

**STATE OF HAWAII**  
**Level of Care (LOC) and At Risk Evaluation**

**COMPLETE ALL SECTIONS OF THE FORM EXCEPT SECTION 14**

1. PLEASE PRINT OR TYPE <input type="checkbox"/> Initial Request <input type="checkbox"/> Annual Review <input type="checkbox"/> Reconsideration <input type="checkbox"/> Other review					
2. PATIENT NAME (Last, First, M.I.) _____		3. BIRTHDATE Month/Day/Year _____	4. SEX _____	5. MEDICARE Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Part B <input type="checkbox"/> Yes <input type="checkbox"/> No ID#: _____	6. MEDICAID ELIGIBLE? <input type="checkbox"/> Yes ID # _____  <input type="checkbox"/> No If no, date applied for Medicaid (Required) _____
7. 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"/> 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 OR CONTACT PERSON): _____ MANAGED CARE PLAN NAME (IF APPLICABLE): _____ Phone ( ) _____ Fax ( ) _____ Email _____					
<b>11. REFERRAL INFORMATION (Completed by Referring Party)</b>			<b>12. ASSESSMENT INFORMATION (Completed by RN, Physician, PCP)</b>		
A. SOURCE(S) OF INFORMATION <input type="checkbox"/> Client <input type="checkbox"/> Records <input type="checkbox"/> Other _____			A. ASSESSMENT DATE _____		
B. RESPONSIBLE PERSON Name _____ Last First MI Relationship _____			B. ASSESSOR'S NAME Name _____ Last First MI Title _____		
C. Language <input type="checkbox"/> English <input type="checkbox"/> Other _____			Signature _____ <input type="checkbox"/> Hard copy signature on file.		
PHONE ( ) _____ FAX ( ) _____			PHONE: ( ) _____ FAX: ( ) _____		
			EMAIL: _____		
<b>13. REQUESTING</b>					
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) [ ] At Risk			BEGIN and END DATES: _____ TO _____ LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX): [ ] 1 month [ ] 3 months [ ] 6 months [ ] 1 year [ ] Other: _____		
<b>14. MEDICAL NECESSITY DETERMINATION – DO NOT COMPLETE</b>					
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) [ ] At Risk			BEGIN AND END DATES: _____ TO _____ LENGTH OF APPROVAL (CHECK ONE BOX): [ ] 1 month [ ] 3 months [ ] 6 months [ ] 1 year [ ] Other: _____		
DEFERRED: [ ] Current 1147 Version Needed [ ] Missing Information [ ] Clinical Question					
NOT APPROVED: <input type="checkbox"/> DOES NOT MEET LEVEL OF CARE REQUESTED <input type="checkbox"/> DOES NOT MEET AT RISK CRITERIA <input type="checkbox"/> INCOMPLETE INFORMATION TO MAKE DETERMINATION					
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: _____

COMPLETE ALL SECTIONS OF THE FORM

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. <b>NAME</b> (Last, First, Middle Initial)	2. <b>BIRTHDATE</b>
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**3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS**

**I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):**

PRIMARY: \_\_\_\_\_

SECONDARY: \_\_\_\_\_

**II. COMATOSE**  No  Yes If "Yes," go to **XVIII.**

**III. VISION / HEARING / SPEECH:**

[0] a. Individual has normal or minimal impairment (with/without corrective device) of:  Hearing  Vision  Speech

[1] b. Individual has impairment (with/without corrective device) of:  
 Hearing  Vision  Speech

[2] c. Individual has complete absence of:  
 Hearing  Vision  Speech

**IV. COMMUNICATION:**

[0] a. Adequately communicates needs/wants.  
 [1] b. Has difficulty communicating needs/wants.  
 [2] c. Unable to communicate needs/wants.

**V. MEMORY:**

[0] a. Normal or minimal impairment of memory.  
 [1] b. Problem with [ ] long-term or [ ] short-term memory.  
 [2] c. Individual has a problem with both long-term and short-term memory.

**VI. MENTAL STATUS / BEHAVIOR: (only one selection for orientation – items a through c. Aggressive and/or abusive and wandering may also be checked with appropriate orientation.) \***

[0] a. Oriented (mentally alert and aware of surroundings).  
 [1] b. Disoriented (partially or intermittently; requires supervision).  
 [2] c. Disoriented and/or disruptive.  
 [3] d. Aggressive and/or abusive. (Examples required in section XX)  
 [4] e. Wanders at  Day  Night  Both, and/or  in danger of self-inflicted harm or self-neglect. (Examples required in section XX)

**VII. FEEDING:**

[0] a. Independent with or without an assistive device.  
 [1] b. Needs supervision or assistance with feeding.  
 [2] c. Is spoon / syringe / tube fed, does not participate.

**VIII. TRANSFERRING:**

[0] a. Independent with or without a device.  
 [2] b. Transfers with minimal /stand-by help of another person.  
 [3] c. Transfers with physical / moderate assistance of another person.  
 [4] d. Does not assist in transfer / requires maximum assist / or is bedfast.

**IX. MOBILITY / AMBULATION: (Check a maximum of 2 for items b through e. If an individual is either independently mobile or unable to walk, no other selections can be made.)**

[0] a. Independently mobile with or without device / self-propels wheelchair.  
 [1] b. Ambulates with/without device / stand-by assist / unsteady / risk for falls.  
 [2] c. Able to walk/be mobile with minimal assistance.  
 [3] d. Able to walk/be mobile with one-person hands-on/moderate assistance.  
 [4] e. Able to walk/be mobile with more than one-person hands-on assistance.  
 [5] f. Unable to walk / immobile.

