NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P.O. Box 700190
Kapolei, Hawaii 96709-0190

December 23, 2013

MEMORANDUM

MEMO NOS.
FFS M13-12 [FFS]
ADMX-1319 [QExA]

TO: Acute Care Hospitals, Physicians, Nursing Facilities, Hospice Providers, and QExA Health Plans

FROM: Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

SUBJECT: AT RISK FOR INSTITUTIONAL LEVEL OF CARE EVALUATION PROCESS

As part of the QUEST Integration 1115 waiver, the Med-QUEST Division's (MQD) programs will provide several home and community based services (HCBS) to Medicaid enrollees living at home who are determined to meet the "At Risk" criteria. To meet the criteria, a beneficiary must be assessed to be at risk of deteriorating to the nursing facility level of care. Functional assessments must be completed by a physician, registered nurse, or other recognized primary care provider using a newly revised three-page 1147 form. The "at risk" services are being provided through the QUEST Expanded Access (QExA) program.

The "at risk" program will have three levels of services that are available depending on the assessed need. Potentially available services include: Home-Delivered Meals, Personal Emergency Response System, Personal Care Services, Adult Day Care and Health, and Skilled or Private Duty Nursing Services. The criteria for obtaining these services are attached.

MQD's Peer Review Organization, Health Services Advisory Group (HSAG), will evaluate and determine whether a recipient meets criteria. The DHS 1147 may be completed by either the health plan or provider using the current submittal processes for 1147s through the secure Web-application (HILOC), via faxing (440-6009), or mailing forms to HSAG. Hard copy 1147 forms can be accessed and downloaded/printed from the Website at http://myhawaiieqro.com or www.med-quest.us. (Please note that forms 1147A and 1147E are not applicable to the At Risk approval process.)

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) or At Risk Evaluation

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

1. PLEASE PRINT OR TYPE ☐ Initial Request ☐ Annual Review ☐ Reconsideration ☐ Other review

2. PATIENT NAME (Last, First, M.I.)	3. BIRTHDATE Month/Day/Year	4. SEX	5. MEDICARE Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:___________________	6. MEDICAID ELIGIBLE? ☐ Yes ID # ______________________ ☐ No Date Applied _________________

7. PRESENT ADDRESS: Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ Other: ____________________

8. Medicaid Provider Number: (If applicable)

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

Phone : ( )_________________ Fax: ( )____________________________

10. RETURN FORM TO (SERVICE COORDINATOR/CONTACT PERSON): ____

MANAGED CARE PLAN NAME (IF APPLICABLE): ____

[ ] VIA FAX (Print Fax Number Below)

Phone ( )________________ Fax ( ) ______________________ Email ____

11. REFERRAL INFORMATION (Completed by Referring Party)

A. SOURCE(S) OF INFORMATION

☐ Client ☐ Records ☐ Other ____________________

B. RESPONSIBLE PERSON

Name ______________________________________
Last First MI

Relationship ______________________________

PHONE ( )_ FAX ( ) _____

C. Language ☐ English ☐ Other ____________________

12. ASSESSMENT INFORMATION (Completed by RN, Physician, PCP)

A. ASSESSMENT DATE _____/_______/_____

B. ASSESSOR'S NAME

Name ______________________________________
Last First MI

Title ______________________________________

Signature _ ______________________________________

☐ Hard copy signature on file.

PHONE: ( ) _________________ FAX: ( ) _____________

EMAIL: ____

13. REQUESTING

CHECK ONE BOX:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)
[ ] At Risk

BEGIN and END DATES: ___________ TO __________

LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months [ ] 1 year

[ ] Other: ____________________

14. MEDICAL NECESSITY DETERMINATION – DO NOT COMPLETE

APPROVAL:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)
[ ] At Risk

BEGIN AND END DATES: ___________ TO __________

LENGTH OF APPROVAL (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months [ ] 1 year

[ ] Other: ____________________

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

NOT APPROVED:

[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] DOES NOT MEET AT RISK CRITERIA [ ] INCOMPLETE INFORMATION TO MAKE DETERMINATION

NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.

DHS REVIEWER'S / DESIGNEE'S SIGNATURE: ______________________________ DATE: __________________

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Phone: (808) 440-6000 Fax: (808) 440-6009

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (Last, First, Middle Initial)	2. **BIRTHDATE**

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):

PRIMARY: ______________________________

____

SECONDARY: ______________________________

____

____

II. COMATOSE ☐ No ☐ Yes If "Yes," go to **XIV.**

III. VISION / HEARING / SPEECH:

[0] a. Individual has normal or minimal impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[1] b. Individual has impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[2] c. Individual has complete absence of: ☐ Hearing ☐ Vision ☐ Speech

IV. COMMUNICATION:

[0] a. Adequately communicates needs/wants.
[1] b. Has difficulty communicating needs/wants.
[2] c. Unable to communicate needs/wants.

