INSTRUCTIONS
DHS FORM 1147a
Rev. 01/09
LEVEL OF CARE (LOC) Re-EVALUATION

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

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

3. ***Sex***: Indicate whether the patient is "M" for male or "F" for female.

4. ***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".

5. ***Present Address:***: Indicate patient's present address, i.e. Home, Hospital, Nursing Facility (NF), Care Home, Extended Adult Residential Care Home (EARCH – Type I & Type II), Community Care Family Foster Home (CCFFH), or other.

   Home: Patient is at his or her residential home or is homeless.
   Hospital: Patient is currently residing in an Acute Care Hospital, i.e. waitlisted at an acute waitlisted level of care.
   Nursing Facility (NF): Patient is currently residing in a nursing facility
   Care Home: Patient is currently residing in a care home – not at nursing facility level of care.
   Extended Adult Resident Care Home (EARCH): Patient is currently residing in a Department of Health or Shared Home with the Department of Human Services which include patients at a care home and nursing facility level of care.
   Community Care Foster Family Home (CCFFH): Patient is currently residing in a Department of Human Services Foster Home which includes patients at a nursing facility level of care.
   Other: Check this box if the patient's present address is not listed above. Write in the description.

6. ***Medicaid Provider Number.***: Enter only if applicable. Patient must be pending Medicaid and currently NOT a patient in a managed care health plan.

7. ***Attending Physician/Primary Care Provider (PCP)***: Print last name, first name, and middle initial, telephone and fax number.

8. ***Return Form to***: Enter the name of the service coordinator or the contact person. Indicate the managed care plan name if applicable, telephone, fax number and email address of the person able to provide additional information about the patient.

9. ***Reasons for LOC Re-Evaluation***: Indicate whether the request is for:

    a. Change in LOC. The change in LOC should be a minor change in functional or skilled nursing status, i.e. waitlisted skilled level of care (IV therapy) to nursing facility intermediate care (discontinued IV therapy – no change in functional status).
    b. Extension of Current LOC, i.e. acute waitlisted, at home and waitlisted for Long Term Care Services,
    c. At home and waitlisted for Long Term Care Services. If a patient is waitlisted for a Long Term Care Service and is at home, check this box.
    d. No longer meeting LOC <u>(NOT meeting an Acute, NF ICF, NF SNF, NF Hospice, NF Subacute I or II, Acute Waitlisted ICF or SNF or Subacute LOC).</u>

        <u>If "No longer meeting LOC" is selected, indicate date of when the patient did not meet the LOC. Must fill out #10 "Date Span" Enter current date span of this patient's LOC on most current APPROVED form.</u>

10. ***Approved LOC on Most Current Form***: Enter the date span on most current approved 1147/1147a/1147e form and check the LOC.

11. ***LOC Being Requested***: Enter date span of LOC being requested and check the requested LOC and enter the requested LOC begin and end dates.

12. ***Current Status***: Specify current primary diagnosis(es). Check if there are additional diagnosis(es), list the most significant diagnosis first. Specify changes in functional capabilities (increases/decreases in ADLs, behavioral and cognitive functioning) and/or nursing needs.

    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 the reasons for the continuation of long term care services.

    Physician's/PCP Signature: Self-explanatory

    Date: Date of physician or PCP's signature

    Electronic submittal of form(s) will be accepted with the box checked that the physician or the primary care provider has signed a hard copy of the form(s) and that the plan of care has been discussed with the physician or primary care provider. The hard copy of the form(s) must be kept in the patient's file.

    Physician's/PCP Name: Self-explanatory

13. ***Medical Necessity/Level of Care Determination***: Completed by DHS reviewer or designee. Leave Blank. DO NOT COMPLETE.

Filing Instructions: Mail, fax, or send forms electronically to:

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