**X. BOWEL FUNCTION / CONTINENCE:**

[0] a. Continent / able to independently perform bowel care.  
 [1] b. Continent with cues / requires reminders to perform bowel care.  
 [2] c. Incontinent (at least once daily) / requires help with bowel care on a regular basis.  
 [3] d. Incontinent (more than once daily) / dependent for all bowel care.

**XI. BLADDER FUNCTION / CONTINENCE:**

[0] a. Continent / able to independently perform bladder care.  
 [1] b. Continent with cues / requires reminders to perform bladder care.  
 [2] c. Incontinent (at least once daily) / requires help with bladder care on a regular basis.  
 [3] d. Incontinent (more than once daily) / dependent for all bladder care.

**XII. BATHING:**

[0] a. Independent bathing.  
 [1] b. Unable to safely bathe without minimal assistance and supervision.  
 [2] c. Unable to safely bathe without moderate assistance.  
 [3] d. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).

**XIII. DRESSING AND PERSONAL GROOMING:**

[0] a. Appropriate and independent dressing, undressing and grooming.  
 [1] b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes).  
 [2] c. Physical assistance needed on a regular basis.  
 [3] d. Requires total help in dressing, undressing, and grooming.

**Complete questions XIV to XVII for At Risk requests only:**

**XIV. HOUSECLEANING:**

[0] a. Independent  
 [2] b. Needs Assistance  
 [3] c. Unable to safely clean the home

**XV. SHOPPING:**

[0] a. Independent  
 [2] b. Needs Assistance  
 [3] c. Unable to safely go shopping

**XVI. LAUNDRY:**

[0] a. Independent  
 [1] b. Needs Assistance  
 [2] c. Unable to safely do the laundry

**XVII. MEAL PREPARATION:**

[0] a. Independent  
 [1] b. Needs Assistance  
 [2] c. Unable to safely prepare a meal

**XVIII. TOTAL POINTS:**

Comatose = 30 points                      Total Points Indicated: \_\_\_\_\_

**XIX. MEDICATIONS/TREATMENTS:**

(List all Significant Medications, Dosage, Frequency, and mode)

Attach additional sheet if necessary	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____

**XX. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS \*Include examples, frequency of occurrences, and interventions for aggressive and/or abusive behaviors, wandering, and/or self-inflicted harm or self-neglect behaviors.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**COMPLETE ALL SECTIONS OF THE FORM**

**APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)**

1. <b>NAME</b> (PRINT Last, First, Middle Initial)	2. <b>BIRTHDATE</b>
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**XXI. SKILLED PROCEDURES:** D = Daily Indicate number of times per day L = Less than once per day N = Not applicable / Never

D	L	N	#
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy care/suctioning in ventilator dependent person
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy care/suctioning in non-ventilator dependent person
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasopharyngeal suctioning in persons with no tracheostomy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Total Parenteral Nutrition (TPN) (Specify number of hours per day): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Maintenance of peripheral/central IV lines
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IV Therapy (Specify agent & frequency): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decubitus ulcers (Stage III and above)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decubitus ulcers (less than Stage III); wound care (Specify nature of ulcer/wound and care prescribed)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wound care (Specify nature of wound and care prescribed) <input type="checkbox"/> debridement <input type="checkbox"/> Irrigation <input type="checkbox"/> packing <input type="checkbox"/> wound vac.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Instillation of medications via indwelling urinary catheters (Specify agent): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intermittent urinary catheterization
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IM/SQ Medications (Specify agent.): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with administration of oral medications (Explain): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing difficulties and/or choking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stable Gastrostomy/Nasogastric/Jejunostomy tube feedings; Enteral Pump? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration (Specify reason person at risk for aspiration)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Initial phase of Oxygen therapy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nebulizer treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Complicating problems of patients on [ <input type="checkbox"/> ] renal dialysis, [ <input type="checkbox"/> ] chemotherapy, [ <input type="checkbox"/> ] radiation therapy, [ <input type="checkbox"/> ] with orthopedic traction (Check problem(s) and describe) : _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral problems related to neurological impairment (Describe): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify condition and describe nursing intervention): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Therapeutic Diet (Describe): _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restorative Therapy (check therapy and submit/attach evaluation and treatment plan): <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

**XXII. SOCIAL SITUATION:**

A. Person can return home    Yes    No    N/A   Community setting can be considered as an alternative to facility?    Yes    No    N/A

B. If person has a home; caregiving support system is willing to provide/continue care.    Yes    No  
 Caregiver requires assistance?    Yes    No  
 Assistance required by Caregiver: \_\_\_\_\_

C. Caregiver name:  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
           Last                      First                      MI  
 Address: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_ Fax (    ) \_\_\_\_\_

**XXIII. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:**

\_\_\_\_\_

\_\_\_\_\_

I HAVE REVIEWED AND AGREE WITH THIS ASSESSMENT.

**PHYSICIAN/PCP/RN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
 Hard copy signature on file. This plan of care has been discussed with the MD/PCP/RN.  
 Physician/PCP/RN Name (PRINT): \_\_\_\_\_