V. MEMORY:

[0] a. Normal or minimal impairment of memory.
[1] b. Problem with [ ] long-term or [ ] short-term memory.
[2] c. Individual has a problem with both long-term and short-term memory.

VI. MENTAL STATUS / BEHAVIOR: (only one selection for orientation – items a through c. Aggressive and/or abusive and wandering may also be checked with appropriate orientation.)

[0] a. Oriented (mentally alert and aware of surroundings).
[1] b. Disoriented (partially or intermittently; requires supervision).
[2] c. Disoriented and/or disruptive.
[3] d. Aggressive and/or abusive.
[4] e. Wanders at [ ] Day [ ] Night [ ] Both, or in danger of self-inflicted harm or self-neglect.

VII. FEEDING/MEAL PREPARATION:

[0] a. Independent with or without an assistive device.
[1] b. Feeds self but needs help with meal preparation.
[2] c. Needs supervision or assistance with feeding.
[4] d. Is spoon / syringe / tube fed, does not participate.

VIII. TRANSFERRING:

[0] a. Independent with or without a device.
[2] b. Transfers with minimal /stand-by help of another person.
[3] c. Transfers with supervision and physical assistance of another person.
[4] d. Does not assist in transfer or is bedfast.

IX. MOBILITY / AMBULATION: (Check a maximum of 2 for items b through e. If an individual is either mobile or unable to walk, no other selections can be made.)

[0] a. Independently mobile with or without device.
[1] b. Ambulates with or without device but unsteady / subject to falls.
[2] c. Able to walk/be mobile with minimal assistance.
[3] d. Able to walk/be mobile with one assist.
[4] e. Able to walk/be mobile with more than one assist.
[5] f. Unable to walk.

X. BOWEL FUNCTION / CONTINENCE:

[0] a. Continent.
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times _________).

XI. BLADDER FUNCTION / CONTINENCE:

[0] a. Continent.
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times _________).

XII. BATHING:

[0] a. Independent bathing.
[1] b. Unable to safely bathe without minimal assistance and supervision.
[3] c. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).

XIII. DRESSING AND PERSONAL GROOMING:

[0] a. Appropriate and independent dressing, undressing and grooming.
[1] b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes).
[2] c. Physical assistance needed on a regular basis.
[3] d. Requires total help in dressing, undressing, and grooming.

XIV. TOTAL POINTS:

Comatose = 30 points

Total Points Indicated: __________

XV. MEDICATIONS/TREATMENTS:

(List all Significant Medications, Dosage, Frequency, and mode) Attach additional sheet if necessary	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______
______________________	[ ]	[ ]	[ ]	______

XVI. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS:

____

____

____

____

DO NOT MODIFY FORM
Legible photocopies and facsimiles will be acknowledged as original

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Department of Human Services
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APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (PRINT Last, First, Middle Initial)	2. **BIRTHDATE**

XVII. SKILLED PROCEDURES: D = Daily Indicate number of times per day **L** = Less than once per day **N** = Not applicable / Never

D #	L √	N √	PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:
___	[ ]	[ ]	Tracheostomy care/suctioning in ventilator dependent person
___	[ ]	[ ]	Tracheostomy care/suctioning in non-ventilator dependent person
___	[ ]	[ ]	Nasopharyngeal suctioning in persons with no tracheostomy
___	[ ]	[ ]	Total Parenteral Nutrition (TPN) {Specify number of hours per day}: ______
___	[ ]	[ ]	Maintenance of peripheral/central IV lines
___	[ ]	[ ]	IV Therapy (Specify agent & frequency): ______
___	[ ]	[ ]	Decubitus ulcers (Stage III and above)
___	[ ]	[ ]	Decubitus ulcers (less than Stage III); wound care {Specify nature of ulcer/wound and care prescribed} ______
___	[ ]	[ ]	Wound care (Specify nature of wound and care prescribed) ☐ debridement ☐ Irrigation ☐ packing ☐ wound vac. ______
___	[ ]	[ ]	Instillation of medications via indwelling urinary catheters (Specify agent): ______
___	[ ]	[ ]	Intermittent urinary catheterization
___	[ ]	[ ]	IM/SQ Medications (Specify agent.): ______
___	[ ]	[ ]	Difficulty with administration of oral medications (Explain): ______
___	[ ]	[ ]	Swallowing difficulties and/or choking
___	[ ]	[ ]	Stable Gastrostomy/Nasogastric/Jejunostomy tube feedings; Enteral Pump? ☐ Yes ☐ No
___	[ ]	[ ]	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration (Specify reason person at risk for aspiration) ______
___	[ ]	[ ]	Initial phase of Oxygen therapy
___	[ ]	[ ]	Nebulizer treatment
___	[ ]	[ ]	Complicating problems of patients on [ ] renal dialysis, [ ] chemotherapy, [ ] radiation therapy, [ ] with orthopedic traction (Check problem(s) and describe) : ______
___	[ ]	[ ]	Behavioral problems related to neurological impairment (Describe): ______
___	[ ]	[ ]	Other (Specify condition and describe nursing intervention): ______

