Louisiana DHH Nursing Facility *Client Face Sheet for LOCET p. 1*
Level of Care Eligibility Tool for Nursing Facilities pp.2-5

Hardcopy version is for use in Nursing Facility Admission Process

A1. Client's Name: _____

A.3.a. Social Security #: _____ b. Medicaid #: _____
(**1** if pending, **0** if none)

c. Private Insurance #: _____ Private Insurance Name: _____

d. Veteran's Administration #: _____ e. Medicare #: _____
(or Comparable Railroad Insurance #)

B.2. DHH Region #: _____

C.1. Gender 1 = Male 2 = Female _____ C.2. Birthdate _____/_____/_____

C.3. Race/Ethnicity: Please answer all (0 = No 1 = Yes)

a. Amer Indian/Alaskan Native _____
b. Asian _____
c. Black/African-American _____
d. Native Hawaiian or other Pacific Islander _____
e. White _____
f. Hispanic or Latino _____

C.4. Marital Status: 1. Never Married 2. Married 3. Widowed 4. Separated 5. Divorced 6. Other _____

D.1. Client Contact Information:

Home Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Tel: _____

Facility Name if known: _____

Parish: _____

Mailing Address (if different from Home Address) **Please leave this section blank if same as Home Address**

Name: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

D.4. Other Contact Information:

Type of Other Contact: 1. Personal Representative 2. Tutor 3. Curator 4. Power of Attorney 5. Other (specify): _____

Name: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Telephone _____

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SECTION A. SETTING THE STAGE

1. The intake analyst will discuss the eligibility determination process/issues generally with the informant, then read the statement to the informant and ask if he/she understands, clarify any misunderstandings, and finally, select the answer given.

"I (informant) understand that the purpose of this interview is to determine if the person being assessed (applicant) meets medical eligibility criteria for publicly funded long-term care services, and that I am expected to provide objective and accurate information about the applicant to assist in this determination."

2. "The following issued have been explained to me:

b. The information I provide will be used to determine medical eligibility for long-term care services funded through the Louisiana Department of Health and Hospitals. [ ]
0. No 1. Yes

c. The results of this interview, and information about how to appeal the results, will be provided in writing to the applicant. [ ]
0. No 1. Yes

d. The Louisiana Department of Health and Hospitals will conduct in-person interviews on a random sample of individuals who have applied to assess the accuracy of the information provided. [ ]
0. No 1. Yes

e. All program requirements must be met for eligibility to any particular program." [ ]
0. No 1. Yes

3. Informant indicates that eligibility determination process/issues have been adequately explained: [ ]
0. No 1. Yes

Signature of Applicant / Informant: _____
Date

****ACS/RO Users – SKIP TO SECTION EE**

SECTION EE. Initial Call and LOCET Type

1. LOCET Initiated by: 1 = Applicant [1]

2. Date/Time LOCET Initiated:

Y	**Y**	**Y**	**Y**		**M**	**M**		**D**	**D**

		:		

(**Military Time**)

3. Type of LOCET : [1]
1. Initial Determination

SECTION FF. Program Choice

1.h. Client chooses Nursing Facility Admission: **0=NO 1=YES** [1]

SECTION GG. Diagnoses:

a. Primary Diagnosis: _____

b. Secondary Diagnosis: _____

ICD-9 Codes (If available)

			.		
			.		

SECTION B. Items/information to collect at beginning of interview process

4. Relationship of informant to applicant (select only one): [ ]
0. Self **(Skip to Item B.7)**
1. Spouse
2. Child or child-in-law
3. Other relative
4. Friend/neighbor
5. Hospital discharge planner
6. Nursing Home admissions staff
7. Other health care professional. Specify._____
8. Other. Please specify. _____

5. Informant's information sources regarding the status/abilities of applicant.
(select all that apply):

	0=NO 1=YES		0=NO 1=YES
a. Direct observation of the applicant ……		d. Review of agency records, care provider status reports, etc……	
b. From paid care providers……			
c. From family or other informal caregivers		e. Other (specify) _____	

If the only source of information in B.5. is Direct Observation of the applicant, answer B.6. Otherwise, skip B6.

