

LEVEL OF CARE DETERMINATION

Program Requested: Nursing Facility HCBS (Initial) HCBS YES/Discretionary Unknown

Identifying Information

Applicant : _____	Date of Request: _____
SSN: _____	Anticipated LOS: _____
Address: _____	Screen Request By: _____
City/State/Zip: _____	Agency: _____ Phone: _____
Phone: _____	Applicant Location: _____
D.O.B. _____ Age: _____ Sex: _____	Significant Other: _____
Medicaid Status: _____	Relationship: _____ Phone: _____
Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Address: _____
County of Application: _____	City/St/Zip: _____
Nursing Facility Admit Date: _____	Other Contacts: _____
Medicare Skilled ? _____ Date _____	_____
Previous Medicaid Screen ? _____ Date _____	_____

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 Foundation Use Only

Review Start Date: _____	HCBS Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
NF Level of Care: <input type="checkbox"/> Yes <input type="checkbox"/> No Level I Date: _____	CMT: _____
Temporary Stay: _____ to _____	NF Placement: _____
RPO Technical Assist: <input type="checkbox"/> RPO Onsite: <input type="checkbox"/>	Effective Date: _____
Comments: _____	Screener: _____ Complete Date: _____
_____	Foundation Contacts: Name and Phone Number
_____	1) _____
_____	2) _____
_____	3) _____
Criteria Met: _____	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.

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

FOUNDATION 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-Hr Supervision Needed <input type="checkbox"/> Yes <input type="checkbox"/> No |
| () Ambulation _____ | () Hearing _____ | () Speech _____ | () Vision _____ |

Respiratory Status: _____

Comments: _____
