FORM 1147a

Department of Human Services
Med-QUEST Division
Medical Standards Branch

STATE OF HAWAII
Level of Care (LOC) Reevaluation
LT

Mountain Pacific Quality Health Foundation
1360 Beretania St., Ste. 500
Honolulu, Hawaii 96814

(Please Type)

1. Patient Name (Last, First, M.I.)	2. Medicaid ID Number	3. Date of Birth Month/Day/Year	4. Sex ☐ F ☐ M	5. Admission Date Month/Day/Year
6. Present address/facility (Specify facility name when applicable)			7. Medicaid Provider I.D. Number	
8. Attending Physician (PRINT Last, First, M.I.)		9. Contact Person (Last, First AND Title) Phone Number		

10. Return form to: _____ Via Fax: _____

Attention _____ Phone _____ Via Mail: _____

Reason(s) – Check all that apply

☐ Admission/Readmission after acute hospitalization to NF – Name: _____ Date: _____

☐ Admission/Readmission after acute hospitalization to home and community-based program. Date: _____

☐ Nursing Home Without Walls (NHWW) ☐ HIV Community Care Program (HCCP)

☐ PACE Program ☐ Other – Name: _____

☐ Residential Alternatives Community Care Program (RACCP) (Case Management Agency)

Transfer from NF to NF – Name: _____ Date: _____

☐ Changes in LOC.

☐ Annual LOC Determination for home and community-based program.

☐ DHS required evaluation (example: Annual LOC Determination for Nursing Facility ICF LOC).

☐ Extension of Acute Waitlisted NF status (date of initial determination) _____ Period requested From (mmddyy):_____ To (mmddyy):_____

☐ At home, waitlisted for NF bed.

☐ At home, waitlisted for home and community-based program.

☐ In Nursing Facility, Requesting Home or Home & Community-Based Program.

☐ Home & Community-Based Program placement not found/not suitable, requesting Nursing Facility.

Approved LOC on most current form – Date: _____			LOC BEING REQUESTED – Effective Date: _____		
☐ Subacute Level I	☐ SNF	☐ ICF	☐ Subacute Level I	☐ SNF	☐ ICF
☐ Subacute Level II	☐ Acute Waitlisted ICF	☐ Acute Waitlisted Subacute	☐ Subacute Level II	☐ Acute Waitlisted ICF	☐ Acute Waitlisted Subacute
☐ Acute Waitlisted SNF	☐ Hospice		☐ Acute Waitlisted SNF	☐ Hospice	

Current Status – Check all that apply

☐ No change in diagnoses – Specify primary diagnoses: _____

☐ Additional diagnoses – List: _____

☐ Functional capabilities ☐ No change ☐ Change(s) – Specify: _____

☐ Nursing needs ☐ No change ☐ Change(s) – Specify: _____

☐ Change in LOC ☐ No change ☐ Change(s) – Specify: _____

Document need for continuing LTC services at level of care being requested: _____

Anticipated time needed at LOC being Requested – Dates From: _____ To: _____ **Effective Date:** _____

Physician's signature: _____ **Date:** _____

Physician's name (PRINT): _____

To Be Completed By State of Hawaii – DHS/DHS Designee Only

Approved for: ☐ Subacute
☐ Level 1 ☐ Level 2
☐ SNF
☐ ICF
☐ Hospice
☐ Acute Waitlisted ICF (approved dates) _____ to _____
☐ Acute Waitlisted SNF (approved dates) _____ to _____
☐ Acute Waitlisted Subacute (approved dates) _____ to _____

Length of approval: ☐ 1 year
Approved LOC effective date
☐ 6 months
Approved LOC effective date
☐ Other – Specify:

Deferred: ☐ New 1147 needed.

DHS Reviewer's/Designee's Signature: _____ Date: _____