**REQUEST FOR LEVEL OF CARE REVIEW**

**Submit to: Area Agency on Aging, District 7 Inc., F32-URG PO Box 500 Rio Grande, Ohio, 45674**

**Phone: 740-245-9123 Fax: 740-245-9148**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Submitter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Return Fax#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pages Submitted (including this page) #\_\_\_\_\_\_\_\_

|  |
| --- |
| **Reason for Request:**  **\_\_\_\_\_Pay Conversion:**  \_\_\_\_\_ Medicare to Medicaid \_\_\_\_\_Hospice to Medicaid \_\_\_\_\_Private pay to Medicaid \_\_\_\_\_Managed care to Medicaid  **\_\_\_\_\_ NF to NF transfer: Date of 1st NF Admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Transfer to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_From\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is the Resident in your facility: \_\_\_\_\_No\_\_\_\_\_Yes LOC effective Date requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Additional form required:**  \_\_\_\_PAS/ID & Review Results letter---OR---Convalescent Stay Statement or Exemption Form 7000 & entire Resident  Review form(3622) **AND**  **\_\_\_\_**3697 Tool with current MD signature & Physician’s Orders for month requested.  **OR**  **\_\_\_\_\_**MDS+& Physician’s Orders for month requested. If using MDS 3.0, send Sections **A, C, D, E, G, I, M, N & O** only! |

Resident’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_County\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Guardian/Authorized Rep/DPOA/Sponsor, please list: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address/Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident capable of self-administering medication? \_\_\_\_\_\_No\_\_\_\_\_Yes

Per Doctor’s order requires 24 hour supervision due to a cognitive impairment to prevent harm? \_\_\_\_\_No\_\_\_\_\_Yes

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **IADL**  *(Instrumental Activities of Daily Living)* | **No Help** | **Supervision** | **Hands On Assistance** |
| 1. Shopping |  |  |  |
| 1. Meal Preparation |  |  |  |
| 1. Environmental (1) House Cleaning |  |  |  |
| (2) Heavy Chores |  |  |  |
| (3) Yard Work/Maint. |  |  |  |
| 1. Laundry |  |  |  |
| 1. Community Access: (1) Telephone |  |  |  |
| (2) Transportation |  |  |  |
| (3) Legal/Finance |  |  |  |

**Physician’s Certification**

*I have reviewed the enclosed MDS or ODJFS 3697 and certify that it is an accurate statement of the Resident’s physical, mental and social/emotional status. I certify the Resident requires:*

***(Check one)*** Intermediate Level of Care\_\_\_\_\_\_\_\_\_\_ Skilled Level of Care\_\_\_\_\_\_\_\_\_\_

***Resident’s condition is Stable\_\_\_\_\_\_\_\_\_\_ Unstable\_\_\_\_\_\_\_\_\_\_***

**Physician’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Revised 11-15-12