☐ Yes ☐ No Therapeutic Diet (Describe): ______

☐ Yes ☐ No Restorative Therapy (check therapy and submit/attach evaluation and treatment plan): ☐ PT ☐ OT ☐ Speech

☐ Yes ☐ No The patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XVIII. SOCIAL SITUATION:

A. Person can return home ☐ Yes ☐ No ☐ N/A Community setting can be considered as an alternative to facility? ☐ Yes ☐ No ☐ N/A

B. If person has a home; caregiving support system is willing to provide/continue care. ☐ Yes ☐ No

Caregiver requires assistance? ☐ Yes ☐ No

Assistance required by Caregiver: ______

C. Caregiver name:

Name: ______ (Last First MI) Relationship: ______

Address: ______ Phone: ( ) ______ Fax ( ) ______

XIX. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

______

I HAVE REVIEWED AND AGREE WITH THIS ASSESSMENT.

PHYSICIAN/PCP/RN SIGNATURE: ______

☐ Hard copy signature on file. This plan of care has been discussed with the MD/PCP/RN. **DATE:** ____/____/____

Physician/PCP/RN Name (PRINT): ______

DO NOT MODIFY FORM
Legible photocopies and facsimiles will be acknowledged as original

QExA health plans or a designee shall complete an 1147 for their members, who do not meet nursing facility level of care but are currently receiving "at risk" services, at their next scheduled assessment. QExA health plans do not need to complete 1147s for this population immediately (i.e., in January 2014).

If there are any questions or concerns, please call Ms. Kathleen Ishihara, Nurse Consultant at (808) 692-8159.

Attachments:
Criteria for At Risk Population
1147 Revised Form and Instructions (Draft)

Criteria for At-Risk Population

The "At- Risk" population is defined as those Hawaii Medicaid beneficiaries who do not meet criteria for nursing facility level of care (NF LOC) but are assessed to be at risk of deteriorating to the institutional level of care if certain long term services and supports (LTSS) are not provided. To be eligible, the individual must reside in his/her home (may live in home with daughter/son/guardian/friend or other family member), is not required to be homebound, and cannot be residing in a care home, foster home, hospital, nursing facility, hospice facility, or ICF/ID.

Individuals that do meet NF LOC and/or are receiving services in a nursing facility, hospital, hospice facility, etc. (in an institutional setting) do not qualify for inclusion in the At-Risk population. The At-Risk population also does not include individuals who meet the criteria for intermediate care facility for persons with intellectual disabilities (ICF/ID) LOC or are receiving services in the Developmental Disabilities or Intellectual Disabilities (DD/ID) 1915(c) waiver.

Eligible Medicaid beneficiaries shall receive at risk services through their QUEST Expanded Access (QExA) health plan. A Medicaid beneficiary who meets At-Risk criteria is eligible to receive the following home and community based services: Home-delivered meals, Personal Emergency Response System (PERS), personal assistance (level I and II), adult day care, adult day health, and skilled nursing services. To meet criteria for the At-Risk population, the beneficiary must have a minimum of five functional points and the 1147 form must include additional documentation to support the functional status and needs. Health plans will provide services based upon medical necessity. Three levels of services are available as follows:

Level	Functional points	Services
I	5 to 7 functional points	▪ home-delivered meals* ▪ PERS
II	8 to 10 functional points	▪ home-delivered meals ** ▪ PERS ▪ personal assistance (level I)
III	Greater than 10 functional points	▪ home-delivered meals** ▪ PERS ▪ personal assistance (both level I and II) ▪ adult day care ▪ adult day health ▪ skilled nursing services

*If home-delivered meals are not available in the area where the individual resides, the health plan may substitute personal assistance level I for meal preparation.

**As meal preparation is included as part of personal care (chore) services, an individual receiving personal care services cannot simultaneously receive home-delivered meals.

Based on current available funding, DHS will have service limits and enact waitlists as described below:

- Level I: No service limit for individuals receiving only home-delivered meals or PERS.

- Level II and III combined: Service limit of 2,500 individuals (split evenly between 'Ohana Health Plan and UnitedHealthcare Community Plan). A waitlist will be maintained should the number of eligible individuals seeking services exceed the service limit.

- Waitlists shall be managed based upon needs of the member.

- QExA health plans may provide HCBS services to individuals who do not meet At-Risk criteria. However, this is at the health plan's discretion and these individuals will not be counted towards their service limit.

