

OHIO DEPARTMENT OF MEDICAID
LEVEL OF CARE ASSESSMENT

I. Demographics Assessment Date

a. Name		b. Address			
c. Phone	d. County	e. Date of Birth	f. Age	g. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
h. Language Spoken <div style="text-align: right;">Barrier <input type="checkbox"/> Yes <input type="checkbox"/> No</div>					
i. Medicaid I. D. <div style="text-align: right;"><input type="checkbox"/> Active <input type="checkbox"/> Pending</div>					
j. Social Security Number	k. Medicare Number	l. Date of Conversion from other Funding to Medicaid			
m. Other Health Insurance					
n. Contact <div style="text-align: right;"><input type="checkbox"/> Guardian <input type="checkbox"/> POA <input type="checkbox"/> Authorized Rep.</div>				o. Phone (Day) Phone (Evening)	

p. Relationship		
q. Usual	Current	Living Arrangement
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Own home/apartment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Relative/friend
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Congregate housing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Group, foster, rest home
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Nursing Facility (NF)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (ICF/IID)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Psychiatric hospital/unit
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Acute care hospital
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other (<i>specify</i>)

II. Reason For Request

a. <input type="checkbox"/> Nursing Facility (NF) Admission (<i>check one of the following</i>) <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/IID (<i>name</i>)		c. <input type="checkbox"/> HCBS services (<i>specify</i>)		
d. <input type="checkbox"/> Assisted Living		e. <input type="checkbox"/> RSS		
f. <input type="checkbox"/> LOC Review		g. <input type="checkbox"/> Other (<i>specify</i>)		
If NF Admission				
NF Name	NF Address	City	State	Zip Code
Estimated Length of Stay		Provider Number		

III. LOC Assessment Summary

a. ADLS (<i>list total to the left of category</i>)	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervision	<input type="checkbox"/> Assistance
b. IADLS (<i>list total to the left of category</i>)	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervision	<input type="checkbox"/> Assistance
c. Medication Administration	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervision	<input type="checkbox"/> Assistance
d. <input type="checkbox"/> Needs 24-hour supervision due to cognitive impairment	e. Medical Condition <input type="checkbox"/> Stable <input type="checkbox"/> Unstable		
f. <input type="checkbox"/> Skilled Nursing Services (<i>list/frequency</i>)			
g. <input type="checkbox"/> Skilled Rehabilitation Services (<i>list/frequency</i>)			

IV. Informal Support Yes No (*If yes, list and describe below*)

V. LOC Recommendation (*to be completed by PAA staff only*)

Based on review of the LOC assessment, it is recommended that the level of care indicated below is appropriate:
 Skilled Intermediate Intermediate/Developmental Disabilities Protective None

ID Number (<i>if applicable</i>)	Signature/Title	Initials
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(*To be completed by client or authorized representative*) I understand my health care options and choose to receive:

- NF Services ICF/IID 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 (*check all that apply*):

- 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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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/Developmental Disabilities Protective None

Certification Signature	Date
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FOR PAA USE ONLY

Date of verbal authorization	PAA Assessor Signature
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Client							Date				
VI. Physicians <i>(Physician, Nurse Practitioner, or Physician Assistant)</i>											
PRIMARY SPECIALTY					OTHER SPECIALTY						
Name					Name						
Address		City	State	Zip Code		Address		City	State	Zip Code	
Phone		Date last seen			Phone		Date last seen				
VII. Diagnoses Source of information <i>(Please Check)</i>											
<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 <i>(INCLUDE SUMMARY OF OVERALL CONDITION)</i> Source of information <i>(Please Check)</i>											
<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"/> Fair	<input type="checkbox"/> Poor			<input type="checkbox"/> Improved Function		<input type="checkbox"/> Maintain Function				
					<input type="checkbox"/> Delay Loss of Function		<input type="checkbox"/> None				
IX. Allergies <i>(include medications, insects, molds, foods, animals, grasses, etc.)</i>											
X. Medication Profile Sources of information <i>(Please Check)</i>											
<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 <i>(continued)</i>		RX	OTC	Dosage/ Frequency	Route	
1)					6)						
2)					7)						
3)					8)						
4)					9)						
5)					10)						
TOTALS					TOTALS						
B) Pharmacy	Address			City		State	Zip Code		Phone		
C) Chemicals <i>(include frequency and amount)</i>											
Alcohol					Caffeine						
Other					Nicotine						

Additional Information attached on trailer sheet

Client	Date
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FOR SECTIONS XI, XII, XIII AND XIV, (Indicate assistance level for every activity below, do not skip any activities)

