

**OHIO DEPARTMENT OF MEDICAID
LEVEL OF CARE ASSESSMENT**

I. DEMOGRAPHICS

Assessment Date: / /

a. Name		
b. Address		
c. Phone	d. County	
e. DOB	f. Age	g. Sex: <input type="checkbox"/> M <input type="checkbox"/> F
h. Language Spoken		Barrier <input type="checkbox"/> Y <input type="checkbox"/> N
i. Medicaid I.D. <input type="checkbox"/> Active <input type="checkbox"/> Pending		
j. Social Security Number	k. Medicare Number	
l. Date of Conversion from other Funding to Medicaid		
m. Other Health Insurance		
n. Contact:		
<input type="checkbox"/> Guardian <input type="checkbox"/> POA <input type="checkbox"/> Authorized Rep.		

o. Phone: (DAY) () (EVENING) ()

p. Relationship:

q. Usual	Current	LIVING ARRANGEMENT (circle)
(1)	(1)	own home/apartment
(2)	(2)	relative/friend
(3)	(3)	congregate housing
(4)	(4)	group, foster, rest home
(5)	(5)	NF
(6)	(6)	ICF/MR
(7)	(7)	psychiatric hospital/unit
(8)	(8)	acute care hospital
(9)	(9)	other (specify)

II. REASON FOR REQUEST

a. <input type="checkbox"/> NF Admission (check one of the following) <input type="checkbox"/> New Admission <input type="checkbox"/> Readmit: original date of admission <input type="checkbox"/> Transfer: from _____ original date of admission
b. <input type="checkbox"/> ICF / MR (name)
c. <input type="checkbox"/> HCBS services (specify)
d. <input type="checkbox"/> ASSISTED LIVING
e. <input type="checkbox"/> RSS f. <input type="checkbox"/> OC Review
g. <input type="checkbox"/> Other (specify)
If NF Admission: NF Name/Address Estimated Length of Stay Provider #

III. LOC ASSESSMENT SUMMARY

a. ADLS (list total by category) <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance
b. IADLS (list total by category) <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance

c. Medication Administration: <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance <input type="checkbox"/> Independent
d. <input type="checkbox"/> Needs 24 hour supervision due to cognitive impairment
e. Condition: <input type="checkbox"/> Stable <input type="checkbox"/> Unstable
f. <input type="checkbox"/> Skilled Nursing Services (list/frequency):
g. <input type="checkbox"/> Skilled Rehabilitation Services (list/frequency):

IV. INFORMAL SUPPORT YES NO If yes, list and describe

V. LOC RECOMMENDATION
Based on review of the LOC assessment, it is recommended that the level of care indicated below is appropriate:

Skilled Intermediate Intermediate/Mental Retardation-Development Disabilities Protective None

ID#: (If Applicable)	Signature/Title:	Initials
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I understand my health care options and choose to receive NF Services ICF/MR Services HCBS Waiver Services Assisted Living Services RSS Other

I authorize Medicaid or the PASSPORT Administrative Agency to release information contained within this assessment, to the following only:
 Agent/Agencies providing me with services, Agent/Agencies funding services which I receive, and Agent/Agencies evaluating the effectiveness of services which I receive.

Client or Authorized Representative:	Date
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ATTENDING PHYSICIAN CERTIFICATION: I certify that I have reviewed the information contained herein, and that the information is a true and accurate reflection of the individual's condition. I certify that the level of care recommended above is required OR that the level of care checked below is required.

Skilled Intermediate Intermediate/Mental Retardation-Development Disabilities Protective None

Physician's Signature	Date
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FOR PAA USE ONLY:

Date of verbal physician authorization	PAA Assessor Signature:
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Client:						Date:			
VI. PHYSICIANS									
PRIMARY					OTHER				
Specialty:					Specialty:				
Name					Name				
Address					Address				
Phone			Date Last Seen		Phone			Date Last Seen	
VII. DIAGNOSES									
SOURCES OF INFORMATION (PLEASE CHECK): <input type="checkbox"/> Physician <input type="checkbox"/> Medical Record <input type="checkbox"/> Record <input type="checkbox"/> Client <input type="checkbox"/> Caregiver <input type="checkbox"/> Authorized Representative									
		Date of Onset	ICD Code			Date of Onset	ICD Code		
1) Primary			()	4)			()		
2)			()	5)			()		
3)			()	6)			()		
VIII. HEALTH HISTORY: (INCLUDE SUMMARY OF OVERALL CONDITION)									
SOURCES OF INFORMATION (CHECK): <input type="checkbox"/> Physician <input type="checkbox"/> Medical Record <input type="checkbox"/> Record <input type="checkbox"/> Client <input type="checkbox"/> Caregiver <input type="checkbox"/> Authorized Representative									
PROGNOSIS					REHABILITATION POTENTIAL				
<input type="checkbox"/> Good					<input type="checkbox"/> Improved Function				
<input type="checkbox"/> Fair					<input type="checkbox"/> Maintain Function				
<input type="checkbox"/> Poor					<input type="checkbox"/> Retard Loss of Function				
					<input type="checkbox"/> None				
IX. ALLERGIES (include medications, insects, molds, foods, animals, grasses, etc.)									
X. MEDICATION PROFILE Sources of information (please check) <input type="checkbox"/> Physician <input type="checkbox"/> Medical Record <input type="checkbox"/> Record <input type="checkbox"/> Client <input type="checkbox"/> Caregiver <input type="checkbox"/> Authorized Representative <input type="checkbox"/> Additional Page Included									
A) MEDICATIONS:	RX	OTC	DOSAGE/ FREQUENCY	ROUTE	MEDICATIONS (continued)	RX	OTC	DOSAGE/ FREQUENCY	ROUTE
1)					6)				
2)					7)				
3)					8)				
4)					9)				
5)					10)				
TOTALS					TOTALS				
B) PHARMACY				ADDRESS			PHONE		
C) CHEMICALS: (include form, frequency and amount)									
A ALCOHOL					A CAFFEINE				
A OTHER					A NICOTINE				

Additional Information attached on trailer sheet

Client:					Date:					
FOR SECTIONS XI, XII, XIII AND XIV , List all sources of information for each item as follows: P=Physician, MR=Medical Record, C=Client, CG=Caregiver, AR=Authorized Representative, AO=Assessor Observation										
XI. ADL Activities of Daily Living	NO HELP	SUPER-VISION	HANDS ON	SOURCES	XII. IADL Instrumental Activities of Daily Living	NO HELP	SUPER-VISION	HANDS ON	SOURCES	
a. Mobility					a. Shopping	1	2	3		
1. Bed	1	2	3		b. Meal Preparation	1	2	3		
2. Transfer	1	2	3		c. Environmental					
3. Locomotion	1	2	3	1. House Cleaning		1	2	3		
				2. Heavy Chores		1	2	3		
b. Bathing	1	2	3		3. Yardwork/Maintenance	1	2	3		
c. Grooming	1	2	3		d. Laundry	1	2	3		
d. Toileting	1	2	3		e. Community Access					
e. Dressing	1	2	3			1. Telephoning	1	2	3	
f. Eating	1	2	3			2. Transportation	1	2	3	
List durable, assistive and adaptive equipment used:					3. Legal/Financial	1	2	3		
					XIII. MEDICATION ADMINISTRATION	1	2	3		
List activity(ies) for which 24-hour supervision is required to prevent harm due to cognitive impairments and explain:										
XIV. BEHAVIOR										
Check if item interferes with functioning and describe below.										
	√	SOURCES				√	SOURCES			
a. Disoriented to person					m. Verbally abusive or aggressive					
b. Disoriented to place					n. Physically abusive or aggressive					
c. Disoriented to time					o. Wanders – mentally					
d. Confusion					p. Wanders – physically					
e. Withdrawn, isolates self					q. Forgetfulness:					
f. Hyperactive					1. Short-Term					
					2. Long-Term					
g. Mood swings					r. Agitation					
h. Inappropriate fears, suspicions					s. Smokes carelessly					
i. Abusive to self					t. Has difficulty concentrating					
j. Drug/Alcohol abuse					u. Has difficulty sleeping					
k. Exhibits bizarre behavior					v. Cannot make own decisions					
l. Neglect of self					w. Other:					
COMMENTS: Describe behavior(s) and level of supervision needed to prevent harm:										

