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

September 15, 2005

MEMORANDUM ACS M05-08

TO: Medicaid Acute Care Hospitals, Nursing Facilities, Physicians and Medicaid Waiver Providers

FROM: Angie Payne, Acting Med-QUEST Division Administrator

SUBJECT: CHANGES TO THE 1147 LEVEL OF CARE FORMS

The Department of Human Services (DHS) Med-QUEST Division (MQD) established a workgroup to examine and resolve issues related to discharging adults from hospitals and nursing homes into the community. One of the identified issues was the recognition that the current 1147 forms did not reflect a nursing facility's quarterly comprehensive assessments of the patient that include offering the choice to live in the community.

The workgroup recommended that the 1147 and 1147a be revised. Prior to finalizing the revisions to these forms, MQD received input from providers of nursing facility services, physicians, and the workgroup. The new forms and process will be implemented October 1, 2005. To expedite the processing of authorizations, the MQD will ONLY accept the new forms for requests submitted on or after January 1, 2006.

The revised 1147 and 1147a forms are attached. The following changes apply:

- As with the previous form, the revised 1147 will be used to approve level of care (skilled nursing, intermediate care, subacute) as well as settings (nursing home, Home and Community Based Services [HCBS], hospice services in nursing facilities, waiver services in the patient/family home, etc.). The format has been revised to improve organization and formatting.

- All initial requests for services for long-term care, hospice services in long term care facilities, and Medicaid waiver services under the Nursing Home Without Walls (NHWW), Residential Alternative Community Care Program (RACCP), HIV Community Care Program (HCCP) and PACE program will be requested on the new 1147 form. Check the box on top of the form for "Initial Request".

- Requests for long-term care or Medically Fragile Community Care Program (MFCCP) waiver services for children/youth less than age 21 will be performed on a new 1147e (children) form. Until the new form is implemented, the 1147 form should be used to request nursing facility and MFCCP services. During the interim period, use the following instructions:

  - Check the appropriate box (initial, annual, etc.) at the top of the form;

  - Complete all information as required;

  - Under Section 13. Requesting, identify the setting and care being requested. Write in any additional information that would normally be provided under EPSDT or the MFCCP waiver. As an example, if subacute care is being requested, write in Level I or II. If MFCCP is being requested, write in "MFCCP" when selecting HCBS services; and

  - Use the 1144E to request EPSDT skilled nursing/personal care and/or case management for children/youth who are medically fragile.

- All required annual reviews must be submitted on the 1147 form, and not the 1147a form as in the past. This will allow the department to have complete, updated information verifying that the person qualifies for a long term care level of care. Check the box on the top of the form for "Annual Review." If performing an annual review, section 11. Referral Information, should be left blank.

- The box "Other Review" is used when the 1147 is being used for purposes other than an initial request or annual review. An example of this is when the department's peer review organization (PRO) requests an 1147 to better assess a recipient's level of care.

- The area for notating that HCBS option counseling has been provided has moved to section 13 that identifies the services being requested. Additionally, a new item, providing information on independent living (IL), has been added. Facilities may contact the Hawaii Centers for Independent Living (HCIL) for brochures or to request assistance in counseling a patient.

- The 1147a form will primarily be used for level of care changes occurring throughout the year and dispositions resulting from offering the patient the choice to live in the community.

- Consistent with the current process, providers shall send the 1147 forms to Health Services Advisory Group (HSAG), the department's Peer Review Organization (PRO).

The Medicaid Provider Manual will be revised to reflect the new forms, and the new forms will be placed on the Med-QUEST Division's website, www.med-QUEST.us

Attachments

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110
Honolulu, Hawaii 96814

Please Print or Type ☐ Initial Request ☐ Annual Review ☐ Other review

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

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 (Last Name, First Name, Middle Initial)
Phone: ( )_____ Fax: ( )_____

9. CONTACT PERSON (Last Name, First Name, AND Title)
Phone: ( )_____ Fax: ( )_____

10. RETURN FORM TO: _____ [ ] VIA FAX (Print Fax Number Below) [ ] BY MAIL (Print Address Below)
Phone ( )_____ Fax ( ) _____ Mail _____

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 or Physician)

A. ASSESSMENT DATE ____/____/____

B. ASSESSOR'S NAME
Name _____
Last First MI
Title _____
Signature _____
PHONE: ( ) _____ FAX: ( ) _____

13. REQUESTING (Check all that apply)

Expected Placement Date: _____

☐ Nursing Facility (NF) ☐ Subacute ☐ SNF ☐ ICF ☐ Acute Waitlist ☐ Subacute ☐ SNF ☐ ICF ☐ Hospice – NF

