INSTRUCTIONS

DHS FORM 1147

SUBACUTE/LONG TERM CARE/HOSPICE LEVEL OF CARE EVALUATION

PAGE 1 - APPLICANT INFORMATION

1. ***NAME:*** *Self-explanatory*

2. ***BIRTHDATE:*** *Self-explanatory*

3. ***AGE:*** *Self-explanatory*

4. ***SEX:*** *Self-explanatory*

5. ***MEDICARE STATUS:***
Answer questions specific to coverage by Medicare. Check Yes or No for Part A coverage. Check Yes or No for Part B Coverage. Enter the Medicare I.D. Number, if the patient is has Part A and B coverage, only Part A, or only Part B.

6. ***MEDICAID STATUS:***
If the person is eligible for Medicaid, check Yes and enter his/her Medicaid I.D. Number. If the patient has applied for Medicaid but has not yet been deemed eligible, check No and enter date applied. DO NOT COMPLETE THE 1147 FORM UNLESS THE PATIENT HAS APPLIED FOR MEDICAID. When the person becomes eligible for Medicaid and has a valid number, a 1147a must be generated and approved by Mountain Pacific in order for that facility to be paid.

7. ***PRESENT ADDRESS:***
If Facility, provide name of the facility; if Residence, provide street address, city, and zip code. Check appropriate box, which describes the address given.

8. ***ATTENDING PHYSICIAN:***
Print name of the attending physician and give his/her phone and fax numbers. The attending physician can be the hospital-based physician responsible for the person's inpatient acute care, the nursing facility medical director, or the patient's primary care physician or physician specialist.

9. ***RETURN FORM TO:***
State how you wish the form sent back to you--by mail or fax--and to whose attention this should be directed. The form may not be mailed or faxed back to you with a cover

sheet. Therefore, it is critical that this information is accurate. For reimbursement of the level of care, enter your facility's provider number for level of care on effective date. If a facility wants a level of care determination ONLY and will not bill for the services, it must submit the 1147 without a provider number.

10. REFERRAL INFORMATION:

A. Contact person: *

B. Title: *

C. Phone/Fax: *

*The name of the person (also, title, and phone and fax numbers) who should be contacted if DHS or its designee require additional information or clarification of information submitted on the 1147 form.

D. Source(s) of Information: *Self-explanatory*

Responsible Person:
The name, relationship, phone and fax numbers, and language spoken of the family member/personal agent who would make decisions for the patient if he/she were not able to act.

E. Requesting:
Check the setting which person or his/her agent requests that long term care (LTC) be provided.

11. ASSESSMENT INFORMATION:

A. Assessment Date:
The date the assessment was completed.

B. Assessor's Name, Title, Signature, Phone and Fax Numbers:
A Registered Nurse (RN) or physician must perform the assessment. The name, title signature, and phone and fax numbers of the assessor should be entered.

C. HCBS Option Counseling provided:
Enter Yes or No as to whether or not the person was given information about home and community based programs and counseling about how his/her needs could be met in the home and community setting. Provide an explanation if the person did not receive information and/or counseling. If a person did receive information and

counseling, provide the name, title or relationship of the person who provided the information and counseling.

12. ***MEDICAL NECESSITY / LEVEL OF CARE ACTION***
Completed by DHS or Designee. Leave Blank. DO NOT COMPLETE.

DISPOSITION
Completed by DHS or Designee. Leave Blank. DO NOT COMPLETE.

PAGE 2 - APPLICANT/CLIENT BACKGROUND INFORMATION

1. NAME: *Self-explanatory*

2. BIRTHDATE: *Self-explanatory*

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS:

I. LIST SIGNIFICANT CURRENT DIAGNOSIS (ES): Primary and Secondary.
List the main diagnosis (ses) or medical conditions related to person's need for long term care. List the most important diagnosis first.

II. COMATOSE:
If the patient is comatose, enter Yes. Do not complete sections III. To XIII. Go directly to section XIV. If the patient is not comatose, enter No and complete entire page.

III. to XII.
Circle the description that best describes the person's functional ability in each section. These sections require an assessment of the patient's activities of daily living. To provide accurate information, the assessor should consult the patient or nursing staff, physicians, caregivers, etc. familiar with the patient. Completion of these sections requires direct knowledge of the patient's functional abilities on the date the assessment is done. Therefore, these sections cannot be completed from medical record review alone.

XIII. TOTAL POINTS:
Enter the score by totaling the points circled in sections III. To XII.

XIV. MEDICATIONS/TREATMENTS:

List the significant medications the patient is currently receiving. These are medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term medications (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than five (5) significant medications, attach orders or treatment sheet.

XV. ADDITIONAL INFORMATIONCONCERNING PATIENT'S FUNCTIONAL STATUS:

Provide any additional clinical information, which will clarify his/her functional status and support his/her need for long term care.

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1. ***NAME:*** *Self-explanatory*

2. ***BIRTHDATE:*** *Self-explanatory*

XVI. SKILLED PROCEDURES:

If the services listed are provided daily, state the number of times they are performed. Check if they are provided less than daily or never provided. Provide explanation, details when requested.

XVII. SOCIAL SITUATION:

A. Caregiving support system is willing to provide/continue to provide care with assistance:

Answer Yes or No and then state the help the caregiver needs in order for him/her to continue in the role of caregiver.

B. Name, Relationship, Address, Phone and Fax Numbers of Caregiver: (Self-explanatory)

C. Person currently has a home and can return home:

Answer Yes or No. If No, answer if, based on his/her clinical status, residential setting is or is not appropriate for the patient.

D. Patient is appropriate for:
Check all the residential settings in which the patient's needs can be appropriately met.

XVIII. RECOMMENDATIONS / DISCHARGE PLANS:

A. Requested LOC:
Enter the LOC the assessor feels most appropriate for the patient and is requesting.

B. Requested Effective Date of Medicaid Coverage:
This is the date being requested as the start of the Medicaid long-term care benefit. For a patient dually eligible for Medicare and Medicaid, enter the date that Medicare coverage will terminate—assuming that the patient has a continuing need for long term care after the Medicare benefit ends.

C. Effective Date of LOC:
This is the date the patient was deemed appropriate for a long term care (LTC) LOC. It does NOT have to be the assessment date provided on Page 1 as the assessment might have been completed while the person was at the acute LOC or after a person who has been at a LTC LOC with Medicare or other health insurance coverage becomes eligible for Medicaid. However, if no date is entered, the assessment date is considered to be the effective date.

D. Hospice Elected: *Self-explanatory*

E. Appropriate for HCBS: *Self-explanatory*

XIX. PHYSICIAN'S SIGNATURE:

A physician who has either prepared or reviewed the 1147 should sign and enter the date of signature. The physician's name should be printed.

Comments:
Comments by the signing physician, or assessor can be entered here. Additional information which would clarify the requested LOC, explain any discrepancies with effective date of LOC, assessment date, and effective date of Medicaid coverage, contribute to a clearer understanding of the patient's medical or social condition, etc. can be entered.