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

Respiratory Status: _____

Comments: _____

_____