☐ Home & Community Based Services (HCBS) ☐ NHWW ☐ RACCP 1 ☐ RACCP 2 ☐ HCCP ☐ PACE Program

HCBS Option Counseling provided: ☐ Yes ☐ No
If NO: explain: _____

If YES, by whom: Name _____ Title: _____

Independent Living (IL) service/material provided: ☐ Yes ☐ No

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

LEVEL OF CARE APPROVAL:
[ ] Subacute
[ ] SNF [ ] ICF
[ ] Acute Waitlisted Subacute [ ] Acute Waitlisted SNF
[ ] Acute Waitlisted ICF [ ] Hospice - NF

EFFECTIVE DATE:_____
LENGTH OF APPROVAL:
[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other – Specify:_____ to_____

SETTING APPROVAL:
[ ] Home and Community-Based Services
☐ Nursing Home Without Walls (NHWW)
☐ Residential Alternatives Community Care Program (RACCP)
Level I _____ Level 2 _____
☐ HIV Community Care Program (HCCP)
☐ PACE Program
[ ] Nursing Facility
[ ] Hospice - NF
[ ] Home
[ ] Extended Care ARCH
[ ] Other _____

Comments: _____

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

[ ] DENIED

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: _____

STATE OF HAWAII
Level of Care (LOC) Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110
Honolulu, Hawaii 96814

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: (refer to instructions)
[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: (refer to instructions)
[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:
Attach additional sheet if more space is needed.

_____

_____

_____

_____

_____

STATE OF HAWAII
Level of Care (LOC) Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110
Honolulu, Hawaii 96814

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

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

XVI. 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.
___	[ ]	[ ]	Nasopharngeal 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.}
			_____
___	[ ]	[ ]	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; Oxygen therapy requiring bronchodilators.
___	[ ]	[ ]	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

XVII. SOCIAL SITUATION:

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

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: _____ Relationship: _____
Last, First MI
Address: _____ Phone: (___) _____ Fax (___) _____

XVIII. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

_____
_____
_____
_____

I HAVE REVIEWED AND AGREE WITH THE LEVEL OF CARE ASSESSMENT, ANTICIPATED PLACEMENT DATE AND REQUESTED PLACEMENT OF THE PATIENT.

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

Physician's Name (PRINT: _____

INSTRUCTIONS
DHS FORM 1147

LEVEL OF CARE (LOC) EVALUATION

Top of Form: Check the appropriate box for the evaluation – initial request for placement into either a nursing home or community-based program; annual review; or other review such as a review requested by the department's contractor for evaluating and determining level of care.

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

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

3. ***Sex***: Self-explanatory

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

5. ***Medicaid Eligible?***: Check "Yes" or "No" to indicate whether the client 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, write in "pending" for I.D.# and write in date applied.

6. ***Present Address/Facility***: Identify facility name if patient is residing in a facility. If patient is at home, enter street address, city and zip code. Check appropriate box that best represents the patient's "home."

7. ***Provider I.D. No.***: Enter the Medicaid Provider I.D. number.

8. ***Attending Physician***: Enter the name of the attending physician, telephone and fax number.

9. ***Contact Person***: Enter the name, telephone and fax numbers of the person able to provide additional information about the patient.

10. ***Return Form***: Indicate how the form should be returned (i.e., fax or mail) and to whose attention. The form will NOT be mailed or faxed back with a cover sheet so information must be accurate.

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

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**: Date the most current assessment was completed.

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

13. ***Requesting***: Enter expected placement date into the facility or community program. Check all services that are being requested. If hospice services has been elected by the patient AND the services will be provided in a nursing facility, attach the appropriate hospice election form. Hospice services in other settings do not require an 1147 form.

Applications for any Medicaid Home and Community-Based Services (HCBS) can be made at the same time as submittal of this form.

Indicate whether counseling on the HCBS option was provided and by whom. If counseling was not provided, provide brief explanation.

Independent Living (IL) services are available to provide information, referral for services, peer counseling and advocacy for the patient. Contact Hawaii Centers for Independent Living (HCIL) for brochures and other information that can be offered to the patient.

14. ***Medical Necessity/Level of Care Action***: Completed by DHS or Designee. Leave Blank. DO NOT COMPLETE.

