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 Phone Number | | | | Facility Email Address | | | | | | Facility Provider Number | | |
| Case Number | | Birthdate | | Race | | | Sex | | County | | | Facility Address/Client Address City, State Zip             , OK | | | | | | | | | | | | | | | | | | |
| 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 REQUESTED:  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)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | |  | | | | |  | | | **Requires Total** | | | |  | |  | |  | | | |  | | | |  | | |  | |
|  | |  | | **Independent** | | | | | **Needs Help** | | | **Assistance** | | | |  | |  | |  | | | | **No** | | | | **History Of** | | | **At Risk** | |
| 1 | | AMBULATION | |  | | | | |  | | |  | | | |  | | 24 | | SUICIDAL | | | |  | | | |  | | |  | |
| 2 | | BLADDER FUNCTION | |  | | | | |  | | |  | | | |  | | 25 | | HOMICIDAL | | | |  | | | |  | | |  | |
| 3 | | BOWEL FUNCTION | |  | | | | |  | | |  | | | |  | | 26 | | SEIZURES | | | |  | | | |  | | |  | |
| 4 | | TRANSFER | |  | | | | |  | | |  | | | |  | |  | |  | | | | **No** | | | | **Moderate** | | | **Excessive** | |
| 5 | | BATHING | |  | | | | |  | | |  | | | |  | | 27 | | FRAILTY | | | |  | | | |  | | |  | |
| 6 | | GROOMING/DRESSING | |  | | | | |  | | |  | | | |  | | 28 | | SWELLING | | | |  | | | |  | | |  | |
| 7 | | EATING | |  | | | | |  | | |  | | | |  | | 29 | | LABORED BREATHING | | | |  | | | |  | | |  | |
| 8 | | MEDICATION ADM. | |  | | | | |  | | |  | | | |  | | 30 | | NAUSEA/DIZZINESS | | | |  | | | |  | | |  | |
|  | |  | |  | | | | |  | | |  | | | |  | | 31 | | TREMORS | | | |  | | | |  | | |  | |
|  | |  | | **No Impairment** | | | | | **Impairment** | | | **Total Loss** | | | |  | |  | |  | | | | **None Noted** | | | | **1-2 Limbs Affected** | | | **3-4 Limbs Affected** | |
| 9 | | SPEECH | |  | | | | |  | | |  | | | |  | | 32 | | CONTRACTURES OR PARALYSIS | | | |  | | | |  | | |  | |
| 10 | | HEARING | |  | | | | |  | | |  | | | |  | |  | |  | | | | **None** | | | | **New** | | | **Old** | |
| 11 | | SIGHT | |  | | | | |  | | |  | | | |  | | 33 | | DECUBITI OR LESIONS | | | |  | | | |  | | |  | |
|  | |  | |  | | | | |  | | | **Does Not** | | | |  | |  | |  | | | |  | | | |  | | |  | |
|  | |  | | **Understandable** | | | | | **Non-Verbal** | | | **Communicate** | | | |  | |  | | **Regular** | | | | **Modified** | | | | **Therapeutic** | | | **Formula Only** | |
| 12 | | COMMUNICATION | |  | | | | |  | | |  | | | |  | | 34 | | DIET | | | |  | | | |  | | |  | |
|  | |  | | **No** | | | | | **Occasionally** | | | **Often** | | | |  | |  | |  | | | | **Yes** | | | | **Partially** | | | **No** | |
| 13 | | IRRATIONAL JUDGMENT | |  | | | | |  | | |  | | | |  | | 35 | | SELF-DIRECTED | | | |  | | | |  | | |  | |
| 14 | | CONFUSED | |  | | | | |  | | |  | | | |  | | 36 | | MANAGES MONEY | | | |  | | | |  | | |  | |
| 15 | | IMPULSIVE | |  | | | | |  | | |  | | | |  | | 37 | | PREPARES MEALS | | | |  | | | |  | | |  | |
| 16 | | HALLUCINATIVE | |  | | | | |  | | |  | | | |  | | 38 | | TELLS TIME | | | |  | | | |  | | |  | |
| 17 | | DELUSIONAL | |  | | | | |  | | |  | | | |  | | 39 | | CARES FOR CLOTHING | | | |  | | | |  | | |  | |
| 18 | | COMPLIANT | |  | | | | |  | | |  | | | |  | | 40 | | MAINTAINS CLEANLINESS/ORDER | | | |  | | | |  | | |  | |
| 19 | | AGITATED | |  | | | | |  | | |  | | | |  | | 41 | | ARRANGES TRANSPORTATION | | | |  | | | |  | | |  | |
| 20 | | FEARFUL | |  | | | | |  | | |  | | | |  | |  | |  | | | | **No** | | | | **Some** | | | **Substantial** | |
| 21 | | WITHDRAWN | |  | | | | |  | | |  | | | |  | |  | |  | | | | **Problem** | | | | **Problem** | | | **Problem** | |
| 22 | | AGGRESSIVE | |  | | | | |  | | |  | | | |  | | 42 | | CONTROL OR SAFETY | | | |  | | | |  | | |  | |
| 23 | | REFUSES ACTIVITIES | |  | | | | |  | | |  | | | |  | |  | |  | | | | |  | | |  | | |  | |
| **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 | | | | |
| 3.PHYSICAL THERAPY | | | | | 7.PSYCHIATRIC | | | | | | | | 11.HABILITATION | | | | | | | | 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, QIDP, 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 intellectual disability?  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/MR  Other |  |

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

MD

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | DO Date: |  | Telephone #: |  |

OKLA HCA REVISED 07-27-10 LTC-300

**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 persons with intellectual disability (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**. Leave Blank.

**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 intellectual disability or chronic developmental disability began. Enter “birth” if present at birth.

**Documentation of ID/DD Included**. Enter “yes” or “no” to indicate 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 intellectual disability.

**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 functioning (IQ Score)**. Enter the level of intellectual disability (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 or check the box for the one number per line that corresponds to the most applicable description of the client’s current condition.

# SECTION C. SERVICES NEEDED

Circle or check the box for the applicable services needed and state the frequency per week for each service circled or checked.

# 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~~QIDP, 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 Boulevard

Oklahoma City, Oklahoma 73105,

## When DHS, DDS Waivered or Public ICF/MR Services are being requested, follow DDS 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: 1-800-522-0114, option 6, option 2. Blank copies of this form must be downloaded from the OHCA Web site at http://www.ohca.state.ok.us/

OKLA HCA REVISED 3/11/2023 LTC-300