (Print Fax Number Below) Phone () _____ Fax () _____ Email () _____					
11. REFERRAL INFORMATION (Completed by Referring Party)			12. ASSESSMENT INFORMATION (Completed by RN, Physician, PCP)		
A. SOURCE(S) OF INFORMATION <input type="checkbox"/> Client <input type="checkbox"/> Records <input type="checkbox"/> Other _____			A. ASSESSMENT DATE ____/____/____		
B. PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY: Name _____ Last First MI			B. ASSESSOR'S NAME Name _____ Last First MI		
Relationship _____			Title _____ Signature _____		
PHONE () _____ FAX () _____			<input type="checkbox"/> Hard copy signature on file.		
C. Language <input type="checkbox"/> English <input type="checkbox"/> Other _____			PHONE: () _____ FAX: () _____		
			EMAIL: () _____		
13. REQUESTING LEVEL OF CARE					
CHECK ONE BOX: [] Nursing Facility (ICF) [] Nursing Facility (SNF) [] Nursing Facility (HOSPICE) [] Nursing Facility (Subacute I) [] Nursing Facility (Subacute II) [] Acute Waitlist (ICF) [] Acute Waitlist (SNF) [] Acute Waitlist (Subacute)			LEVEL OF CARE BEGIN and END DATES: _____ TO _____ LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX): [] 1 month [] 3 months [] 6 months [] Other: _____		
14. MEDICAL NECESSITY / LEVEL OF CARE DETERMINATION – DO NOT COMPLETE					
LEVEL OF CARE APPROVAL: [] Nursing Facility (ICF) [] Nursing Facility (SNF) [] Nursing Facility (HOSPICE) [] Nursing Facility (Subacute I) [] Nursing Facility (Subacute II) [] Acute Waitlist (ICF) [] Acute Waitlist (SNF) [] Acute Waitlist (Subacute)			LEVEL OF CARE BEGIN and END DATES: _____ TO _____ LENGTH OF APPROVAL (CHECK ONE BOX): [] 1 month [] 3 months [] 6 months [] Other: _____		
Comments: _____					
DEFERRED: [] Current 1147e Version Needed [] Missing Information					
[] DOES NOT MEET LEVEL OF CARE REQUESTED [] INCOMPLETE INFORMATION TO DETERMINE LEVEL OF CARE					
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: _____					

1. NAME (PRINT Last Name, First Name, Middle Initial)		2. BIRTHDATE	
3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS		4. Nursing Intervention	
A. LIST CURRENT SIGNIFICANT DIAGNOSIS(ES):		Frequency/Complexity	
PRIMARY:		<input type="checkbox"/> Ventilator	Continuous
		<input type="checkbox"/>	Intermittent, specify time on ventilator:
		<input type="checkbox"/> Tracheostomy	
		<input type="checkbox"/> Oxygen therapy	Continuous
		<input type="checkbox"/>	Intermittent
SECONDARY:		<input type="checkbox"/> Nebulized Medications	TID or less
		<input type="checkbox"/>	>TID
		<input type="checkbox"/> Vascular access catheter	
		<input type="checkbox"/> Parenteral nutrition	Continuous
B. MEDICATION/TREATMENTS (Attach additional sheet if necessary) List all Significant Medications, Dosage and Frequency		<input type="checkbox"/>	Intermittent
1.		<input type="checkbox"/> Gastrostomy/jejunostomy/nasogastric tube	Gravity feedings
2.		<input type="checkbox"/>	Pump feedings
3.		<input type="checkbox"/> Ileostomy/colostomy	
4.		<input type="checkbox"/> Urinary bladder catheterization	Intermittent or continuous
5.		<input type="checkbox"/> Orthopedic appliance	Splint/cast (each)
6.		<input type="checkbox"/>	Complex (describe)
C. ACTIVITIES OF DAILY LIVING: Identify only assistance required due to developmental delays:		<input type="checkbox"/> Isolation/reverse isolation	
<input type="checkbox"/> Feeding <input type="checkbox"/> Transferring <input type="checkbox"/> Mobility/Ambulation		<input type="checkbox"/> Enteral Medications	8 doses/day or less
<input type="checkbox"/> Toileting <input type="checkbox"/> Bathing <input type="checkbox"/> Dressing/Grooming		<input type="checkbox"/>	>8 doses/day
		<input type="checkbox"/> IM/SQ medications	4 doses/day or less
D. FAMILY/SOCIAL CONSIDERATIONS		<input type="checkbox"/>	>4 doses/day
1. Child can return home <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		<input type="checkbox"/> IV medications	4 doses/day or less
2. Community setting can be considered as an alternative to facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		<input type="checkbox"/>	>4 doses/day
3. If child has a home, caregiving support system is willing to provide/continue care? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Oral medications	Less than 12 doses/day
a. Assistance required by Caregiver: _____		<input type="checkbox"/>	12 or more doses/day
b. Caregiver Name/relationship: _____/_____		<input type="checkbox"/> Monitor (Apnea, Pulse Oximeter, C-R)	
Address: _____ Phone: _____		<input type="checkbox"/> Special Skin Care (Burn, decubiti)	Localized
Fax: _____ Email address: _____		<input type="checkbox"/>	Extensive (describe)
E. Additional information concerning functional status and justification for LOC, i.e. apnea events, transitioning from tube feeds, isolette, parent teaching/training, behavior, communication, vision etc:		<input type="checkbox"/> Wound Care (describe):	
_____		<input type="checkbox"/> Restorative therapy (PT, OT, Speech – include treatment plan)	
_____		<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):	
_____		<input type="checkbox"/> Comatose	
I HAVE REVIEWED AND AGREE WITH THE LEVEL OF CARE ASSESSMENT.			
Physician's/PCP Signature: _____		Physician's/PCP Name (Print): _____	
<input type="checkbox"/> Hard copy signature on file. This plan of care has been discussed with the MD/PCP.		Date: _____	