

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.

### 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) Yes No	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

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Occasionally disoriented | <input type="checkbox"/> Inappropriate Behavior | <input type="checkbox"/> Medication Misuse     | <input type="checkbox"/> Sleep Problems   |
| <input type="checkbox"/> Disoriented              | <input type="checkbox"/> Confused               | <input type="checkbox"/> Alcohol/Drug Misuse   | <input type="checkbox"/> Worried/Anxious  |
| <input type="checkbox"/> Unresponsive             | <input type="checkbox"/> Long-Term Memory Loss  | <input type="checkbox"/> Isolation             | <input type="checkbox"/> Loss of Interest   |
| <input type="checkbox"/> Impaired Judgment        | <input type="checkbox"/> Short-Term Memory Loss | <input type="checkbox"/> Danger to Self/Others | 24-Hour Supervision Needed <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Ambulation _____         | <input type="checkbox"/> Hearing _____          | <input type="checkbox"/> Speech _____          | <input type="checkbox"/> Vision _____   |

Respiratory Status: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_