Additional documentation required to support meeting At-Risk criteria:

In addition to the functional assessment point scores, the 1147 form must contain documented evidence or examples of the individual's situation, functional deficits, and limitations, and must demonstrate how he/she would benefit from the LTSS. For example, the "comments" should describe one or more of the following:

- Caregiver support system is unable to provide 24/7 supervision and recipient cannot be left alone during day (e.g., family/caregiver support system works outside home during day).

- The individual requires assistance with medically necessary tasks (due to memory, mental status/behavior, or physical limitations), such as insulin administration or basic wound care.

- The individual may be unsteady and may have fallen previously, but is able to get self to restroom and/or change own incontinence pads.

Maximum length of approval is for a one-year period, based on individual needs, and may be renewed if medically necessary. The review and approval of an individual as meeting At-Risk criteria will be based upon information contained on the Form 1147 only (assessment, functional scores and needs, comments, etc.); 1147A forms and 1147E forms will not be reviewed for At-Risk population criteria.

INSTRUCTIONS
DHS FORM 1147
Rev. 01/14
LEVEL OF CARE (LOC) AND AT RISK EVALUATION

1. ***Check the appropriate box for the evaluation:*** Check type of request - initial, annual, reconsideration or other review, i.e. 3 month review to determine continued stay.

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

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

4. ***Sex***: Indicate whether the patient is “M” for male or “F” for female.

5. ***Medicare***: Check the appropriate box indicating whether patient has Medicare Part A and B and enter patient’s Medicare I.D. number, if eligible for either Part A or B.

6. ***Medicaid Eligible***: Check “Yes” or “No” to indicate whether the patient is currently Medicaid eligible. Enter Medicaid I.D. number assigned by the Department of Human Services, if eligible. If the patient has applied for Medicaid but has not yet been deemed eligible, print or type in “pending” for I.D. # and print or type in date applied. Forms will be processed only if patient has a Medicaid number or has the date of the Medicaid application.

7. ***Present Address***: Indicate patient’s present address, i.e. Home, Hospital, Nursing Facility (NF), Care Home, Extended Adult Residential Care Home (EARCH – Type I & Type II), Community Care Family Foster Home (CCFFH), or other.

   Home: Patient is at his or her residential home or is homeless.
   Hospital: Patient is currently residing in an Acute Care Hospital, i.e. waitlisted at an acute waitlisted level of care.
   Nursing Facility (NF): Patient is currently residing in a nursing facility.
   Care Home: Patient is currently residing in a care home – not at nursing facility level of care.
   Extended Adult Resident Care Home (EARCH): Patient is currently residing in a Department of Health or Shared Home with the Department of Human Services which include Patients at a care home and nursing facility level of care.
   Community Care Foster Family Home (CCFFH): Patient is currently residing in a Department of Human Services Foster Home which includes Patients at a nursing facility level of care.
   Other: Check this box if the patient’s present address is not listed above. Write in the description.

8. ***Medicaid Provider Number***: Enter only if applicable. Patient must be pending Medicaid and currently NOT a patient in a managed care health plan.

9. ***Attending Physician/Primary Care Provider (PCP)***: Enter the name of the attending physician or primary care provider, telephone and fax number.

10. ***Return Form to***: Enter the name of the service coordinator or the contact person. Indicate the managed care plan name if applicable, telephone, fax number and email address of the person able to provide additional information about the patient.

11. ***Referral Information***: Complete all sections for an initial request. Skip this section, if this is an annual or "other" review.

    A. Source(s) of Information: Identify the source(s) of patient information received.

    B. Responsible Person: Provide the name, relationship, phone and fax numbers of the family member/personal agent who will be making decisions for the patient.

    C. Language: Check the box of the primary language spoken by the patient. If checking "Other," indicate the language spoken. Information is used to obtain interpreters.

12. ***Assessment Information***: Complete all sections.

    A. Assessment Date: Indicate the date of the most current assessment.

    B. Assessor's Name, Title, Signature, Phone and Fax Numbers: A registered nurse (RN), physician or primary care provider must perform the assessment. Enter the name, title and telephone, fax number and email address of the assessor. The assessor must sign the form.

    Electronic submittal of form(s) will be accepted with the box checked that a signature of the RN, physician or primary care provider has signed a hard copy of this form and the hard copy of the form(s) can be found in the patient's file.

13. ***Requesting***: Check what is being requested (either level of care or at risk). Indicate the begin and end date of the request. If hospice services have been elected by the patient AND the services will be provided in a nursing facility, attach the hospice election and physician verification form. *Hospice services in other settings do not require an 1147 form.*

    Indicate the length of approval requested. Check one box.

14. ***Medical Necessity Determination***: Completed by DHS reviewer or designee. Leave Blank. DO NOT COMPLETE.

PAGE 2 AND 3– APPLICANT/PATIENT BACKGROUND INFORMATION

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

2. ***Birthdate***: Self-explanatory

3. ***Functional Status Related to Health Conditions***: Complete all sections.

