STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
NURSING FACILITY LEVEL OF CARE ASSESSMENT

ADMISSION DATE

○ DISCHARGE ○ DECEASED Date

**A. IDENTIFYING INFORMATION** — **OHCA USE ONLY**

| Client Name (Last, First, MI) | Social Security Number | Date of Birth | RACE | Hisp | Gender | Coverage | OHCA USE ONLY |
|---|---|---|---|---|---|---|---|
| | | | | ○ Y ○ N | ○ M ○ F | | **Level II Required:** ○ Yes ○ No |
| Facility Name / Address / City / State / Zip | | | | | | | **Level II Completed Date** |
| FACILITY PROVIDER NUMBER | DHS Case Number | RID NUMBER | New Admit/Inter-facility Transfer/Name of Transferring Facility | | | | **Reviewer Initials/Date** |

COUNTY

PRIOR LIVING ARRANGEMENT: ○ Own Home ○ Mental Hospital (MD) ○ ICF/MR ○ Relative's Home ○ Hospital ○ SNF ○ Other ○ Asst. Living ○ Res Care ○ NF (ICF) ○ Group Home

**DHS USE ONLY** ○ **I agree** ○ **I disagree with NF assessment (See attached).**
**Nurse Signature:**

**B. CLIENT ASSESSMENT**

| | ADLs | Independent | Needs Help | Total Assistance |
|---|---|---|---|---|
| 1 | DRESSING/GROOMING | ○ | ○ | ○ |
| 2 | BATHING | ○ | ○ | ○ |
| 3 | EATING | ○ | ○ | ○ |
| 4 | TRANSFERRING | ○ | ○ | ○ |
| 5 | MOBILITY | ○ | ○ | ○ |
| 6 | BOWEL/BLADDER FUNCTION | ○ | ○ | ○ |
| | **IADLs** | **Independent** | **Needs Help** | **Total Assistance** |
| 7 | ANSWERS/CALLS ON TELEPHONE | ○ | ○ | ○ |
| 8 | SHOPPING/ERRANDS | ○ | ○ | ○ |
| 9 | ARRANGES TRANSPORTATION | ○ | ○ | ○ |
| 10 | PREPARES MEALS | ○ | ○ | ○ |
| 11 | LAUNDRY | ○ | ○ | ○ |
| 12 | HOUSEKEEPING/CLEANLINESS | ○ | ○ | ○ |
| 13 | MANAGES MONEY | ○ | ○ | ○ |
| 14 | MANAGES MEDICATION | ○ | ○ | ○ |
| | **NUTRITION** | **Regular** | **Modified** | **Therapeutic** | **Formula Only** |
| 15 | DIET | ○ | ○ | ○ | ○ |
| | | | | | **Doesn't** |
| | | **Understandable** | **Non-Verbal** | **Communicate** |
| 16 | **COMMUNICATION** | ○ | ○ | ○ |
| | | **No Problem** | **Some Problems** | **Substantial Problems** |
| 17 | **HEALTH OR SAFETY ISSUES** | ○ | ○ | ○ |
| 18 | **CONSUMER SUPPORT** | ○ | ○ | ○ |
| 19 | **SOCIAL RESOURCES** | ○ | ○ | ○ |
| | | **Low Risk** | **Mod.Risk** | **High Risk** |
| 20 | **HEALTH ASSESSMENT** | ○ | ○ | ○ |

| | | No Impairment | Impairment | Total Loss |
|---|---|---|---|---|
| 21 | **SPEECH** | ○ | ○ | ○ |
| 22 | **HEARING** | ○ | ○ | ○ |
| 23 | **VISION** | ○ | ○ | ○ |
| | | **No** | **Moderate** | **Excessive** |
| 24 | **HEART DISEASE** | ○ | ○ | ○ |
| 25 | **HYPERTENSION/STROKE** | ○ | ○ | ○ |
| 26 | **EMPHYSEMA/COPD** | ○ | ○ | ○ |
| 27 | **DIABETES** | ○ | ○ | ○ |
| 28 | **ARTHRITIC CONDITIONS** | ○ | ○ | ○ |
| 29 | TERMINAL ILLNESS | ○ | ○ | ○ |
| | | | | **Substantial** |
| | **MENTAL STATUS** | **No Problem** | **Some Problem** | **Problem** |
| 30 | MEMORY/RECALL | ○ | ○ | ○ |
| 31 | IRRATIONAL BEHAVIOR | ○ | ○ | ○ |
| 32 | CONFUSED | ○ | ○ | ○ |
| 33 | IMPULSIVE | ○ | ○ | ○ |
| 34 | HALLUCINATIVE | ○ | ○ | ○ |
| 35 | DELUSIONAL | ○ | ○ | ○ |
| 36 | TX COMPLIANCE | ○ | ○ | ○ |
| 37 | AGITATED | ○ | ○ | ○ |
| 38 | FEARFUL | ○ | ○ | ○ |
| 39 | WITHDRAWN | ○ | ○ | ○ |
| 40 | AGGRESSIVE | ○ | ○ | ○ |
| 41 | REFUSES ACTIVITIES | ○ | ○ | ○ |
| 42 | SUICIDAL | ○ | ○ | ○ |
| 43 | HOMICIDAL | ○ | ○ | ○ |
| 44 | SEIZURES | ○ | ○ | ○ |

**C. SERVICES PROVIDED**

| FREQ | | FREQ | | FREQ | | FREQ | | FREQ | |
|---|---|---|---|---|---|---|---|---|---|
| Ventilator/Respirator | | Vital Signs Eval. | | Sterile Dressing | | Ostomy Care | | Injections | |
| Decubitus/Lesion Care | | Rehab. PT/OT | | Intake & Output | | Trach. Care | | Isolation | |
| Medication Regulation | | Speech Therapy | | Behavior Observ. | | Tube Feeding | | IV Fluids | |
| Retrain Bowel/Bladder | | Active Treatment | | Catheter Care | | Suctioning | | Oxygen | |

