STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
ICF/ID LEVEL OF CARE ASSESSMENT
(See Instructions on 2nd page)

A. IDENTIFYING INFORMATION

Client Name (Last, First, MI)	Social Security Number	Facility Name	Facility Provider Number

Case Number	Birthdate	Race	Sex	County	Facility Address/Client Address	City	Zip

Date Services Began:	Requested Approval Date:	Date of Onset of ID and/or Developmental Disability:	Documentation of ID/DD Included: ◯ Yes ◯ No

Special Education for ID: ◯ Yes ◯ No	Highest Grade Completed:	Gainful Employment: ◯ Yes ◯ No	Is or Has Been Married: ◯ Yes ◯ No	Level of ID (IQ Score):

TYPE OF REQUEST: ☐ Application ☐ Review ☐ Reconsideration

LEVEL REQUEST: ☐ ICF/ID-Private ☐ ICF/ID-Public ☐ ICF/ID-Waiver

PRIOR LIVING ARRANGEMENT: ☐ Own Home ☐ Mental Hospital (IMD) ☐ ICF/ID ☐ Relative's Home ☐ Hospital ☐ SNF ☐ Asst. Living ☐ Residential Care ☐ NF (ICF) ☐ Group Home ☐ Other

B. CLIENT ASSESSMENT (Check one number per line)

		Independent	Needs Help	Requires Total Assistance
1	AMBULATION	◯ 1	◯ 2	◯ 3
2	BLADDER FUNCTION	◯ 1	◯ 2	◯ 3
3	BOWEL FUNCTION	◯ 1	◯ 2	◯ 3
4	TRANSFER	◯ 1	◯ 2	◯ 3
5	BATHING	◯ 1	◯ 2	◯ 3
6	GROOMING/DRESSING	◯ 1	◯ 2	◯ 3
7	EATING	◯ 1	◯ 2	◯ 3
8	MEDICATION ADM.	◯ 1	◯ 2	◯ 3

		No Impairment	Impairment	Total Loss
9	SPEECH	◯ 1	◯ 2	◯ 3
10	HEARING	◯ 1	◯ 2	◯ 3
11	SIGHT	◯ 1	◯ 2	◯ 3

		Understandable	Non-Verbal	Does Not Communicate
12	COMMUNICATION	◯ 1	◯ 2	◯ 3

		No	Occasionally	Often
13	IRRATIONAL JUDGMENT	◯ 1	◯ 2	◯ 3
14	CONFUSED	◯ 1	◯ 2	◯ 3
15	IMPULSIVE	◯ 1	◯ 2	◯ 3
16	HALLUCINATIVE	◯ 1	◯ 2	◯ 3
17	DELUSIONAL	◯ 1	◯ 2	◯ 3
18	COMPLIANT	◯ 1	◯ 2	◯ 3
19	AGITATED	◯ 1	◯ 2	◯ 3
20	FEARFUL	◯ 1	◯ 2	◯ 3
21	WITHDRAWN	◯ 1	◯ 2	◯ 3
22	AGGRESSIVE	◯ 1	◯ 2	◯ 3
23	REFUSES ACTIVITIES	◯ 1	◯ 2	◯ 3

		No	History Of	At Risk
24	SUICIDAL	◯ 1	◯ 2	◯ 3
25	HOMICIDAL	◯ 1	◯ 2	◯ 3
26	SEIZURES	◯ 1	◯ 2	◯ 3

		No	Moderate	Excessive
27	FRAILTY	◯ 1	◯ 2	◯ 3
28	SWELLING	◯ 1	◯ 2	◯ 3
29	LABORED BREATHING	◯ 1	◯ 2	◯ 3
30	NAUSEA/DIZZINESS	◯ 1	◯ 2	◯ 3
31	TREMORS	◯ 1	◯ 2	◯ 3

		None Noted	1-2 Limbs Affected	3-4 Limbs Affected
32	CONTRACTURES OR PARALYSIS	◯ 1	◯ 2	◯ 3

		None	New	Old
33	DECUBITI OR LESIONS	◯ 1	◯ 2	◯ 3

		Regular	Modified	Therapeutic	Formula Only
34	DIET	◯ 1	◯ 2	◯ 3	◯ 4

		Yes	Partially	No
35	SELF-DIRECTED	◯ 1	◯ 2	◯ 3
36	MANAGES MONEY	◯ 1	◯ 2	◯ 3
37	PREPARES MEALS	◯ 1	◯ 2	◯ 3
38	TELLS TIME	◯ 1	◯ 2	◯ 3
39	CARES FOR CLOTHING	◯ 1	◯ 2	◯ 3
40	MAINTAINS CLEANLINESS/ORDER	◯ 1	◯ 2	◯ 3
41	ARRANGES TRANSPORTATION	◯ 1	◯ 2	◯ 3

		No Problem	Some Problem	Substantial Problem
42	CONTROL OR SAFETY	◯ 1	◯ 2	◯ 3

C. SERVICES NEEDED (State frequency per week for applicable services needed.)

	FREQ		FREQ		FREQ		FREQ		FREQ
1. MEDICATION REGULATION		5. SPEECH THERAPY		9. VOCATIONAL		13. ACADEMIC		17. ACTIVE TREATMENT	
2. RETRAIN BOWEL/BLADDER		6. PSYCHOLOGICAL		10. SKILLED NURSING		14. NUTRITIONAL		18. OSTOMY CARE	
3. PHYSICAL THERAPY		7. PSYCHIATRIC		11. HABILATATION		15. FOSTER CARE		19. CATHETER CARE	
4. OCCUPATIONAL THERAPY		8. PRE-VOCATIONAL		12. ADL'S		16. BEHAVIORAL PROGRAM		20. OTHER	

D. PSYCHOTROPIC MEDICATIONS

Ordered Medication and Dosage	RA	FREQ	Ordered Medication and Dosage	RA	FREQ

E. ALTERNATIVES

1. Does your experience with the client suggest the possibility of mental illness? ◯ Yes ◯ No
2. If a lower level of care is appropriate, is an alternative placement available? ◯ Yes ◯ No ◯ Not Appropriate

I understand that this report 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 Laws. I certify that to the best of my knowledge the foregoing information is true, accurate and complete. I have read the instructions on the back of this form and understand them completely.

