

**INSTRUCTIONS FOR  
DHS FORM 1147 & FILL IN FORM 1147  
LEVEL OF CARE (LOC) EVALUATION**

**General Instructions for the fill in form:** Navigate through the form by tabbing or clicking on the boxes or shaded areas, shift + tab to move backward. To fill in the check box, utilize the space bar, enter key or use the mouse to expose the hand/pointer and right click on the box. Enter the dates in mm/dd/yyyy, example: 07/01/2005.

**Top of Form:** Check the appropriate box for the evaluation – initial request for placement into either a nursing home or community-based program; annual review; or other review such as a review requested by the State’s contractor for evaluating and determining level of care.

1. **Patient Name:** Self-explanatory
2. **Birthdate:** Self-explanatory
3. **Sex:** Self-explanatory
4. **Medicare:** Check the appropriate box indicating whether client has Medicare Part A and B and enter client’s Medicare I.D. number, if eligible for either Part A or B.
5. **Medicaid Eligible?:** Check “Yes” or “No” to indicate whether the client is currently Medicaid eligible. Enter Medicaid I.D. number assigned by the Department of Human Services, if eligible. If the patient has applied for Medicaid but has not yet been deemed eligible, print or type in “pending” for I.D.# and print or type in date applied.
6. **Present Address/Facility:** Identify facility name if patient is residing in a facility. If patient is at home, enter street address, city and zip code. Check appropriate box that best represents the patient’s “home.”
7. **Provider I.D. No.:** Enter the Medicaid Provider I.D. number.
8. **Attending Physician:** Enter the name of the attending physician, telephone and fax number.
9. **Contact Person:** Enter the name, telephone and fax numbers of the person able to provide additional information about the patient.
10. **Return Form:** Indicate how the form should be returned (i.e., fax or mail) and the contact person or facility name. The form will NOT be mailed or faxed back with a cover sheet so information must be accurate.

11. **Referral Information:** Complete all sections for an initial request. Skip this section, if this is an annual or “other” review.
- A. **Source(s) of Information:** Identify the source(s) of patient information received.
  - B. **Responsible Person:** Provide the name, relationship, phone and fax numbers of the family member/personal agent who will be making decisions for the patient.
  - C. **Language:** Check the box of the primary language spoken by the patient. If checking “Other,” indicate the language spoken. Information is used to obtain interpreters.
12. **Assessment Information:** Complete all sections.
- A. **Assessment Date:** Indicate the date of the most current assessment.
  - B. **Assessor’s Name, Title, Signature, Phone and Fax Numbers:** A registered nurse (RN) or physician must perform the assessment. Enter the name, title and telephone and fax numbers of the assessor. The assessor must sign the form.
13. **Requesting:** Enter expected placement date or effective date of the annual renewal into the facility or community program. Check all services that are being requested. If hospice services have been elected by the patient AND the services will be provided in a nursing facility, attach the hospice election and physician verification form. Hospice services in other settings do not require an 1147 form.

Applications for any Medicaid Home and Community-Based Services (HCBS) can be made at the same time as submittal of this form.

Indicate whether counseling on the HCBS option was provided and by whom. If counseling was not provided, provide brief explanation.

Independent Living (IL) services are available to provide information, referral for services, peer counseling and advocacy for the patient. Contact Hawaii Centers for Independent Living (HCIL) at (808) 522-5400 for brochures and other information that can be offered to the patient.

14. **Medical Necessity/Level of Care Action:** Completed by DHS or Designee. Leave Blank. DO NOT COMPLETE.

## PAGE 2 AND 3– APPLICANT/CLIENT BACKGROUND INFORMATION

1. **Name:** Self-explanatory
2. **Birthdate:** Self-explanatory
3. **Functional Status Related to Health Conditions:** Complete all sections.
  - A. **List significant current diagnosis(es):** List the main diagnosis(es) or medical conditions related to the person’s need for long-term care.
  - B. **Comatose:** If patient is comatose, check “Yes” box and go directly to Section XIV. If patient is not comatose, check “No” and complete rest of section.
  - C. **Sections III. Vision/Hearing/Speech through XIII Dressing and Personal Grooming:** Select the description that best describes the patient’s functioning.

Note: Make only one selection in all sections except VI. Mental Status/Behavior and IX. Mobility/Ambulation. For Mental Status/Behavior, make only one selection for orientation (items a through c). Aggressive and/or abusive and wandering may also be checked with the appropriate orientation. For Mobility/Ambulation, check a maximum of 2 for items b through e. If an individual is either mobile or unable to walk, no other selections can be made.
  - D. **Section XIV. Total Points:** Add the points from each section to obtain total. Comatose patients are assigned 30 points.
  - E. **Section XV. Medications/Treatments:** List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than significant medications than available lines, attach orders or treatment sheet.
  - F. **Section XVI. Additional Information Concerning Patient’s Functional Status:** Use the space to provide additional information on the patient’s functional status. This section may be used to identify the extent of the assistance (minimal, with assistance or total) that is required. Attach a separate sheet if more space is required.
4. **Section XVII. Skilled Procedures:** Check the particular skilled procedure(s) that the patient requires. If the care is daily (D), indicate the number of times per day

that care is required. If care is less than once per day check “L”. If the care is not applicable, check “N”.

5. **Section XVIII. Social Situation:**

- A. **Person can return home:** Identify whether the patient can return home. The home can be a family member’s (daughter, son, brother, sister, parents, etc.) home as well as the patient’s own home. If the person does not have a home, indicate whether the patient can be placed in a residential setting such as an Extended ARCH, assisted living facility or RACCP home.
- B. **Caregiving support:** If the patient has a home, identify whether the caregiving support is willing/able to provide care. If caregiver requires assistance, identify the assistance required.
- C. **Caregiver name.** Provide the caregiver’s name, relationship, address and phone numbers.

6. **Section XIX. Comments on Nursing Requirements or Social Situation:** Provide any additional information that would help explain the patient’s nursing requirements or social situation.

**Physician’s Signature:** Self-explanatory.

**Date:** Indicate the date of the physician’s signature.

**Physician’s Name:** Self-explanatory.