

**STATE OF HAWAII**  
**Level of Care (LOC) Re-Evaluation**

Please Print or Type

1. PATIENT NAME (Last, First, M.I.) _____	2. BIRTHDATE Month/Day/Year _____	3. SEX _____	4. MEDICAID ID NUMBER _____
5. PRESENT ADDRESS: 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"/> CCFH <input type="checkbox"/> Other _____			6. Medicaid Provider Number: (If applicable) _____
7. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) ( Last Name, First Name, Middle Initial) _____ Phone ( ) _____ Fax ( ) _____			
8. RETURN FORM TO (SERVICE COORDINATOR/CONTACT PERSON): _____ MANAGED CARE PLAN NAME (IF APPLICABLE): _____ VIA <input type="checkbox"/> FAX (Print Fax Number Below) Phone ( ) _____ Fax ( ) _____ Email ( ) _____			
<b>9. REASON(S) FOR LOC RE-EVALUATION</b>			
<input type="checkbox"/> Change in LOC <input type="checkbox"/> Extension of Current LOC <input type="checkbox"/> At home and waitlisted for Long Term Care Services: <input type="checkbox"/> NF or <input type="checkbox"/> Home and Community Based Services <input type="checkbox"/> No longer meeting LOC (NOT in acute, NF ICF, NF SNF, NF Hospice, NF Subacute I or II, Acute waitlisted ICF or SNF or Subacute) as of date: _____ Fill out #10, then do not proceed.			
10. APPROVED LOC ON MOST CURRENT FORM (Date Span) From: _____ TO _____	11. LOC BEING REQUESTED LOC BEGIN and END DATES: _____ TO _____		
<input type="checkbox"/> Nursing Facility (ICF) <input type="checkbox"/> Nursing Facility (SNF) <input type="checkbox"/> Nursing Facility (HOSPICE) <input type="checkbox"/> Nursing Facility (Subacute I) <input type="checkbox"/> Nursing Facility (Subacute II) <input type="checkbox"/> Acute Waitlist (ICF) <input type="checkbox"/> Acute Waitlist (SNF) <input type="checkbox"/> Acute Waitlist (Subacute)	<input type="checkbox"/> Nursing Facility (ICF) <input type="checkbox"/> Nursing Facility (SNF) <input type="checkbox"/> Nursing Facility (HOSPICE) <input type="checkbox"/> Nursing Facility (Subacute I) <input type="checkbox"/> Nursing Facility (Subacute II) <input type="checkbox"/> Acute Waitlist (ICF) <input type="checkbox"/> Acute Waitlist (SNF) <input type="checkbox"/> Acute Waitlist (Subacute)		
<b>12. CURRENT STATUS</b>			
Specify Current Primary Diagnosis _____			
<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) _____			
DOCUMENT NEED AT REQUESTED LOC: _____			
PHYSICIAN'S/PCP SIGNATURE: _____ DATE: _____			
<input type="checkbox"/> Hard copy signature on file. This plan of care has been discussed with the MD/PCP.			
Physician's/PCP Name (PRINT): _____			
<b>13. MEDICAL NECESSITY/LEVEL OF CARE DETERMINATION – DO NOT COMPLETE</b>			
LEVEL OF CARE APPROVAL:  <input type="checkbox"/> Nursing Facility (ICF) <input type="checkbox"/> Nursing Facility (SNF) <input type="checkbox"/> Nursing Facility (HOSPICE) <input type="checkbox"/> Nursing Facility (Subacute I) <input type="checkbox"/> Nursing Facility (Subacute II) <input type="checkbox"/> Acute Waitlist (ICF) <input type="checkbox"/> Acute Waitlist (SNF) <input type="checkbox"/> Acute Waitlist (Subacute)	LOC BEGIN AND END DATES: _____ TO _____  LENGTH OF APPROVAL (CHECK ONE BOX): <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____		
DEFERRED: <input type="checkbox"/> Current 1147 Version Needed <input type="checkbox"/> Missing Information			
<input type="checkbox"/> DOES NOT MEET LEVEL OF CARE REQUESTED <input type="checkbox"/> INCOMPLETE INFORMATION TO DETERMINE LEVEL OF CARE			
DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____			