I. **List significant current diagnosis(es)**: List the primary and secondary diagnosis(es) or medical conditions related to the patient's need for long-term care.

II. **Comatose**: If patient is comatose, check "Yes" box and go directly to Section XIV. If patient is not comatose, check "No" and complete rest of section.

III. **Vision/Hearing/Speech through XIII Dressing and Personal Grooming**: Select the description that best describes the patient's functioning.

Note: Make only one selection in all sections except VI. Mental Status/Behavior and IX. Mobility/Ambulation. For Mental Status/Behavior, make only one selection for orientation (items a through c). Aggressive and/or abusive and wandering may also be checked with the appropriate orientation. For Mobility/Ambulation, check a maximum of 2 for items b through e. If an individual is either mobile or unable to walk, no other selections can be made.

XIV. **Total Points**: Add the points from each section to obtain total. Comatose patients are assigned 30 points.

XV. **Medications/Treatments**: List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (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 significant medications than available lines, attach orders or treatment sheet.

XVI. **Additional Information Concerning Patient's Functional Status**: Use the space to provide additional information on the patient's functional status. This section may be used to identify the extent of the assistance (minimal, with assistance or total) that is required. Attach a separate sheet if more space is required. See attachment Functional Status related to Health Conditions on scoring this section.

XVII. **Skilled Procedures**: Check the particular skilled procedure(s) that the patient requires. If the care is daily (D), indicate the number of times per day that care is required. If care is less than once per day check "L". If the care is not applicable, check "N".

If restorative therapy is being requested, attach the evaluation and treatment plan(s) AND indicate whether the patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XVIII. **Social Situation**:

A. **Person can return home**: Identify whether the patient can return home. The home can be a family member's (daughter, son, brother, sister, parents, etc.) home as well as the patient's own home. Check "NA" if the patient is already in a home environment. If the individual does not have a home, indicate whether the patient can be placed in a community setting. Check "NA" if the patient is already in a community setting.

B. **Caregiving support**: If the patient has a home, identify whether the caregiving support is willing/able to provide care. If caregiver requires assistance, identify the assistance required.

C. **Caregiver name**. Provide the caregiver's name, relationship, address, phone and fax numbers.

XIX. **Comments on Nursing Requirements or Social Situation:** Provide any additional information that would help explain the Patient's nursing requirements or social situation.

Physician/PCP/RN Signature: Self-explanatory.

Electronic submittal of form(s) will be accepted with the box checked that the physician, the primary care provider, or the registered nurse has signed a hard copy of the form(s) and that the plan of care has been discussed with the physician, primary care provider, or registered nurse. The hard copy of the form(s) must be kept in the Patient's file.

Date: Indicate the date of the physician, Primary Care Provider, or Registered Nurses' signature.

Physician's/PCP/RN Name (Print): Self-explanatory.

Filing Instructions: Fax, or send forms electronically to:

Health Services Advisory Group, Inc.
1440 Kapiolani Blvd., Suite 1110,
Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

STATE OF HAWAII
Department of Human Services
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STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

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Phone: (808) 440-6000 Fax: (808) 440-6009

1. PLEASE PRINT OR TYPE ☐ Initial Request ☐ Annual Review ☐ Reconsideration ☐ Other review

2. PATIENT NAME (Last, First, M.I.)	3. BIRTHDATE Month/Day/Year	4. SEX	5. MEDICARE Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:__________	6. MEDICAID ELIGIBLE? ☐ Yes ID # __________ ☐ No Date Applied

7. PRESENT ADDRESS: Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ Other: __________

8. Medicaid Provider Number: (If applicable)

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

Phone : ( )__________ Fax: ( )__________

10. RETURN FORM TO (SERVICE COORDINATOR/CONTACT PERSON): __________

MANAGED CARE PLAN NAME (IF APPLICABLE): __________

[ ] VIA FAX (Print Fax Number Below)

Phone ( )__________ Fax ( ) __________ Email ( ) __________

11. REFERRAL INFORMATION (Completed by Referring Party)

A. SOURCE(S) OF INFORMATION

☐ Client ☐ Records ☐ Other __________

B. RESPONSIBLE PERSON

Name __________
Last First MI

Relationship __________

PHONE ( )_ FAX ( ) _____

C. Language ☐ English ☐ Other __________

12. ASSESSMENT INFORMATION (Completed by RN, Physician, PCP)

A. ASSESSMENT DATE ____/____/____

B. ASSESSOR'S NAME

Name __________
Last First MI

Title __________

Signature __________

☐ Hard copy signature on file.

