STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) Re-Evaluation

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

Please Print or Type

1. PATIENT NAME (Last, First, M.I.)	2. BIRTHDATE Month/Day/Year	3. SEX	4. MEDICAID ID NUMBER

5. PRESENT ADDRESS: Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ Other _____

6. Medicaid Provider Number: (If applicable)

7. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial)

_____

Phone ( )_____ Fax ( ) _____

8. RETURN FORM TO (SERVICE COORDINATOR/CONTACT PERSON): _____

MANAGED CARE PLAN NAME (IF APPLICABLE): _____

VIA [ ] FAX (Print Fax Number Below)
Phone ( )_____ Fax ( )_____ Email ( ) _____

9. REASON(S) FOR LOC RE-EVALUATION

[ ] Change in LOC
[ ] Extension of Current LOC
[ ] At home and waitlisted for Long Term Care Services: ☐ NF or ☐ Home and Community Based Services
[ ] No longer meeting LOC (NOT in acute, NF ICF, NF SNF, NF Hospice, NF Subacute I or II, Acute waitlisted ICF or SNF or Subacute) as of date: _____. Fill out #10, then do not proceed.

10. APPROVED LOC ON MOST CURRENT FORM (Date Span) From: _____ TO _____	11. LOC BEING REQUESTED LOC BEGIN and END DATES: _____ TO _____
[ ] Nursing Facility (ICF)	[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)	[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)	[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)	[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)	[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)	[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)	[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)	[ ] Acute Waitlist (Subacute)

12. CURRENT STATUS

Specify Current Primary Diagnosis _____

[ ] Additional Diagnoses (list diagnoses) _____

[ ] Functional Capabilities ( ) No Change ( ) Change(s) {Specify} _____

[ ] Nursing needs ( ) No Change ( ) Change(s) {Specify} _____

DOCUMENT NEED AT REQUESTED LOC: _____

_____

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

☐ Hard copy signature on file. This plan of care has been discussed with the MD/PCP.

Physician's/PCP Name (PRINT): _____

13. MEDICAL NECESSITY/LEVEL OF CARE DETERMINATION – DO NOT COMPLETE

LEVEL OF CARE APPROVAL:	LOC BEGIN AND END DATES: _____ TO _____
[ ] Nursing Facility (ICF)	LENGTH OF APPROVAL (CHECK ONE BOX):
[ ] Nursing Facility (SNF)	[ ] 1 month [ ] 3 months
[ ] Nursing Facility (HOSPICE)	[ ] 6 months [ ] 1 year
[ ] Nursing Facility (Subacute I)	[ ] Other: _____
[ ] Nursing Facility (Subacute II)	
[ ] Acute Waitlist (ICF)	
[ ] Acute Waitlist (SNF)	
[ ] Acute Waitlist (Subacute)	

DEFERRED: [ ] Current 1147 Version Needed [ ] Missing Information

[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] INCOMPLETE INFORMATION TO DETERMINE LEVEL OF CARE

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