6. If information source is from direct observation of applicant, indicate how recently observation occurred:
1. within last three days
2. within last week
3. within last month
4. more than one month ago

7. Current location of applicant (select only one):
0. Private home/apt
1. Hospital
2. Adult Residential Center (Assisted living)/board & care
3. Nursing home
4. Group Home or ICF/DD
5. Shelter (for homeless, disaster-related or otherwise)
6. Other, please specify_____

Pathway 1. Activities of Daily Living

***** Please use the following to describe each activity:**

a. Independent: No help or oversight --OR-- Help/oversight provided only 1 or 2 times during last 7 days.
b. Supervision: Oversight, encouragement or cueing provided 3 or more times during last 7 days, --OR— Supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days.
c. Limited assistance: Applicant highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times–OR– More help provided only 1 or 2 times during last 7 days.
d. Extensive assistance: While applicant performed part of activity over last 7-day period, help of following type provided 3 or more times:
-Weight bearing support
- Full performance by another during part (but not all) of last 7 days
e. Total Dependence: Full performance by another during all of last 7 days.
f. Activity did not occur during entire 7 days (regardless of ability).
g. Unknown to Informant

12A. *Locomotion.* Describe how the applicant moves between locations inside his/her place of residence. (If the applicant uses a wheelchair, code self-sufficiency once in chair.) Use the above codes to describe the applicant's self-performance during last 7 days:
_____ A through G only

12B *Eating*. Describe how the applicant eats and drinks (regardless of skill). (Includes intake of nourishment by other means, e.g., tube feeding...) Use the above codes to describe the applicant's self-performance during last 7 days:
_____ A through G only

12C. *Transfer*. Describe how the applicant moves to and from surfaces, e.g., bed, chair, wheelchair, standing position. (EXCLUDE transferring to/from bath/toilet.) Use the above codes to describe the applicant's self-performance during last 7 days:
_____ A through G only

12D. *Bed Mobility.* Describe how the applicant moves to and from a lying position, turns side to side, and positions body while in bed. Use the above codes to describe the applicant's self-performance during last 7 days:
_____ A through G only

12E. *Toilet Use*. Describe how the applicant uses the toilet (or commode, bedpan, urinal). (Includes transfer on/off toilet, cleaning self, changing pad, managing ostomy or catheter, adjusting clothes.) Use the above codes to describe the applicant's self-performance during last 7 days:
_____ A through G only

12F. *Dressing*. Describe how the applicant dresses and undresses him/herself, including prostheses, orthotics, fasteners, belts, shoes, and underwear. Use the above codes to describe the applicant's self-performance during last 7 days:
_____ A through G only

12G. *Personal Hygiene.* Describe how the applicant grooms him/herself, including combing hair, brushing teeth, washing/drying face/hands, shaving. (EXCLUDE baths and showers.) Use the above codes to describe the applicant's self-performance during last 7 days:

_____ A through G only

12H. *Bathing.* Describe how the applicant takes a full-body bath/shower or sponge bath (excluding hair or washing back). Use the above codes to describe the applicant's self-performance during last 7 days:

_____ A through G only

Pathway 2. Cognitive Performance

13A. *Short-term Memory.* Does the applicant appear to recall recent events, for instance, when the applicant ate at his/her last meal and what he/she ate?

0 = Memory OK **1 = Memory problem** **2 = Unknown to Informant** 0 or 1 or 2 only ☐

13C. *Cognitive Skills for Daily Decision-making.* How does the applicant make decisions about the tasks of daily life, such as planning how to spend his/her day, choosing what to wear, reliably using canes/walkers or other assistive equipment if needed?

a. Independent – decisions consistent/reasonable
b. Minimally impaired – some difficulty in new situations or decisions poor and requires cueing/supervision in specific situations only
c. Moderately impaired – decisions consistently poor or unsafe; cues or supervision required at all times
d. Severely impaired – never/rarely made decisions
e. Unknown to Informant

A through E only ☐

13D. *Making Self Understood.* How clearly is the applicant able to express or communicate his/her needs/requests? (Includes speech, writing, sign language, or word boards.)

a. Understood—expresses ideas without difficulty
b. Usually understood – difficulty finding words or finishing thoughts; prompting may be required
c. Sometimes understood – ability is limited to making concrete requests
d. Rarely/never understood
e. Unknown to Informant

☐ A through E only

Pathway 3. Physician Involvement

14A. *Physician visits.* In the last 14 days, how many days has a physician (or authorized assistant or practitioner) examined the applicant? (Do not count emergency room exams or hospital in-patient visits.)