PAGE 2 AND 3– APPLICANT/CLIENT BACKGROUND INFORMATION

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

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

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

   A. **List significant current diagnosis(es)**: List the main diagnosis(ses) or medical conditions related to the person's need for long-term care.

   B. **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.

   C. **Sections 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.

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

   E. **Section 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.

   F. **Section 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.

4. **Skilled Procedures**: For each type of nursing care, indicate whether the patient requires the particular care. 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".

5. **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. If the person does not have a home,

indicate whether the patient can be placed in a residential setting such as an Extended ARCH, assisted living facility or RACCP home.

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 and phone numbers.

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

Physician's Signature: Self-explanatory.
Date: Date that physician signs the form.
Physician's Name: Self-explanatory.

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) Reevaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110
Honolulu, Hawaii 96814

(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 (PRINT Last Name, First Name, M.I.)
Phone ( )_____ Fax ( ) _____

9. CONTACT PERSON (Last Name, First Name, AND Title)
Phone ( )_____ Fax ( ) _____

9. RETURN FORM TO: _____ VIA [ ] FAX (Print Fax Number Below) [ ] BY MAIL (Print Address Below)

Phone ( )_____ Fax ( )_____ (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 ( ) 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) _____

[ ] Subacute [ ] SNF
[ ] ICF [ ] Acute Waitlist Subacute
[ ] Acute Waitlist SNF [ ] Acute Waitlist ICF
[ ] Hospice - NF

13. LOC BEING REQUESTED (effective date) _____

Anticipated time: From _____ to _____
[ ] Subacute [ ] SNF [ ] ICF
[ ] Acute Waitlist [ ] Subacute [ ] SNF [ ] ICF
[ ] 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 (PRINT): _____

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

APPROVED FOR:
[ ] Subacute [ ] SNF [ ] ICF
[ ] Acute Waitlist Subacute [ ] Acute Waitlist SNF [ ] Acute Waitlist SNF
[ ] Hospice - NF

EFFECTIVE DATE: _____
LENGTH OF APPROVAL
[ ] 1 year [ ] 6 months
[ ] Other – Specify: _____ To _____

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

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

INSTRUCTIONS
DHS FORM 1147a

LEVEL OF CARE (LOC) REEVALUATION

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

2. ***Medicaid I.D. Number***: Enter Medicaid I.D. number assigned by the Department of Human Services. If the I.D. number is unknown, use one of the availability eligibility verification systems to find the I.D. number of the patient. If the patient has applied for Medicaid but has not yet been deemed eligible, write in "pending".

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

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

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

6. ***Present Address/Facility***: Identify facility name if patient is residing in a facility. If patient is at home, enter street address, city and zip code. Check appropriate box that best represents the patient's "home."

7. ***Medicaid Provider I.D. No.***: Enter the Provider I.D. number.

8. ***Attending Physician***: Enter the name of the attending physician, telephone and fax number.

9. ***Contact Person***: Enter the name, telephone and fax numbers of the person able to provide additional information about the patient.

10. ***Return Form***: Indicate how the form should be returned (i.e., fax or mail) and to whose attention. The form will NOT be mailed or faxed back with a cover sheet so information must be accurate.

11. ***Reasons for LOC Re-Evaluation***: Self-explanatory. If in nursing home, and patient elects and is appropriate for a home and community-based waiver program, make referral directly to the home and community-based waiver program. Complete the disposition section.

12. ***Approved LOC on Most Current Form***: Check the box of the current LOC approved for the patient (most current 1147 form) and enter the effective date of the LOC.

13. ***LOC Being Requested***: Check the requested LOC and enter the requested effective date. Enter the anticipated time that would be required at the requested LOC.

14. ***Current Status***: List current and new diagnoses that affect medical care. If there are multiple diagnoses, list the most significant diagnosis first. Specify changes in functional capabilities (increases/decreases in ADLs, behavioral and cognitive functioning. Identify changes (increases/decreases) in skilled nursing needs and any changes in LOC (increases/decreases in functional capabilities or skilled nursing needs sufficient to change a person's LOC).

    Document Need at Requested LOC: If the answers to "current status" are sufficient to the document the need, enter "see above." Use this space to provide additional information as to why long term care services should be continued.

    Physician's Signature: Self-explanatory

    Date: Date of physician's signature

    Physician's Name: Self-explanatory.

15. ***Medical Necessity/Level of Care Action***: Completed by DHS or Designee. Leave Blank. DO NOT COMPLETE.