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					<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
1. Bed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3		b. Meal Preparation					<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
2. Transfer	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3		c. Environmental								
3. Locomotion	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3		1. House Cleaning					<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
b. Bathing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3		2. Heavy Chores					<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
c. Grooming	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3		3. Yardwork/Maintenance					<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
d. Toileting	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3		d. Laundry					<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
e. Dressing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3		Community Access								
f. Eating	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3		1. Telephoning					<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
List durable, assistive and adaptive equipment used					2. Transportation					<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
					3. Legal/Financial					<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
					XIII. Medication Administration					<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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		Source
a. <input type="checkbox"/> Disoriented to person		m. <input type="checkbox"/> Verbally abusive or aggressive	
b. <input type="checkbox"/> Disoriented to place		n. <input type="checkbox"/> Physically abusive or aggressive	
c. <input type="checkbox"/> Disoriented to time		o. <input type="checkbox"/> Wanders – mentally	
d. <input type="checkbox"/> Confusion		p. <input type="checkbox"/> Wanders – physically	
e. <input type="checkbox"/> Withdrawn, isolates self		q. <input type="checkbox"/> Forgetfulness	
r. <input type="checkbox"/> Hyperactive		1. <input type="checkbox"/> Short Term	
		2. <input type="checkbox"/> Long Term	
s. <input type="checkbox"/> Mood swings		r. <input type="checkbox"/> Agitation	
t. <input type="checkbox"/> Inappropriate fears, suspicions		s. <input type="checkbox"/> Smokes carelessly	
u. <input type="checkbox"/> Abusive to self		t. <input type="checkbox"/> Has difficulty concentrating	
v. <input type="checkbox"/> Drug/Alcohol abuse		u. <input type="checkbox"/> Has difficulty sleeping	
w. <input type="checkbox"/> Exhibits bizarre behavior		v. <input type="checkbox"/> Cannot make own decisions	
x. <input type="checkbox"/> Neglect to self		w. <input type="checkbox"/> 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 Complications 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 Complications 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 Complications 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 Complications 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 Complications 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 Complications 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 Complications 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 Complications 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. DEVELOPMENTAL DISABILITIES *(Complete only for a client requesting an ICF-IID/DD LOC)*

PSYCHOLOGICAL EVALUATION ATTACHED

"Persons with related conditions" is defined as persons who have severe, chronic disabilities that meets all of the following conditions

1. The disability is attributed to: Yes No

a. Cerebral palsy

b. Epilepsy or,

c. Any other condition, other than mental illness, found to be closely related to developmental disability because this results in impairment of general intellectual functioning or adaptive behavior similar to that of developmentally disabled persons, and requires treatment or services.

2. Was manifested before the person reached age 22

Yes No

3. Is likely to continue indefinitely Yes No

4. Results in substantial functional limitations in three (3) or more of the following areas of major life activity:

a. Self-care Yes No

b. Understanding Yes No

c. Learning Yes No

d. Mobility Yes No

e. Self-direction Yes No

f. Capacity for independent living Yes No

ADDITIONAL COMMENTS/SUMMARIES LEVEL OF CARE TRAILER SHEET

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

ADDITIONAL MEDICATION PROFILE

A) Medications	RX	OTC	Dosage/ Frequency	Route	Medications <i>(continued)</i>	RX	OTC	Dosage/ Frequency	Route
11)	<input type="checkbox"/>	<input type="checkbox"/>			16)	<input type="checkbox"/>	<input type="checkbox"/>		
12)	<input type="checkbox"/>	<input type="checkbox"/>			17)	<input type="checkbox"/>	<input type="checkbox"/>		
13)	<input type="checkbox"/>	<input type="checkbox"/>			18)	<input type="checkbox"/>	<input type="checkbox"/>		
14)	<input type="checkbox"/>	<input type="checkbox"/>			19)	<input type="checkbox"/>	<input type="checkbox"/>		
15)	<input type="checkbox"/>	<input type="checkbox"/>			20)	<input type="checkbox"/>	<input type="checkbox"/>		

Additional Information attached on trailer sheet

INSTRUCTIONS FOR COMPLETEING
ODM 03697 LEVEL OF CARE ASSESSMENT

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: Place check mark next to 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: PAA Staff to complete recommendation after Section III, LOC Assessment Summary is completed;
LOC recommendation must be supported by Section III. PAA staff completing recommendation must sign recommendation, document client’s choice of service settings, ensure client’s or authorized representative’s signature has been obtained, and obtain certification.

PAGE 2

SECTION VI – PHYSICIANS: Complete as indicated.

SECTION VII – DIAGNOSES: Place check mark(s) next to source(s) of information and complete as indicated.

SECTION VIII – HEALTH HISTORY: Place check mark(s) next to 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: Place check mark(s) next to source(s) of information and complete as indicated.

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

PAGE 3

SECTION XI – ADLS, XII – IADLS AND

XIII – MEDICATION ADMINISTRATION: Place check mark(s) next to type of help needed by applicant to complete each activity. *Note:* Person submitting form must ensure all activities are completed, do not skip any activities. Refer to Ohio Administrative Code rules 5160-3-05, 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:

Place check mark(s) next to 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 three (3) if additional information related to Page three (3) is included on the trailer sheet or if additional information related to Page three (3) is attached to the ODM 03697.

PAGE 4

SECTION XV – SYSTEMS REVIEW: Complete as indicated.

SECTION XVI –DEVELOPMENTAL DISABILITIES: Complete as indicated.

NOTE: Check box at bottom of Page two (2) if additional information related to Page two (2) is included on the trailer sheet or if additional information related to Page two (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 two (2) in Section X, Medication Profile, is insufficient.