INSTRUCTIONS
DHS FORM 1147
Rev. 05/14
LEVEL OF CARE (LOC) AND AT RISK EVALUATION

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

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

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

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

5. ***Medicare***: Check the appropriate box indicating whether patient has Medicare Part A and B and enter patient's Medicare I.D. number, if eligible for either Part A or B.

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. Forms will be processed only if patient has a Medicaid number or 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.

    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.

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

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. **Responsible Person**: Provide the name, relationship, phone and fax numbers of the family member/personal agent 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***: Complete all sections.

    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), physician or primary care provider 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, physician or primary care provider 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***: Check what is being requested (either level of care or at risk). 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 verification form. *Hospice services in other settings do not require an 1147 form.*

    Indicate the length of approval requested. Check one box.

14. ***Medical Necessity Determination***: Completed by DHS reviewer or designee. Leave Blank. DO NOT COMPLETE.

PAGE 2 AND 3–APPLICANT/PATIENT BACKGROUND INFORMATION

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

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

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

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

II. **Comatose**: If patient is comatose, check "Yes" box and go directly to Section XVIII. If patient is not comatose, check "No" and complete rest of section.

III. **Vision/Hearing/Speech through XIII Dressing and Personal Grooming**: Select the description that best describes the patient's functioning.

Note: Make only one selection in all sections except VI. Mental Status/Behavior and IX. Mobility/Ambulation. For Mental Status/Behavior, make only one selection for orientation (items a through c). Aggressive and/or abusive and wandering may also be checked with the appropriate orientation. For Mobility/Ambulation, check a maximum of 2 for items b through e. If an individual is either mobile or unable to walk, no other selections can be made.

XIV. **Housecleaning through XVII Meal Preparation (complete only for At-Risk criteria):**

Select the description that best describes the patient's functioning.

   a) Independent

   b) Able to complete some tasks with some assistance, includes oversight/cuing

   c) Unable to complete tasks on own or needs assistance

XVIII. **Total Points**: Add the points from each section to obtain total. Comatose patients are assigned 30 points.

XIX. **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 significant medications than available lines, attach orders or treatment sheet.

XX. **Additional Information Concerning Patient's Functional Status**: Use the space to provide additional information on the patient's functional status. This section may be used to identify the extent of the assistance (minimal, with assistance or total) that is required. Attach a separate sheet if more space is required. See attachment Functional Status related to Health Conditions on scoring this section.

XXI. **Skilled Procedures**: Check the particular skilled procedure(s) that the patient requires. If the care is daily (D), indicate the number of times per

day that care is required. If care is less than once per day check "L". If the care is not applicable, check "N".

If restorative therapy is being requested, attach the evaluation and treatment plan(s) AND indicate whether the patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XXII.   **Social Situation**:

    A.   **Person 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. 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.

    B.   **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.

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

XXIII.   **Comments on Nursing Requirements or Social Situation:** Provide any additional information that would help explain the Patient's nursing requirements or social situation.

Physician/PCP/RN Signature: Self-explanatory.

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

Date: Indicate the date of the physician, Primary Care Provider, or Registered Nurses' signature.

Physician's/PCP/RN Name (Print): Self-explanatory.

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

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    1440 Kapiolani Blvd., Suite 1110,
    Honolulu, HI 96814
    Phone: (808) 440-6000   Fax: (808) 440-6009