STATE OF MONTANA
Department of Public Health and Human Services

Level-of-Care Determination

Program Requested: ☐ **Nursing Facility** ☐ **HCBS (Initial)** ☐ **HCBS Yes/Discretionary** ☐ **Unknown**

Identifying Information

Applicant SSN: ____________________
Address: ____________________
City/State/ZIP: ____________________
Phone: ____________________
DOB ________ Age: ________ Sex: ________
Medicaid Status: ____________________
Veteran: ☐ Yes ☐ No
County of Application: ____________________
Nursing Facility Admit Date: ____________________
Medicare Skilled? _____ Date ____________________
Previous Medicaid Screen? _____ Date ____________________

Date of Request: ____________________
Anticipated LOS: ____________________
Screen Request By: ____________________
Agency: ____________ Phone: ____________
Applicant Location: ____________________
Significant Other: ____________________
Relationship: ____________ Phone: ____________
Address: ____________________
City/State/ZIP: ____________________
Other Contacts: ____________________
____
____

Health Care Professional: ____________________ Phone: ____________
Medical Diagnoses/Summary: ____________________
____

Special Treatments/Medications/Therapies/Equipment: ____________________
____

Social and Other Information: ____________________
____
____

Dementia: ☐ Yes ☐ No Traumatic Brain Injury: ☐ Yes ☐ No Communication Deficit: ☐ Yes ☐ No

For Mountain-Pacific Quality Health Use Only

Review Start Date: ____________________
NF Level of Care: ☐ Yes ☐ No Level I Date: ________
Temporary Stay: ____________ to ____________
RPO Technical Assist: ☐ RPO Onsite: ☐
Comments: ____________________
____
____
____

Criteria Met: ____________________

HCBS Referral: ☐ Yes ☐ No Date: ____________
CMT: ____________________
NF Placement: ____________________
Effective Date: ____________________
Screener: ________ Complete Date: ____________
Mountain-Pacific Quality Health Contact Name/Phone Number
1) ____________________
2) ____________________
3) ____________________
4) ____________________

Compliance Review ☐ Yes ☐ No By: ____________________ Date: ____________
cc: Case Management Team ______; Nursing Facility ______; Referral Source ______

Rating Scale Definitions:

Follow this scale when completing the Functional Assessment Portion of the Screen.

0 = Independent: The individual is able to fulfill ADL/IADL needs without the regular use of human or mechanical assistance, prompting or supervision.

1 = With Aids/Difficulty: To fulfill ADL/IADL, the individual requires consistent availability of mechanical assistance or the expenditure of undue effort.

2 = With Help: The individual requires consistent human assistance, prompting or supervision, in the absence of which the ADL/IADL cannot be completed. The individual does however actively participate in the completion of the activity.

3 = Unable: The individual cannot meaningfully contribute to the completion of the task.

Follow this scale when completing the Functional Capabilities Portion of the Screen.

0 = Good: Within normal limits.

1 = Mild Impairment: Some loss of functioning, however, loss is correctable and/or loss does not prevent the individual's capacity to meet his/her needs.

2= Significant Impairment: Loss of functioning that prevents the individual from meeting his/her needs.

3 = Total Loss: No reasonable residual capacity.

Name ____

Functional Assessment

Coding for Functional Assessment: 0 – Independent 1 – With Mechanical Aids 2 – With Human Help 3 – Unable

MOUNTAIN-PACIFIC QUALITY HEALTH USE ONLY

		Current Status/Service	Adequate (circle)	Comments
	Bathing		Yes No	
	Mobility		Yes No	
	Toileting/ Continence		Yes No	
	Transfers		Yes No	
	Eating		Yes No	
	Grooming		Yes No	
	Environmental Modification		Yes No	
	Medication		Yes No	
	Equipment		Yes No	
	Dressing		Yes No	
	Respite		Yes No	
	Shopping		Yes No	
	Cooking		Yes No	
	Housework		Yes No	
	Laundry		Yes No	
	Money Management		Yes No	
	Telephone		Yes No	
	Transportation		Yes No	
	Socialization/ Leisure Activities		Yes No	
	Ability to Summon Emergency Help		Yes No	

Patient Mental Status: (check all appropriate responses) Oriented: □ Person □ Place □ Time

Coding for Functional Capabilities: 0 – Good 1 – Mild Impairment 2 – Severe Impairment 3 – Total Loss

( ) Occasionally disoriented ( ) Inappropriate Behavior ( ) Medication Misuse ( ) Sleep Problems
( ) Disoriented ( ) Confused ( ) Alcohol/Drug Misuse ( ) Worried/Anxious
( ) Unresponsive ( ) Long-Term Memory Loss ( ) Isolation ( ) Loss of Interest
( ) Impaired Judgment ( ) Short-Term Memory Loss ( ) Danger to Self/Others 24-Hour Supervision Needed □Yes □No
( ) Ambulation _________ ( ) Hearing ____________ ( ) Speech ___________ ( ) Vision ____________

Respiratory Status: ____

Comments: ____

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