CHILDREN/YOUTH <u>Under Age 21</u> LEVEL OF CARE (LOC) EVALUATION

<u>PURPOSE:</u>

A Medicaid Provider shall use the DHS 1147E "Children/Youth Under Age 21 Level of Care" form to evaluate a child or youth under age 21 level of care as documentation for requested Medicaid services.

<u>SPECIFIC INSTRUCTIONS:</u>

1. ***Check the appropriate box for the evaluation***: Check type of request – initial, six month, annual or other review, i.e. 3-month review to determine continued stay.

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

3. ***Birthdate***: Self-explanatory

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

5. **Private/Other Insurance**: Check the appropriate box indicating whether patient has private or other insurance. Indicate the insurer's company name and ID number.

6. ***Medicaid Eligible***: Check "Yes" or "No" to indicate whether the patient is currently Medicaid eligible. Enter Medicaid I.D. number assigned by the Department of Human Services, if eligible.

    If the patient has applied for Medicaid but has not yet been deemed eligible, print or type in "pending" for I.D. # and print or type in date applied for Medicaid. Forms will be processed only if patient has a Medicaid number <u>or</u> has the date of the Medicaid application.

7. ***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.

    <u>Home:</u> Patient is at his or her residential home or is homeless.
    <u>Hospital:</u> Patient is currently residing in an Acute Care Hospital, i.e. waitlisted at an acute waitlisted level of care.
    <u>Nursing Facility (NF):</u> Patient is currently residing in a nursing facility.
    <u>Care Home:</u> Patient is currently residing in a care home – not at nursing facility level of care.
    <u>Extended Adult Resident Care Home (EARCH):</u> 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.

<u>Community Care Foster Family Home (CCFFH)</u>: Patient is currently residing in a Department of Human Services Foster Home which includes patients at a nursing facility level of care.

<u>Other</u>: Check this box if the patient's present address is not listed above. Write in the description.

8. *Medicaid Provider Number*: Enter only if applicable. Patient must be pending Medicaid and currently NOT a patient in a managed care health plan. If the patient is pending Medicaid and the provider requests EPSDT services, submit an 1144 form to Affiliated Computer Services (ACS) with the approved 1147e or 1147a.

9. *Attending Physician/Primary Care Provider (PCP)*: Enter the name of the attending physician or primary care provider, telephone and fax number.

10. *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.

11. *Referral Information*: Complete all sections for an initial request. Skip this section, if this is an annual or "other" review.

    a. **Source(s) of Information**: Identify the source(s) of patient information received.

    b. **Parent/Legal Guardian/Responsible Party**: Provide the name, relationship, phone and fax numbers of the Parent/Legal Guardian/Responsible Party who will be making decisions for the patient.

    c. **Language**: Check the box of the primary language spoken by the patient. If checking "Other," indicate the language spoken. Information is used to obtain interpreters.

12. *Assessment Information*: Sections must be completed by a RN or PCP (MD, DO, APRN-Rx, or PA)

    A. **Assessment Date**: Indicate the date of the most current assessment.

    B. **Assessor's Name, Title, Signature, Phone and Fax Numbers**: A registered nurse (RN) or primary care provider (PCP): Medical doctor (MD), doctor of osteopathic medicine (DO), advanced practice registered nurse with prescriptive authority (APRN-Rx), or physician assistant (PA), must perform the assessment. Enter the name, title and telephone, fax number and email address of the assessor. The assessor must sign the form. Electronic submittal of form(s) will be accepted with the box checked that a signature of the RN or PCP (MD, DO, APRN-Rx, or PA) has signed a hard copy of this form and the hard copy of the form(s) can be found in the patient's file.

13. *Requesting Level of Care*: Check service that is being requested. Indicate the begin and end date of the request. If hospice services have been elected by the patient AND the services will be provided in a nursing facility, attach the hospice election and physician certification of terminal illness form signed by two different physicians. Hospice services in other settings do not require an 1147 form.

Indicate the length of approval requested. Check one box.

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

PAGE 2 – APPLICANT/PATIENT BACKGROUND INFORMATION

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

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

3. ***Functional Status Related to Health Conditions***: Complete all sections.

   A. **List current significant diagnosis(es)**: List the primary and secondary diagnosis(ses) or medical conditions related to the person's need for long-term care.

   B. **Medications/Treatments**: List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than five (6) significant medications, attach orders or treatment sheet. As an option to completing this section, the most current prescription listing can be attached. If using this option, please indicate "attached" in this area.

   C. **Activities of Daily Living**: Check all of the areas that the individual requires assistance on a regular basis, considering developmental age. If the patient is a newborn, he/she is not expected to toilet, feed, transfer and dress him/herself. Therefore, these areas would NOT be checked. However, in the case of a 3-year old, the developmentally appropriate child would be expected to walk, toilet and feed himself. If the child requires assistance in those areas, the appropriate boxes should be checked.

   D. **Family/Social Considerations**:

      1. **Child can return home**: Identify whether the patient can return home. The home can be a family member's (daughter, son, brother, sister, parents, etc.) home as well as the patient's own home. Check "NA" if the patient is already in a home environment.

      2. **Community Setting:** If the individual does not have a home, indicate whether the patient can be placed in a community setting. Check "NA" if the patient is already in a community setting.

      3. **Caregiving support**: If the patient has a home, identify whether the caregiving support is willing/able to provide care. If caregiver requires assistance, identify the assistance required.

4. **Caregiver name**. Provide the caregiver's name, relationship, address, phone and fax numbers.

E. **Additional Information:** Provide any additional information, comments or explanation of the child's functional assessment, nursing intervention requirements.

4. **Nursing Interventions**: Check the nursing intervention(s) that apply. Include frequency and complexity as applicable.

RN or PCP (MD, DO, APRN-Rx, or PA) Signature: Provide signature.

Electronic submittal of the form(s) will be accepted with the box checked that the RN or PCP (MD, DO, APRN-Rx, or PA) has signed a hard copy of the form(s) and that the plan of care has been discussed with the RN or PCP. The hard copy of the form(s) must be kept in the patient's file.

Date: Indicate the date of the RN's or PCP's (MD, DO, APRN-Rx, or PA) signature.

RN or PCP (MD, DO, APRN-Rx, or PA) Name (Print): Print name.

FILING/DISTRIBUTION:

Mail, fax, or send forms electronically to:

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