0 1 2 3 4 5 6 7+ 0 through 15 only ☐

14B. *Physician orders.* In the last 14 days, how many times has a physician (or authorized assistant or practitioner) changed the applicant's orders? (Do not include order renewals without change; do not count hospital in-patient order changes.)

0 1 2 3 4 5 6 7+ 0 through 15 only ☐

Pathway 4. Treatments and Conditions

15A. Has the applicant received any of the following health treatments, or been diagnosed with any of the following health conditions? **0. No** **1. Yes** **2. Unknown to Informant**

a. Stage 3-4 pressure sores in the last 14 days……. ☐
b. Intravenous feedings in the last 7 days……... ☐
c. Intravenous medications in the last 14 days…… ☐
d. Tracheostomy care, ventilator/respirator, suctioning in last 14 days…… ☐
e. Pneumonia in the last 14 days…… ☐
f. Daily respiratory therapy in the last 14 days…. ☐
g. Daily insulin injections with 2 or more order changes last 14 days…… ☐
h. Peritoneal or hemodialysis in the last 14 days ☐

0 or 1 or 2 only (a–d) 0 or 1 or 2 only (e–h)

Pathway 5: Skilled Rehabilitation Therapies

16A. Record the total minutes each of the following therapies was administered or scheduled (for at least 15 minutes a day). Enter "0" if none or less that 15 minutes daily.

a = Total number of minutes provided in last 7 days
b = Total number of minutes scheduled for next 7 days but not yet administered

1. Speech Therapy a = _____ b = _____
2. Occupational Therapy a = ____ b = ____
3. Physical Therapy a = _____ b = _____

0 through 999 only

Pathway 6. Behavior

****Please use the following codes for behavior symptom frequency in last 7 days:**

a. Behavior not exhibited in last 7 days
b. Behavior of this type occurred 1 to 3 days in last 7 days
c. Behavior of this type occurred 4 to 6 days, but less than daily
d. Behavior of this type occurred daily
e. Unknown to Informant

17A. *Wandering.* In the last seven days, did the applicant wander, that is, move around with no rational purpose, seemingly oblivious to his/her needs or safety? _____ A through E only

17B. *Verbally abusive behavior.* In the last seven days, did the applicant threaten or scream at others? Code for behavior symptom frequency in last 7 days: _____ A through E only

17C. *Physically abusive behavior.* In the last seven days, did the applicant hit, shove, scratch, or otherwise act physically abusive or sexually abusive toward other people? Code for behavior symptom frequency in last 7 days:

_____ A through E only

17D. *Socially inappropriate/disruptive behavior.* In the last seven days, did the applicant make noise, engage in self-abusive acts, disrobe in public, hoard items, or rummage through others' belongings? Code for behavior symptom frequency in last 7 days:

_____ A through E only

17E. *Mental Health Problem/Condition.*

Applicants who need long term care may experience delusions and hallucinations *that impact the applicant's ability to live independently in the community.* If present at any point in last 7 days, code:

0 = NO This applicant DID NOT experience delusions or hallucinations which impacted his/her ability to function in the community within the last 7 days.

1 = YES This applicant DID experience delusions or hallucinations which impacted his/her ability to function in the community within the last 7 days.

2 = Unknown to informant

a. Delusions
b. Hallucinations

[ ] [ ] 0 or 1 or 2 only

Pathway 7: Service Dependency

18. Code if the applicant is currently being served by EDA Waiver, ADHC Waiver services, LT PCS or is currently in a nursing home.

a = Not approved for or receiving these services before 12/01/2006.
b = Was approved for these services prior to 12/01/2006, has had no break in service since 12/01/2006, and requires ongoing services to maintain current functional status.

[ ] A or B only

Items to be filled out by intake analyst after completing LOCET form:

J19A. How many minutes did this contact and interview take? _____

J19B. Date LOCET completed

Y	**Y**	**Y**	**Y**		**M**	**M**		**D**	**D**

J19C.a. Signature of Intake Analyst

My signature below indicates that I attest to the fact that I have conducted the LOCET interview recorded within this document, and that the Intake Analyst Registration number shown below in Item J19.C.c. has been issued to me by the Office of Aging and Adult Services.

_____

Signature Printed Name

J19C.b. Date of Intake Analyst Signature

Y	**Y**	**Y**	**Y**		**M**	**M**		**D**	**D**

Telephone Number of Intake Analyst _____

J19C.c. LOCET Intake Analyst Registration Number _____