REQUEST FOR LEVEL OF CARE REVIEW

Client Name: _____ Date of Birth:_____

Medicaid #:_____ County:_____

Original Admission Date: _____

Returned from hospital (used up leave days) _____ LOC effective date requested:_____

Private pay to Medicaid_____ Is there a caregiver in the community available to assist?_____

Transfer to/from

_____

If transfer, was resident in previous facility more than 180 days? Yes ___ No ___

Estimated length of stay (check one): Less than 180 days ____ Indefinite ___

(Check one) Rehab Potential: Good ___ Fair ___ Poor ___

Prognosis: Good ___ Fair ___ Poor ___

I have reviewed the enclosed Information/MDS and certify that it is an accurate statement of the resident's current Physical, mental and social/emotional status. I certify the resident requires:

(Check one) Intermediate level of care ____ or Skilled level of care ____

Physician's signature: _____ Date: _____

For Source: P=Physician, MR=Medic. Record, C=Clt, CG= Caregiver, AO=Assessor Observation

ADL's	No Help	Supervision	Hands On	Source
Mobility 1. Bed 2.Transfer 3.Locom.	 1 1 1	 2 2 2	 3 3 3	
Bathing	1	2	3	
Grooming	1	2	3	
Dressing	1	2	3	
Toileting	1	2	3	
Eating	1	2	3	

IADL'S	No Help	Supervision	Hands On	Source
Shopping	1	2	3	
Meal Prepar.	1	2	3	
Environ. 1.House cleaning 2.Heavy Chores 3.Yardwk	 1 1 1	 2 2 2	 3 3 3	
Laundry	1	2	3	
Commun. Access 1 Teleph. 2 Trans. 3 Financ.	 1 1 1	 2 2 2	 3 3 3	
Medicat. Admin.	1	2	3	