INSTRUCTIONS
DHS 1147a

LEVEL OF CARE (LOC) REEVALUATION

APPLICANT INFORMATION

1. ***Patient Name:*** *Self-explanatory*

2. ***Medicaid I.D. Number***:
The Medicaid I.D. Number and check digit should be entered; if the patient has applied for Medicaid but has not yet been deemed eligible please write in "Pending."

3. ***Birthdate: Self-explanatory***

4. ***Sex:*** *Self-explanatory*

5. ***Admission Date:***
Date of admission to the current level of care (LOC).

6. ***Present Address/Facility:***
If Facility, provide name of the facility; if Residence, provide street address, city, and zip code.

7. ***Medicaid Provider ID:***
Medicaid Provider I.D. number specific to the LOC (example, if waitlisted in an acute hospital, provide the appropriate waitlisted number)--if unknown, state "waitlisted SNF.")

8. ***Attending Physician:*** *Self-explanatory*

9. ***Contact Person: and Phone Number:***
The name and phone number of the person able to provide additional information about the patient if needed.

10. ***Return Form***:
State how you wish the form sent back to you--by mail or fax and to whose attention this should be directed. The form will not be mailed or faxed back to you with a cover sheet. Therefore, it is critical that this information is accurate.

REASON(S): (Check all that apply) S*elf-explanatory; except, as follows:*

Change in LOC
Check this if a LOC change is being requested. The blocks "Approved LOC on Most Current Form" and "LOC Being Requested" specify the specific LOC change being requested.

In Nursing Facility, Requesting Home and Community Based Program
Do not check this unless the patient needs information on home and community based options. A direct referral to the Home and Community Based Program in which the patient is interested should be done.

APPROVED LOC ON MOST CURRENT FORM (date): The LOC approved in Section 12. Page 1 of the most current 1147 form or on the most current 1147a should be checked and the effective date of the LOC should be entered.

LOC BEING REQUESTED (effective date). The LOC being requested should be checked and the requested effective date should be entered.

CURRENT STATUS: (Check all that apply)

No change in diagnoses: *(List diagnoses)*
Diagnoses should be taken from the most current 1147 Form (page 2), or on the most current 1147a. The primary diagnosis should be listed first.

Additional Diagnoses: *(List diagnoses)*
Any new diagnosis (ses) which affect(s) the medical care and NOT listed on the most current 1147/1147a Form should be entered. If more than one, the most important diagnosis should be listed first.

Changes in Functional Capabilities: *(Specify)*
These refer to increases/decreases/ in ADLs, behavioral, and cognitive functioning.

Changes in Nursing Needs: *(Specify)*
These refer to increases/decreases in skilled nursing needs

Changes in LOC: *(Specify current LOC and explain the change)*
These refer to increases/decreases in functional capabilities or skilled nursing needs sufficient to change a person's LOC.

DOCUMENT NEED FOR CONTINUING LTC SERVICES:
This is an assessment of the individual and his/her current status and why LTC services need to be continued. If the answers to "current status" are sufficient to document the need, you may enter "see above."

ANTICIPATED TIME NEEDED AT CURRENT LOC: *Self-explanatory*

EFFECTIVE DATE:
This is the effective date of the LOC being requested.

PHYSICIAN'S SIGNATURE: *Self-explanatory*

DATE is the date the physician signature was obtained.

PHYSICIAN'S NAME: S*elf-explanatory*