Additional Information attached on trailer sheet

Client:	Date:
XV. SYSTEMS REVIEW: Condition: Check if condition is unstable and explain. Check if medical complications are present and explain. Check if no abnormalities are reported. INTERVENTIONS: Describe all medical interventions/treatments including tasks performed by licensed professionals, and frequency of those tasks. SOURCES OF INFORMATION (Check): <input type="checkbox"/> Physician <input type="checkbox"/> Medical Record <input type="checkbox"/> Client <input type="checkbox"/> Caregiver <input type="checkbox"/> Authorized Representative	
A) EYES, EARS, MOUTH, AND THROAT: Condition: <input type="checkbox"/> No abnormalities <input type="checkbox"/> Unstable <input type="checkbox"/> Medical Compliance Explanation: Interventions: Description: Performed by (check and list frequency): <input type="checkbox"/> RN <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> Other (specify)	
B) NEUROLOGICAL: Condition: <input type="checkbox"/> No abnormalities <input type="checkbox"/> Unstable <input type="checkbox"/> Medical Compliance Explanation: Interventions: Description: Performed by (check and list frequency): <input type="checkbox"/> RN <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> Other (specify)	
C) PULMONARY: Condition: <input type="checkbox"/> No abnormalities <input type="checkbox"/> Unstable <input type="checkbox"/> Medical Compliance Explanation: Interventions: Description: Performed by (check and list frequency): <input type="checkbox"/> RN <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> Other (specify)	
D) CARDIOVASCULAR AND CIRCULATORY: Condition: <input type="checkbox"/> No abnormalities <input type="checkbox"/> Unstable <input type="checkbox"/> Medical Compliance Explanation: Interventions: Description: Performed by (check and list frequency): <input type="checkbox"/> RN <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> Other (specify)	
E) MUSCULOSKELETAL: Condition: <input type="checkbox"/> No abnormalities <input type="checkbox"/> Unstable <input type="checkbox"/> Medical Compliance Explanation: Interventions: Description: Performed by (check and list frequency): <input type="checkbox"/> RN <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> Other (specify)	
F) GASTROINTESTINAL: Condition: <input type="checkbox"/> No abnormalities <input type="checkbox"/> Unstable <input type="checkbox"/> Medical Compliance Explanation: Interventions: Description: Performed by (check and list frequency): <input type="checkbox"/> RN <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> Other (specify)	
G) GENITOURINARY: Condition: <input type="checkbox"/> No abnormalities <input type="checkbox"/> Unstable <input type="checkbox"/> Medical Compliance Explanation: Interventions: Description: Performed by (check and list frequency): <input type="checkbox"/> RN <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> Other (specify)	
H) SKIN: Condition: <input type="checkbox"/> No abnormalities <input type="checkbox"/> Unstable <input type="checkbox"/> Medical Compliance Explanation: Interventions: Description: Performed by (check and list frequency): <input type="checkbox"/> RN <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> Other (specify)	

Additional Information attached on trailer sheet

Client:	Date:
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XVI. MENTAL RETARDATION/DEVELOPMENT DISABILITIES: Refer to OAC 5101:3-3-07 (Complete only for a client requesting an ICF/MR LOC.)
 PSYCHOLOGICAL EVALUATION ATTACHED

<p>"Persons with related conditions" is defined as persons who have severe, chronic disabilities that meets all of the following conditions:</p> <p>1. The disability is attributed to: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>a. Cerebral palsy</p> <p>b. Epilepsy or,</p> <p>c. Any other condition, other than mental illness, found to be closely related to mental retardation because this results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these people.</p>	<p>2. Was manifested before the person reached age 22 YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>3. Is likely to continue indefinitely YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>4. Results in substantial functional limitations in 3 or more of the following areas of major life activity:</p> <p>a. Self-care YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>b. Understanding YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>c. Learning YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>d. Mobility YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>e. Self-direction YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>f. Capacity for independent living YES <input type="checkbox"/> NO <input type="checkbox"/></p>
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ADDITIONAL COMMENTS/SUMMARIES **LEVEL OF CARE TRAILER SHEET**