PHONE: ( ) __________ FAX: ( ) __________

EMAIL: ( ) __________

13. REQUESTING

CHECK ONE BOX:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)
[ ] At Risk

BEGIN and END DATES: __________ TO __________

LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months [ ] 1 year

[ ] Other: __________

14. MEDICAL NECESSITY DETERMINATION – DO NOT COMPLETE

APPROVAL:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)
[ ] At Risk

BEGIN AND END DATES: __________ TO __________

LENGTH OF APPROVAL (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months [ ] 1 year

[ ] Other: __________

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

NOT APPROVED:

[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] DOES NOT MEET AT RISK CRITERIA [ ] INCOMPLETE INFORMATION TO MAKE DETERMINATION

NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.

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

DO NOT MODIFY FORM
Legible photocopies and facsimiles will be acknowledged as original

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

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

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (Last, First, Middle Initial)	2. **BIRTHDATE**

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):

PRIMARY: ____________________

____

SECONDARY: ____________________

____

____

II. COMATOSE ☐ No ☐ Yes If "Yes," go to **XIV.**

III. VISION / HEARING / SPEECH:
[0] a. Individual has normal or minimal impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[1] b. Individual has impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[2] c. Individual has complete absence of: ☐ Hearing ☐ Vision ☐ Speech

IV. COMMUNICATION:
[0] a. Adequately communicates needs/wants.
[1] b. Has difficulty communicating needs/wants.
[2] c. Unable to communicate needs/wants.

V. MEMORY:
[0] a. Normal or minimal impairment of memory.
[1] b. Problem with [ ] long-term or [ ] short-term memory.
[2] c. Individual has a problem with both long-term and short-term memory.

VI. MENTAL STATUS / BEHAVIOR: (only one selection for orientation – items a through c. Aggressive and/or abusive and wandering may also be checked with appropriate orientation.)
[0] a. Oriented (mentally alert and aware of surroundings).
[1] b. Disoriented (partially or intermittently; requires supervision).
[2] c. Disoriented and/or disruptive.
[3] d. Aggressive and/or abusive.
[4] e. Wanders at [ ] Day [ ] Night [ ] Both, or in danger of self-inflicted harm or self-neglect.

VII. FEEDING/MEAL PREPARATION:
[0] a. Independent with or without an assistive device.
[1] b. Feeds self but needs help with meal preparation.
[2] c. Needs supervision or assistance with feeding.
[4] d. Is spoon / syringe / tube fed, does not participate.

VIII. TRANSFERRING:
[0] a. Independent with or without a device.
[2] b. Transfers with minimal /stand-by help of another person.
[3] c. Transfers with supervision and physical assistance of another person.
[4] d. Does not assist in transfer or is bedfast.

IX. MOBILITY / AMBULATION: (Check a maximum of 2 for items b through e. If an individual is either mobile or unable to walk, no other selections can be made.)
[0] a. Independently mobile with or without device.
[1] b. Ambulates with or without device but unsteady / subject to falls.
[2] c. Able to walk/be mobile with minimal assistance.
[3] d. Able to walk/be mobile with one assist.
[4] e. Able to walk/be mobile with more than one assist.
[5] f. Unable to walk.

X. BOWEL FUNCTION / CONTINENCE:
[0] a. Continent.
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times ____________).

XI. BLADDER FUNCTION / CONTINENCE:
[0] a. Continent.
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times ____________).

XII. BATHING:
[0] a. Independent bathing.
[1] b. Unable to safely bathe without minimal assistance and supervision.
[3] c. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).

XIII. DRESSING AND PERSONAL GROOMING:
[0] a. Appropriate and independent dressing, undressing and grooming.
[1] b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes).
[2] c. Physical assistance needed on a regular basis.
[3] d. Requires total help in dressing, undressing, and grooming.

XIV. TOTAL POINTS:

Comatose = 30 points

Total Points Indicated: ________

XV. MEDICATIONS/TREATMENTS:

(List all Significant Medications, Dosage, Frequency, and mode) Attach additional sheet if necessary	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	

XVI. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS:

____

____

____

____

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STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

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APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (PRINT Last, First, Middle Initial)	2. **BIRTHDATE**

XVII. SKILLED PROCEDURES: **D** = Daily Indicate number of times per day **L** = Less than once per day **N** = Not applicable / Never

