STATE OF HAWAII
Department of Human Services
Med-QUEST Division

Reset Form

STATE OF HAWAII
Level of Care (LOC) Reevaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110 Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

Please Type

1. PATIENT NAME (Last, First, M.I.)	2. MEDICAID ID NO.	3. BIRTHDATE Month/Day/Year	4. SEX	5. ADMIT DATE Month/Day/Year
6. PRESENT ADDRESS (Specify Facility Name When Applicable) Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ Other				7. PROVIDER I.D. NO.
8. ATTENDING PHYSICIAN (TYPE Last Name, First Name, M.I.) Phone (808) Fax (808)		9. CONTACT PERSON (Last Name, First Name, AND Title) Phone (808) Fax (808)		
10. RETURN FORM TO: VIA ☐ FAX (Type Fax Number Below) ☐ BY MAIL (Type Address Below) Phone (808) Fax (808) (Mail)				

11. REASON(S) FOR LOC RE-EVALUATION (Check all that apply)

☐ Admission/Readmission after acute hospitalization to: Date:
- ☐ NF(name)
- ☐ Home & Community-based Services (HCBS) Program:
  - ☐ Nursing Home Without Walls (NHWW)
  - ☐ PACE Program
  - ☐ Residential Alternatives Community Care Program (RACCP)
  - ☐ HIV Community Care Program (HCCP)
  - ☐ Other (name)
  - (Case Management Agency)

☐ Transfer from NF to NF (name) Date:

☐ Change in LOC

☐ Extension of Acute Waitlist NF status (date of initial determination) (period requested) From: To

☐ At home, ☐ waitlisted for NF or ☐ waitlisted for HCBS program

☐ In NF, and discharge options offered. Complete disposition below:

☐ Disposition (check all that apply):
- ☐ Returned Home ☐ Extended Care ARCH ☐ Hospice - NF ☐ Other:
- ☐ Placed in HCBS Waiver Program ☐ NHWW ☐ RACCP 1 ☐ RACCP 2 ☐ HCCP ☐ PACE
- ☐ Inappropriate for HCBS ☐ No waiver "slot" available ☐ No willing provider ☐ No willing caregiver

12. APPROVED LOC ON MOST CURRENT FORM (Date)		13. LOC BEING REQUESTED (Effective Date)			
☐ Subacute Level I	☐ Subacute Level II	Anticipated time: From	to		
☐ SNF	☐ ICF	☐ Subacute Level I	☐ Subacute Level II	☐ SNF	☐ ICF
☐ Acute Waitlist Subacute	☐ Acute Waitlist SNF	☐ Acute Waitlist	☐ Subacute	☐ SNF	☐ ICF
☐ Acute Waitlist ICF	☐ Hospice - NF	☐ Hospice - NF			

14. CURRENT STATUS (Check all that apply)

☐ No change in diagnoses (Specify Primary Diagnoses)

☐ Additional Diagnoses (list diagnoses)

☐ Functional Capabilities ☐ No Change ☐ Change(s) {Specify}

☐ Nursing needs ☐ No Change ☐ Change(s) {Specify}

☐ Change in LOC ☐ No Change ☐ Change(s) {Specify}

DOCUMENT NEED AT REQUESTED LOC:

PHYSICIAN'S SIGNATURE: _____ **DATE:**

Physician's Name (TYPE):

15. MEDICAL NECESSITY/LEVEL OF CARE ACTION – DO NOT COMPLETE

APPROVED FOR:	EFFECTIVE DATE: _____
[ ] Subacute I [ ] Subacute II [ ] SNF [ ] ICF	LENGTH OF APPROVAL
[ ] Acute Waitlist Subacute [ ] Acute Waitlist SNF [ ] Acute Waitlist ICF	[ ] 1 year [ ] 6 months
[ ] Hospice - NF	[ ] Other – Specify: _____ To _____

DEFERRED: [ ] New 1147 Needed. [ ] Other. Reason: _____

DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____