INSTRUCTIONS
DHS FORM 1147a & FILL IN FORM 1147a

LEVEL OF CARE (LOC) REEVALUATION

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.

1. ***Patient Name***: Self-explanatory

2. ***Medicaid I.D. Number***: Enter Medicaid I.D. number assigned by the Department of Human Services. If the I.D. number is unknown, use one of the availability eligibility verification systems to find the I.D. number of the patient. If the patient has applied for Medicaid but has not yet been deemed eligible, write in “pending”.

3. ***Birthdate***: Self-explanatory

4. ***Sex***: Self-explanatory

5. ***Admit Date***: Date of admission to the current level of care (LOC).

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. ***Medicaid Provider I.D. No.***: Enter the 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. ***Reasons for LOC Re-Evaluation***: Self-explanatory. If the patient is in a nursing home, and patient elects and is appropriate for a home and community-based waiver program, make referral directly to the home and community-based waiver program. Complete the disposition section.

12. ***Approved LOC on Most Current Form***: Check the box of the current LOC approved for the patient (most current 1147 form) and enter the effective date of the LOC.

13. ***LOC Being Requested***: Check the requested LOC and enter the requested effective date. Enter the anticipated time that would be required at the requested LOC.

14. ***Current Status***: List current and new diagnoses that affect medical care. If there are multiple diagnoses, list the most significant diagnosis first. Specify changes in functional capabilities (increases/decreases in ADLs, behavioral and cognitive functioning. Identify changes (increases/decreases) in skilled nursing needs and any changes in LOC (increases/decreases in functional capabilities or skilled nursing needs sufficient to change a person's LOC).

    Document Need at Requested LOC: If the answers to "current status" are sufficient to the document the need, enter "see above." Use this space to provide additional information as to the reasons for the continuation of long term care services.

    Physician's Signature: Self-explanatory

    Date: Date of physician's signature

    Physician's Name: Self-explanatory

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