D #	L √	N √	PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:
___	[ ]	[ ]	Tracheostomy care/suctioning in ventilator dependent person
___	[ ]	[ ]	Tracheostomy care/suctioning in non-ventilator dependent person
___	[ ]	[ ]	Nasopharyngeal suctioning in persons with no tracheostomy
___	[ ]	[ ]	Total Parenteral Nutrition (TPN) {Specify number of hours per day}: ___
___	[ ]	[ ]	Maintenance of peripheral/central IV lines
___	[ ]	[ ]	IV Therapy (Specify agent & frequency): ___
___	[ ]	[ ]	Decubitus ulcers (Stage III and above)
___	[ ]	[ ]	Decubitus ulcers (less than Stage III); wound care {Specify nature of ulcer/wound and care prescribed} ___
___	[ ]	[ ]	Wound care (Specify nature of wound and care prescribed) ☐ debridement ☐ Irrigation ☐ packing ☐ wound vac. ___
___	[ ]	[ ]	Instillation of medications via indwelling urinary catheters (Specify agent): ___
___	[ ]	[ ]	Intermittent urinary catheterization
___	[ ]	[ ]	IM/SQ Medications (Specify agent.): ___
___	[ ]	[ ]	Difficulty with administration of oral medications (Explain): ___
___	[ ]	[ ]	Swallowing difficulties and/or choking
___	[ ]	[ ]	Stable Gastrostomy/Nasogastric/Jejunostomy tube feedings; Enteral Pump? ☐ Yes ☐ No
___	[ ]	[ ]	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration (Specify reason person at risk for aspiration) ___
___	[ ]	[ ]	Initial phase of Oxygen therapy
___	[ ]	[ ]	Nebulizer treatment
___	[ ]	[ ]	Complicating problems of patients on [ ] renal dialysis, [ ] chemotherapy, [ ] radiation therapy, [ ] with orthopedic traction (Check problem(s) and describe) : ___
___	[ ]	[ ]	Behavioral problems related to neurological impairment (Describe): ___
___	[ ]	[ ]	Other (Specify condition and describe nursing intervention): ___

☐ Yes ☐ No Therapeutic Diet (Describe): ___

☐ Yes ☐ No Restorative Therapy (check therapy and submit/attach evaluation and treatment plan): ☐ PT ☐ OT ☐ Speech

☐ Yes ☐ No The patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XVIII. SOCIAL SITUATION:

A. Person can return home ☐ Yes ☐ No ☐ N/A Community setting can be considered as an alternative to facility? ☐ Yes ☐ No ☐ N/A

B. If person has a home; caregiving support system is willing to provide/continue care. ☐ Yes ☐ No

Caregiver requires assistance? ☐ Yes ☐ No

Assistance required by Caregiver: ___

C. Caregiver name:

Name: ___ Last First MI Relationship: ___

Address: ___ Phone: ( ) ___ Fax ( ) ___

XIX. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

___

I HAVE REVIEWED AND AGREE WITH THIS ASSESSMENT.

PHYSICIAN/PCP/RN SIGNATURE: ___

☐ Hard copy signature on file. This plan of care has been discussed with the MD/PCP/RN. **DATE:** ___ / ___ / ___

Physician/PCP/RN Name (PRINT): ___

INSTRUCTIONS
DHS FORM 1147
Rev. 01/14
LEVEL OF CARE (LOC) AND AT RISK EVALUATION

1. ***Check the appropriate box for the evaluation:*** Check type of request - initial, annual, reconsideration or other review, i.e. 3 month review to determine continued stay.

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

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

4. ***Sex***: Indicate whether the patient is "M" for male or "F" for female.

5. ***Medicare***: Check the appropriate box indicating whether patient has Medicare Part A and B and enter patient's Medicare I.D. number, if eligible for either Part A or B.

6. ***Medicaid Eligible***: Check "Yes" or "No" to indicate whether the patient is currently Medicaid eligible. Enter Medicaid I.D. number assigned by the Department of Human Services, if eligible. If the patient has applied for Medicaid but has not yet been deemed eligible, print or type in "pending" for I.D. # and print or type in date applied. Forms will be processed only if patient has a Medicaid number or has the date of the Medicaid application.

7. ***Present Address***: Indicate patient's present address, i.e. Home, Hospital, Nursing Facility (NF), Care Home, Extended Adult Residential Care Home (EARCH – Type I & Type II), Community Care Family Foster Home (CCFFH), or other.

   <u>Home:</u> Patient is at his or her residential home or is homeless.
   <u>Hospital:</u> Patient is currently residing in an Acute Care Hospital, i.e. waitlisted at an acute waitlisted level of care.
   <u>Nursing Facility (NF):</u> Patient is currently residing in a nursing facility.
   <u>Care Home:</u> Patient is currently residing in a care home – not at nursing facility level of care.
   <u>Extended Adult Resident Care Home (EARCH):</u> Patient is currently residing in a Department of Health or Shared Home with the Department of Human Services which include Patients at a care home and nursing facility level of care.
   <u>Community Care Foster Family Home (CCFFH):</u> Patient is currently residing in a Department of Human Services Foster Home which includes Patients at a nursing facility level of care.
   <u>Other:</u> Check this box if the patient's present address is not listed above. Write in the description.

8. ***Medicaid Provider Number***: Enter only if applicable. Patient must be pending Medicaid and currently NOT a patient in a managed care health plan.

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9. *Attending Physician/Primary Care Provider (PCP)*: Enter the name of the attending physician or primary care provider, telephone and fax number.

