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 ☐ Male ☐ Female
h. Language Spoken Barrier ☐ Yes ☐ No				
i. Medicaid I. D. ☐ Active ☐ Pending				
j. Social Security Number	k. Medicare Number	l. Date of Conversion from other Funding to Medicaid		
m. Other Health Insurance				
n. Contact ☐ Guardian ☐ POA ☐ Authorized Rep.		o. Phone *(Day)* Phone *(Evening)*		

p. Relationship		
q. **Usual**	**Current**	**Living Arrangement**
☐	☐	☐ Own home/apartment
☐	☐	☐ Relative/friend
☐	☐	☐ Congregate housing
☐	☐	☐ Group, foster, rest home
☐	☐	☐ Nursing Facility (NF)
☐	☐	☐ (ICF/IID)
☐	☐	☐ Psychiatric hospital/unit
☐	☐	☐ Acute care hospital
☐	☐	☐ Other *(specify)*

II. Reason For Request

a. ☐ Nursing Facility (NF) Admission *(check one of the following)*

☐ New Admission ☐ Readmit: original date of admission ☐ Transfer: from original date of admission

b. ☐ ICF/IID *(name)* _____ c. ☐ HCBS services *(specify)* _____

d. ☐ Assisted Living e. ☐ RSS

f. ☐ LOC Review g. ☐ Other *(specify)* _____

If NF Admission

NF Name	NF Address	City	State	Zip Code

Estimated Length of Stay	Provider Number

III. LOC Assessment Summary

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

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 *(if applicable)*	Signature/Title	Initials

(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

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

FOR PAA USE ONLY

Date of verbal authorization	PAA Assessor Signature

Client	Date

VI. Physicians *(Physician, Nurse Practitioner, or Physician Assistant)*

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 *(Please Check)*

☐ Physician ☐ Medical Record ☐ Record ☐ Client ☐ Caregiver ☐ Authorized Representative

	Date of Onset	ICD Code		Date of Onset	ICD Code
1) Primary			4)		
2)			5)		
3)			6)		

VIII. Health History ***(INCLUDE SUMMARY OF OVERALL CONDITION)*** Source of information *(Please Check)*

☐ Physician ☐ Medical Record ☐ Record ☐ Client ☐ Caregiver ☐ Authorized Representative

PROGNOSIS

☐ Good ☐ Fair ☐ Poor

REHABILITATION POTENTIAL

☐ Improved Function ☐ Maintain Function

☐ Delay Loss of Function ☐ None

IX. Allergies *(include medications, insects, molds, foods, animals, grasses, etc.)*

X. Medication Profile Sources of information *(Please Check)*

☐ Physician ☐ Medical Record ☐ Record ☐ Client ☐ Caregiver

☐ Authorized Representative ☐ Additional Page Included

A) Medications	RX	OTC	Dosage/ Frequency	Route	Medications *(continued)*	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 *(include frequency and amount)*

Alcohol	Caffeine
Other	Nicotine

☐ Additional Information attached on trailer sheet

Client	Date

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

☐ Physician ☐ Medical Record ☐ Client ☐ Caregiver ☐ Authorized Representative

A) EYES, EARS, MOUTH, AND THROAT Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency)*: ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

B) NEUROLOGICAL Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

C) PULMONARY Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

D) CARDIOVASCULAR AND CIRCULATORY Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

E) MUSCULOSKELETAL Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

F) GASTROINTESTINAL Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

G) GENITOURINARY Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

H) SKIN Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

☐ Additional Information attached on trailer sheet

Client	Date

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	

ADDITIONAL MEDICATION PROFILE

A) Medications	RX	OTC	Dosage/ Frequency	Route	Medications *(continued)*	RX	OTC	Dosage/ Frequency	Route
11)	☐	☐			16)	☐	☐		
12)	☐	☐			17)	☐	☐		
13)	☐	☐			18)	☐	☐		
14)	☐	☐			19)	☐	☐		
15)	☐	☐			20)	☐	☐		

☐ 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.