_____ _____ _____
ICF/ID Administrator, Co-Administrator, QMRP, Licensed Nurse, Case Manager or Social Worker | Date | Telephone Number

F. PHYSICIAN'S EVALUATION AND RECOMMENDATION (Optional if other medical information is attached.)

1. Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____
2. Primary Diagnosis: _____ ICD-9-CM Code: _____ Onset Date: _____
   Secondary Diagnosis: _____ ICD-9-CM-Code: _____ Onset Date: _____
3. Do the findings of your evaluation suggest the possibility of ID? ◯ Yes ◯ No
4. Will the health status of client interfere with participation in the active treatment of an ICF/ID program? ◯ Yes ◯ No
5. Status of client's condition: ◯ Stable ◯ Unstable ◯ Deteriorating
6. Client's habilitative/rehabilitative potential: ◯ Good ◯ Fair ◯ Minimal
7. Level of care recommendation in view of the above: ◯ SNF ◯ NF ◯ ICF/ID ◯ Other _____

I attest to the accuracy and completeness of information stated in Section F. only.

◯ MD
_____ ◯ DO Date: _____ Telephone Number: _____

INSTRUCTIONS FOR OHCA FORM LTC-300

This form is used to submit information to the OHCA/Level of Care Evaluation Unit (LOCEU) when a decision is needed for care in an intermediate facility for the intellectualy disabled (ICF/ID) or for Home and Community Based Waiver for persons with intellectual disability.

SECTION A. IDENTIFYING INFORMATION
Client Name. Enter client's name, last, first, middle initial.
Social Security Number. Enter client's own Social Security Number.
Facility Name. Enter facility name if applicable.
Facility Provider Number. Enter facility provider number if applicable.
Case Number. Enter client's DHS case number (Medicaid Number).
Birthdate. Enter client's date of birth.
Race. Enter client's race—one letter.
Sex. Enter "M" for male client; enter "F" for female client.
County. Enter name of county.
Facility Address/Client Address. Enter address of facility or home address of client.
Date Services Began. Enter the date the client was admitted to the facility or the date waivered services commenced.
Requested Approval Date. Enter the requested approval date.
Date of Onset of Intellectual Disability and/or Developmental Disability. Enter the date when ID or chronic developmental disability began. Enter "birth" if present at birth.
Documentation of ID/DD Included. Enter "yes" or "no" if documentation of ID/DD is included with this form.
Special Education for ID. Enter "yes" or "no" as to whether client as ever participated in special education classes for mentally retarded.
Highest Grade Completed. Enter the highest grade in school completed by the client.
Gainful Employment. Enter "yes" or "no" as to whether client has ever been gainfully employed (economically self-sufficient).
Is or Has Been Married. Enter "yes" or "no" as to whether client has been married.
Level of Intellectual Disability (IQ Score). Enter the level of ID (profound, severe, moderate or mild) and the full-scale IQ score on the most current psychological evaluation period.
Type of Request. Check appropriate box to indicate type of request.
Level Requested. Check appropriate box to indicate level of care requested.
Prior Living Arrangement. Check the box to indicate the client's residence immediately prior to facility admission or waiver inclusion.
SECTION B. CLIENT ASSESSMENT
Circle the one number per line that corresponds to the most applicable description of the client's current condition.
SECTION C. SERVICES NEEDED
Circle applicable services needed and state the frequency per week for each service circled.
SECTION D. PSYCHOTROPIC MEDICATIONS
List name, dosage, and route of administration of client's four most critical currently ordered psychotropic medications. If no psychotropic medications are administered, enter "none".
SECTION E. ALTERNATIVES
Check appropriate box as indicated in answer to the question.
Certification of Person Completing the ICF/ID Level of Care Assessment:

> **Enter the signature of ICF/ID administrator/co-administrator, QMRP, case manager, licensed nurse, or social worker completing the form. Circle appropriate title. Enter the telephone number of the person signing and the date it was signed. This signature attests to the validity of all the information completed above.**

SECTION F. PHYSICIAN'S EVALUATION AND RECOMMENDATION (OPTIONAL IF MEDICAL EVALUATION IS ATTACHED).
Complete all sections including a recommendation for client's level of care.
Attestation by Physician Completing Section F:

> **Enter date, telephone number and signature of physician. Check the appropriate type of physician.**

ROUTING OF FORMS

When Private ICF/ID services are being requested, current (within the last 90 days) medical information which includes a recommendation for level of care signed by a physician, the original copy of Form LTC-300, one copy of a current (within the last 12 months) psychological examination and one copy of the pertinent section of the individual Development Plan or other appropriate documentation relative to discharge planning, and a statement that the client is not homicidal or suicidal will be submitted to LOCEU. One copy of this form will be retained in the client's facility record.

Mail the entire packet to:

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

When DHS, DDSD Waivered or Public ICF/ID Services are being requested, follow DDSD application procedures.

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: 405-522-7133 or 405-522-7674. Blank copies of this form must be downloaded from the OHCA Web site at http:// www.ohca.state.ok.us/