Indicate Section	Comments/Summary
Section	
Section	
Section	
Section	
Section	
Section	
Section	
Section	

ADDITIONAL MEDICATION PROFILE

A) MEDICATIONS:	RX	OTC	DOSAGE/ FREQUENCY	ROUTE	MEDICATIONS (continued)	RX	OTC	DOSAGE/ FREQUENCY	ROUTE
11)					16)				
12)					17)				
13)					18)				
14)					19)				
15)					20)				
TOTALS					TOTALS				

Additional Information attached on trailer sheet

**LEVEL OF CARE ASSESSMENT (ODM 03697)
INSTRUCTIONS**

GENERAL INSTRUCTION: Complete entire form by providing requested information or by indicating N/A

PAGE 1

SECTION I – DEMOGRAPHICS: Complete as indicated. For I-1, list either anticipated Medicaid vendor payment effective date for NF resident converting to Medicaid from other payment source, or list N/A.

SECTION II – REASON FOR REQUESTS: Check only one letter and complete as indicated.

SECTION III – LOC ASSESSMENT SUMMARY: Complete as indicated after remainder of form is completed; summary must be supported by documentation on pages 2-5.

SECTION IV – INFORMAL SUPPORT: Complete as indicated.

SECTION V – LOC RECOMMENDATION: Complete as indicated after Section III, LOC Assessment Summary is completed; LOC recommendation must be supported by Section III. Person completing form must sign recommendation, must document client's choice of service settings, obtain client's signature, and obtain physician's certification.

PAGE 2

SECTION VI – PHYSICIANS: Complete as indicated.

SECTION VII – DIAGNOSES: Circle source(s) of information and complete as indicated.

SECTION VIII – HEALTH HISTORY: Circle source(s) of information and complete as indicated. Indicate applicant's prognosis and rehabilitation potential.

SECTION IX – ALLERGIES: Complete as indicated.

SECTION X – MEDICATION PROFILE Circle source(s) of information and complete as indicated.

NOTE: Check box at bottom of Page 2 if additional information related to Page 2 is included on the trailer sheet or if additional information related to Page 2 is attached to the ODM 03697.

PAGE 3

SECTION XI – ADLS, XII – IADLS AND XIII – MEDICATION ADMINISTRATION: Circle type of help needed by applicant to complete each activity. Note: Refer to Ohio Administrative Code rules 5101:3-3-05, 06, and -08 for definitions of supervision, assistance, and ADLS. List sources of information for each activity using the code, as indicated.

In space provided, list activity(ies) for which applicant requires 24-hour supervision to prevent harm due to cognitive impairment(s). Description must be supported by Section VII, diagnoses.

SECTION XIV – BEHAVIOR: Check behaviors that interfere with functioning. List sources of information for each activity using the code, as indicated. In space provided, describe behavior and amount of supervision needed to prevent harm to applicant (e.g. needs supervision while awake; needs 24-hour supervision, etc.)

NOTE: Check box at bottom of Page 3 if additional information related to Page 3 is included on the trailer sheet or if additional information related to Page 3 is attached to the ODM 03697.

PAGE 4

SECTION XV – SYSTEMS REVIEW: Complete as indicated.

**SECTION XVI – MENTAL RETARDATION/
DEVELOPMENTAL DISABILITIES** Complete as indicated.

NOTE: Check box at bottom of Page 2 if additional information related to Page 2 is included on the trailer sheet or if additional information related to Page 2 is attached to the ODM 03697.

ADDITIONAL COMMENTS/SUMMARIES: Use for additional comment/summary by indicating section number and continuing narrative description. Also use to reference attached medical record copies by indicating section number and the phrase “see attached”.

ADDITIONAL MEDICATION PROFILE: Use if space provided on Page 2 in Section X, Medication Profile, is insufficient.