10. *Return Form to*: Enter the name of the service coordinator or the contact person. Indicate the managed care plan name if applicable, telephone, fax number and email address of the person able to provide additional information about the patient.

11. *Referral Information*: Complete all sections for an initial request. Skip this section, if this is an annual or "other" review.

    A. **Source(s) of Information**: Identify the source(s) of patient information received.

    B. **Responsible Person**: Provide the name, relationship, phone and fax numbers of the family member/personal agent who will be making decisions for the patient.

    C. **Language**: Check the box of the primary language spoken by the patient. If checking "Other," indicate the language spoken. Information is used to obtain interpreters.

12. *Assessment Information*: Complete all sections.

    A. **Assessment Date**: Indicate the date of the most current assessment.

    B. **Assessor's Name, Title, Signature, Phone and Fax Numbers**: A registered nurse (RN), physician or primary care provider must perform the assessment. Enter the name, title and telephone, fax number and email address of the assessor. The assessor must sign the form.

    Electronic submittal of form(s) will be accepted with the box checked that a signature of the RN, physician or primary care provider has signed a hard copy of this form and the hard copy of the form(s) can be found in the patient's file.

13. *Requesting*: Check what is being requested (either level of care or at risk). Indicate the begin and end date of the request. If hospice services have been elected by the patient AND the services will be provided in a nursing facility, attach the hospice election and physician verification form. *Hospice services in other settings do not require an 1147 form.*

    Indicate the length of approval requested. Check one box.

14. *Medical Necessity Determination*: Completed by DHS reviewer or designee. Leave Blank. DO NOT COMPLETE.

PAGE 2 AND 3– APPLICANT/PATIENT BACKGROUND INFORMATION

1. *Name*: Self-explanatory

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2. ***Birthdate***: Self-explanatory

3. ***Functional Status Related to Health Conditions***: Complete all sections.

    I. **List significant current diagnosis**(es): List the primary and secondary diagnosis(es) or medical conditions related to the patient's need for long-term care.

    II. **Comatose**: If patient is comatose, check "Yes" box and go directly to Section XIV. If patient is not comatose, check "No" and complete rest of section.

    III. **Vision/Hearing/Speech through XIII Dressing and Personal Grooming**: Select the description that best describes the patient's functioning.

    Note: Make only one selection in all sections except VI. Mental Status/Behavior and IX. Mobility/Ambulation. For Mental Status/Behavior, make only one selection for orientation (items a through c). Aggressive and/or abusive and wandering may also be checked with the appropriate orientation. For Mobility/Ambulation, check a maximum of 2 for items b through e. If an individual is either mobile or unable to walk, no other selections can be made.

    XIV. **Total Points**: Add the points from each section to obtain total. Comatose patients are assigned 30 points.

    XV. **Medications/Treatments**: List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (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 significant medications than available lines, attach orders or treatment sheet.

    XVI. **Additional Information Concerning Patient's Functional Status**: Use the space to provide additional information on the patient's functional status. This section may be used to identify the extent of the assistance (minimal, with assistance or total) that is required. Attach a separate sheet if more space is required. See attachment Functional Status related to Health Conditions on scoring this section.

    XVII. **Skilled Procedures**: Check the particular skilled procedure(s) that the patient requires. If the care is daily (D), indicate the number of times per day that care is required. If care is less than once per day check "L". If the care is not applicable, check "N".

    If restorative therapy is being requested, attach the evaluation and treatment plan(s) AND indicate whether the patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

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XVIII. **Social Situation**:

A. **Person can return home**: Identify whether the patient can return home. The home can be a family member's (daughter, son, brother, sister, parents, etc.) home as well as the patient's own home. Check "NA" if the patient is already in a home environment. If the individual does not have a home, indicate whether the patient can be placed in a community setting. Check "NA" if the patient is already in a community setting.

B. **Caregiving support**: If the patient has a home, identify whether the caregiving support is willing/able to provide care. If caregiver requires assistance, identify the assistance required.

C. **Caregiver name**. Provide the caregiver's name, relationship, address, phone and fax numbers.

XIX. **Comments on Nursing Requirements or Social Situation:** Provide any additional information that would help explain the Patient's nursing requirements or social situation.

Physician/PCP/RN Signature: Self-explanatory.

Electronic submittal of form(s) will be accepted with the box checked that the physician, the primary care provider, or the registered nurse has signed a hard copy of the form(s) and that the plan of care has been discussed with the physician, primary care provider, or registered nurse. The hard copy of the form(s) must be kept in the Patient's file.

Date: Indicate the date of the physician, Primary Care Provider, or Registered Nurses' signature.

Physician's/PCP/RN Name (Print): Self-explanatory.

Filing Instructions: Mail, fax, or send forms electronically to:

Health Services Advisory Group, Inc.
1440 Kapiolani Blvd., Suite 1110,
Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

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