STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
CHILDREN/YOUTH UNDER AGE 21
Level of Care Evaluation

HEALTH SERVICES ADVISORY GROUP
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

1. PLEASE PRINT OR TYPE ☐ Initial Request ☐ Six Months ☐ Annual Review ☐ Other review

2. PATIENT NAME (Last, First, M.I.)	3. BIRTHDATE Month/Day/Year	4. SEX	5. Private/Other Insurance ☐ Yes ☐ No Ins. Co.:_____ ID#: _____	6. MEDICAID ELIGIBLE? ☐ Yes ID # _____ ☐ No If no, date applied for Medicaid (Required)_____

7. PRESENT ADDRESS (Specify Facility Name When Applicable) Present Address is: ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ Other: _____

8. Medicaid Provider Number: (If applicable)

9. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial)
_____
Phone : ( )_____ Fax: ( )_____

10. RETURN FORM TO (SERVICE COORDINATOR OR CONTACT PERSON): _____
MANAGED CARE PLAN NAME (IF APPLICABLE): _____
[ ] VIA FAX (Print Fax Number Below)
Phone ( )_____ Fax ( ) _____ Email ( ) _____

11. REFERRAL INFORMATION (Completed by Referring Party)

A. SOURCE(S) OF INFORMATION
☐ Client ☐ Records ☐ Other _____

B. PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY:
Name _____
Last First MI
Relationship _____
PHONE ( ) _____ FAX ( ) _____

C. Language ☐ English ☐ Other _____

12. ASSESSMENT INFORMATION

Complete by RN or PCP (MD, DO, APRN-Rx, PA)

A. ASSESSMENT DATE ____/____/____

B. ASSESSOR'S NAME
Name _____
Last First MI Title
Signature _____
☐ Hard copy signature on file.
PHONE: ( ) _____ FAX: ( ) _____
EMAIL: ( ) _____

13. REQUESTING LEVEL OF CARE

CHECK ONE BOX:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)

LEVEL OF CARE BEGIN and END DATES: _____ TO _____

LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months

[ ] Other: _____

14. MEDICAL NECESSITY / LEVEL OF CARE DETERMINATION – DO NOT COMPLETE

LEVEL OF CARE APPROVAL:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)

LEVEL OF CARE BEGIN and END DATES: _____ TO _____

LENGTH OF APPROVAL (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months

[ ] Other: _____

Comments: _____

DEFERRED: [ ] Current 1147e Version Needed [ ] Missing Information

[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] INCOMPLETE INFORMATION TO DETERMINE LEVEL OF CARE

NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.

DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____

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1. **NAME** (PRINT Last Name, First Name, Middle Initial)

2. **BIRTHDATE**

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

A. LIST CURRENT SIGNIFICANT DIAGNOSIS(ES):

PRIMARY:

SECONDARY:

B. MEDICATION/TREATMENTS (Attach additional sheet if necessary)
List all Significant Medications, Dosage and Frequency

1.
2.
3.
4.
5.
6.

C. ACTIVITIES OF DAILY LIVING: Identify only assistance required due to developmental delays:

☐ Feeding ☐ Transferring ☐ Mobility/Ambulation

☐ Toileting ☐ Bathing ☐ Dressing/Grooming

D. FAMILY/SOCIAL CONSIDERATIONS

1. Child can return home ☐ Yes ☐ No ☐NA
2. Community setting can be considered as an alternative to facility?
   ☐ Yes ☐ No ☐NA
3. If child has a home, caregiving support system is willing to provide/continue care? ☐ Yes ☐ No
   a. Assistance required by Caregiver:_____
   _____
   b. Caregiver Name/relationship: _____/_____
   Address: _____ Phone: _____
   Fax: _____ Email address: _____

E. Additional information concerning functional status and justification for LOC, i.e. apnea events, transitioning from tube feeds, isolette, parent teaching/training, behavior, communication, vision etc:

_____
_____
_____
_____
_____
_____

4. Nursing Intervention	**Frequency/Complexity**
☐ Ventilator	Continuous
☐	Intermittent, specify time on ventilator:
☐ Tracheostomy	
☐ Oxygen therapy	Continuous
☐	Intermittent
☐ Nebulized Medications	TID or less
☐	>TID
☐ Vascular access catheter	
☐ Parenteral nutrition	Continuous
☐	Intermittent
☐ Gastrostomy/jejunostomy/nasogastric tube	Gravity feedings
☐	Pump feedings
☐ Ileostomy/colostomy	
☐ Urinary bladder catheterization	Intermittent or continuous
☐ Orthopedic appliance	Splint/cast (each)
☐	Complex (describe)
☐ Isolation/reverse isolation	
☐ Enteral Medications	8 doses/day or less
☐	>8 doses/day
☐ IM/SQ medications	4 doses/day or less
☐	>4 doses/day
☐ IV medications	4 doses/day or less
☐	>4 doses/day
☐ Oral medications	Less than 12 doses/day
☐	12 or more doses/day
☐ Monitor (Apnea, Pulse Oximeter, C-R)	
☐ Special Skin Care (Burn, decubiti)	Localized
☐	Extensive (describe)
☐ Wound Care (describe):	
☐ Restorative therapy (PT, OT, Speech – include treatment plan)	
☐ Initial discharge from hospital	
☐ Readmission for exacerbation of existing medical condition or new diagnosis	
☐ Acute, episodic illness requiring physician or emergency room visits	
☐ Other specialized nurse interventions (explain):	
☐ Comatose	

I HAVE REVIEWED AND AGREE WITH THE LEVEL OF CARE ASSESSMENT.

RN, PCP (MD, DO, APRN-Rx, PA) Signature:_____ RN, PCP (MD, DO, APRN-Rx, PA) Name (Print):_____

☐ Hard copy signature on file. This plan of care has been discussed with the RN or PCP Date: _____