Nevada Medicaid and Nevada Check Up
First Health Services Corporation

Level of Care Assessment Form for Nursing Facilities

To Transmit Request: Phone: (800) 525-2395 Fax: (866) 480-9903 Mail: 4300 Cox Road, Glen Allen, VA 23060

DATE OF REQUEST: ______ /______ /________

REASON FOR SCREENING: ☐ Initial Placement ☐ Retro-Eligibility ☐ Service Level Change ☐ Time Limitation

SERVICE LEVEL: ☐ Standard ☐ Pediatric Specialty Care I ☐ Pediatric Specialty Care II ☐ Ventilator Dependent

PROVIDER INFORMATION

Provider Name: ____________________ Provider Medicaid Number: ____________

Address: ____________________ City: ________ State: ____ Zip Code: ______

Person Completing This Form: ____________________ Professional Title: ____________

Contact Phone: ____________ Contact Fax: ____________ Contact Pager: ____________

RECIPIENT INFORMATION

Last Name: ____________ First Name: ____________ MI: ___ Recipient ID Number: ________

Date of Birth: ________ SSN: __________ Screening Location: ☐ Acute ☐ Nursing Facility ☐ Home ☐ Other

Name of Admitting Nursing Facility: ____________________ Admit Date: __________

MEDICAL HISTORY

Diagnosis / ICD-9 Code Related to Placement (*list up to three*): 1.Diagnosis:____________ICD-9 Code:______

2.Diagnosis:____________ICD-9 Code:______ 3.Diagnosis:____________ICD-9 Code:______

Medications: ________________________________

1 **Can recipient safely self-administer medications?** ☐ Yes ☐ No - List barriers: ____________

2 **Special Needs:** ☐ Central Line ☐ Feeding Tube (G-tube, J-tube, NG tube) ☐ Glucose Monitoring
☐ Insulin Coverage (sliding scale with variable coverage) ☐ IV ☐ O2 ☐ Ostomy ☐ Pediatric Specialty Care ☐ PICC
☐ Saline-Lock ☐ Secured (Alzheimer) Unit ☐ Specialty Bed ☐ Suctioning ☐ Trach ☐ Ventilator Dependent ☐ Wound Care
☐ DME: ____________________ ☐ Other: ____________________

For checked items above, list the frequency/duration of treatment, the stage/grade/size/location of wounds and/or any other specific treatments: ________________________________

3 **Activities of Daily Living (ADL): Check all boxes that pertain and add comments as necessary.**

Activity	Self Care	Super-vision	Assis-tance	Depen-dent	Comments
Bed Mobility					
Transfer					
Locomotion					☐ No Devices ☐ Wheelchair ☐ Walker ☐ Cane ☐ Other
Dressing					
Eating/Feeding					
Hygiene					
Bathing					
Bladder Function					☐ Continent ☐ Incontinent ☐ Catheter
Bowel Function					☐ Continent ☐ Incontinent

4 **Recipient's Need for Supervision:** ☐ Behavior Problem
☐ Resists Care ☐ Socially Inappropriate ☐ Wandering
☐ Physically Abusive ☐ Safety Risk ☐ Verbally Abusive

5 **Instrumental Activities of Daily Living (IADL)**
☐ Meal Preparation
☐ Homemaking Services - related to personal care

Comments: ________________________________