○ No Services Needed

**Primary Diagnosis:** **Code:**

**Secondary Diagnosis:** **Code:**

**D. COMMENTS**

**LEVEL I PASRR SCREEN** **THIS SECTION IS BEING COMPLETED BY:**

○ NF Authorized Official ○ Hospital Authorized Official ○ DHS Official

IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED YES, CONTACT LOCEU FOR CONSULTATION:

**Does the individual have any:**

1. ○ Yes ○ No Evidence of serious mental illness including possible disturbances in orientation or mood (dementia or other organic mental disorders are **not** considered a serious mental illness)?
2. ○ Yes ○ No Diagnosis of a serious mental illness (such as a schizophrenic, paranoid, panic, mood or other severe anxiety or depressive disorder, somatoform disorder, personality disorder, or other psychotic disorder, or another mental disorder that may lead to a chronic disability)?
3. ○ Yes ○ No Recent history of mental illness or been prescribed a psychotropic medication for a possibly undiagnosed mental illness in the absence of a justifiable neurological disorder (within the last two years)?
4. ○ Yes ○ No Diagnosis of mental retardation or a related condition?
5. ○ Yes ○ No History of mental retardation or a related condition?
6. ○ Yes ○ No Evidence of possible mental retardation or related condition (cognitive or behavior functions)?

THE CLIENT ○ IS ○ IS NOT A DANGER TO SELF OR OTHERS.

Exempted Hospital Discharge: (See instructions for definition) ○ Yes ○ No

Short term stay category ○ Delirium ○ Emergency ○ Respite (Refer to instructions for further information.) ○ Not Applicable

Consultation Date LOCEU/OHCA staff name Consultation and any Level II evaluation results

**I certify that, to the best of my knowledge, the foregoing information is true, accurate and complete. I understand that this information may be relied upon in the payment of claims from Federal and State Funds, and that any willful falsification, or concealment of a material fact, may be prosecuted under Federal and State Law.**

**Name and Title** **Signature** **Date** **Telephone No.**

## INSTRUCTIONS FOR OHCA FORM LTC-300R

This form is used to submit information to the OHCA/Level of Care Evaluation Unit (LOCEU) when a decision is needed for care in a Nursing Facility.

**SECTION A. IDENTIFYING INFORMATION**
**Admission Date.** Enter date of admission to the facility.
**Discharge/Deceased Date.** Enter date of discharge or date of death if needed.
**Client Name**. Enter client's name, last, first, middle initial.
**Social Security Number**. Enter client's own Social Security Number.
**Birth date**. Enter client's date of birth
**Race**. Enter client's race—one letter.
**Sex.** Circle M or F.
**Medicaid/Private Pay/VA/Medicare.** Enter applicable pay source.
**Facility Name/Address**. Enter facility name, city, and zip code.
**Facility Provider Number**. Enter facility provider number.
**DHS Case Number**. Enter client's DHS case number.
**RID Number.** Enter client's Medicaid number.
**New Admit/Inter-facility Transfer/Name of Transferring Facility.** Circle admit type and enter name of transferring facility, if applicable.
**County.** Enter name of county.
**Prior Living Arrangement**. Check the box to indicate the client's residence immediately prior to facility admission.
**SECTION B. CLIENT ASSESSMENT**
Check the one box per line that corresponds to the most applicable description of the client's current condition.
**SECTION C. SERVICES NEEDED**
Check the applicable services and indicate the frequency per week for each service being given.
**SECTION D. COMMENTS**
Use this space to provide additional pertinent information.
Enter Primary and Secondary Diagnoses and codes.
**SECTION E. LEVEL I PASRR SCREEN**
Check appropriate box to identify official completing the form.
On lines 1 through 6, check Yes or No as appropriate to individual's condition prior to admission. Note: A 'Yes' answer on any of the six questions will necessitate a telephone call to LOCEU to see if a Level II PASRR evaluation is needed.
**ADMISSION INDICATIONS.**
**Danger to Self or Others.** Check whether Applicant 'Is' or 'Is Not' a danger to self or others.
**Exempted Hospital Discharge**. Should be checked **if all of the following** are met.
The individual has indications of mental illness or mental retardation or a related condition, but is not a danger to self and/or others, is being released from an acute medical care hospital, and meets the following conditions:

- The individual is being admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital, and
- The individual requires NF services for the condition for which he/she received care in the Hospital; and
- The individual is likely to require less than 30 days of NF Services as certified by the attending physician (LOCEU may request this documentation).

**Short-term stay category.** Should be checked if admission is provisional admission for Delirium, Emergency, or Respite. (These admissions require prior approval by LOCEU).
**Consultation with LOCEU Staff.** If any questions of Section E. Level I PASRR Screen are answered 'Yes', Consultation with LOCEU staff should be documented here. Indicate name of LOCEU staff member, consult decision, and date of consult in this section.
**PASRR Completion date.** Indicate date of most recent Level II PASRR evaluation and evaluation findings here.
**Signature.** Should be signed by an authorized NF Designee or Official (Administrator, DON, Social Worker) or DHS Official.

**ROUTING OF FORMS**

The completed form must be received by OHCA within 10 days of admission to:

Oklahoma Health Care Authority
Attn.: Level of Care Evaluation Unit
4345 N. Lincoln Blvd.
Oklahoma City, OK. 73105

**If you have any questions about any part of this form, please call the Level of Care Evaluation Unit at the Oklahoma Health Care Authority: 405-522-7399. Blank copies of this form must be downloaded from the OHCA Web site at http://okhca.org.**