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39	WITHDRAWN	○	○	○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.