OHIO DEPARTMENT OF MEDICAID
LEVEL OF CARE ASSESSMENT

I. DEMOGRAPHICS

Assessment Date: / /

a. Name

b. Address

c. Phone | d. County

e. DOB | f. Age | g. Sex: ☐ M ☐ F

h. Language Spoken | Barrier ☐ Y ☐ N

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) ( ) (EVENING) ( )

p. Relationship:

q. Usual	Current	LIVING ARRANGEMENT *(circle)*
(1)	(1)	own home/apartment
(2)	(2)	relative/friend
(3)	(3)	congregate housing
(4)	(4)	group, foster, rest home
(5)	(5)	NF
(6)	(6)	ICF/MR
(7)	(7)	psychiatric hospital/unit
(8)	(8)	acute care hospital
(9)	(9)	other (specify)

II. REASON FOR REQUEST

a. ☐ NF Admission *(check one of the following)*
☐ New Admission
☐ Readmit: original date of admission
☐ Transfer: from
original date of admission

b. ☐ ICF / MR *(name)*

c. ☐ HCBS services *(specify)*

d. ☐ ASSISTED LIVING

e. ☐ RSS f. ☐ OC Review

g. ☐ Other *(specify)*

If NF Admission:
NF Name/Address
Estimated Length of Stay
Provider #

III. LOC ASSESSMENT SUMMARY

a. ADLS *(list total by category)*
☐ Independent
☐ Supervision
☐ Assistance

b. IADLS *(list total by category)*
☐ Independent
☐ Supervision
☐ Assistance

c. Medication Administration:
☐ Supervision ☐ Assistance ☐ Independent

d. ☐ Needs 24 hour supervision due to cognitive impairment

e. 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

V. LOC RECOMMENDATION

Based on review of the LOC assessment, it is recommended that the level of care indicated below is appropriate:

☐ Skilled ☐ Intermediate ☐ Intermediate/Mental Retardation-Development Disabilities ☐ Protective ☐ None

ID#: *(If Applicable)* | Signature/Title: | Initials

I understand my health care options and choose to receive ☐ NF Services ☐ ICF/MR 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:

☐ 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

ATTENDING PHYSICIAN 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/Mental Retardation-Development Disabilities ☐ Protective ☐ None

Physician's Signature | Date

FOR PAA USE ONLY:

Date of verbal physician authorization | PAA Assessor Signature:

Client:	Date:

VI. PHYSICIANS

PRIMARY Specialty:		OTHER Specialty:	
Name		Name	
Address		Address	
Phone	Date Last Seen	Phone	Date Last Seen

VII. DIAGNOSES
SOURCES 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)
SOURCES OF INFORMATION (CHECK): ☐ Physician ☐ Medical Record ☐ Record ☐ Client ☐ Caregiver ☐ Authorized Representative

PROGNOSIS	**REHABILITATION POTENTIAL**
☐ Good	☐ Improved Function
☐ Fair	☐ Maintain Function
☐ Poor	☐ Retard 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	PHONE

C) CHEMICALS: (include form, frequency and amount)

ALCOHOL	CAFFEINE
OTHER	NICOTINE

☐ Additional Information attached on trailer sheet

Client:	Date:

FOR SECTIONS XI, XII, XIII AND XIV, 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
a. Mobility				
1. Bed	1	2	3	
2. Transfer	1	2	3	
3. Locomotion	1	2	3	
b. Bathing	1	2	3	
c. Grooming	1	2	3	
d. Toileting	1	2	3	
e. Dressing	1	2	3	
f. Eating	1	2	3	

List durable, assistive and adaptive equipment used:

XII. IADL Instrumental Activities of Daily Living	NO HELP	SUPER-VISION	HANDS ON	SOURCES
a. Shopping	1	2	3	
b. Meal Preparation	1	2	3	
c. Environmental				
1. House Cleaning	1	2	3	
2. Heavy Chores	1	2	3	
3. Yardwork/Maintenance	1	2	3	
d. Laundry	1	2	3	
e. Community Access				
1. Telephoning	1	2	3	
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		√	SOURCES
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:		
f. Hyperactive			1. Short-Term		
			2. Long-Term		
g. Mood swings			r. Agitation		
h. Inappropriate fears, suspicions			s. Smokes carelessly		
i. Abusive to self			t. Has difficulty concentrating		
j. Drug/Alcohol abuse			u. Has difficulty sleeping		
k. Exhibits bizarre behavior			v. Cannot make own decisions		
l. Neglect of 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 Compliance
Explanation:
Interventions: Description:
Performed by *(check and list frequency)*: ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

B) NEUROLOGICAL:
Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Compliance
Explanation:
Interventions: Description:
Performed by *(check and list frequency)*: ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

C) PULMONARY:
Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Compliance
Explanation:
Interventions: Description:
Performed by *(check and list frequency)*: ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

D) CARDIOVASCULAR AND CIRCULATORY:
Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Compliance
Explanation:
Interventions: Description:
Performed by *(check and list frequency)*: ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

E) MUSCULOSKELETAL:
Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Compliance
Explanation:
Interventions: Description:
Performed by *(check and list frequency)*: ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

F) GASTROINTESTINAL:
Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Compliance
Explanation:
Interventions: Description:
Performed by *(check and list frequency)*: ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

G) GENITOURINARY:
Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Compliance
Explanation:
Interventions: Description:
Performed by *(check and list frequency)*: ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

H) SKIN:
Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Compliance
Explanation:
Interventions: Description:
Performed by *(check and list frequency)*: ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

☐ Additional Information attached on trailer sheet

Client:	Date:

XVI. MENTAL RETARDATION/DEVELOPMENT DISABILITIES: Refer to OAC 5101:3-3-07 (Complete only for a client requesting an ICF/MR 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 mental retardation because this results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these people.
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 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)				
TOTALS					TOTALS				

☐ Additional Information attached on trailer sheet

LEVEL OF CARE ASSESSMENT (ODM 03697)
INSTRUCTIONS

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: Check 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: Complete as indicated after Section III, LOC Assessment Summary is completed; LOC recommendation must be supported by Section III. Person completing form must sign recommendation, must document client's choice of service settings, obtain client's signature, and obtain physician's certification.

PAGE 2

SECTION VI – PHYSICIANS: Complete as indicated.

SECTION VII – DIAGNOSES: Circle source(s) of information and complete as indicated.

SECTION VIII – HEALTH HISTORY: Circle 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 Circle source(s) of information and complete as indicated.

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

PAGE 3

SECTION XI – ADLS, XII – IADLS AND XIII – MEDICATION ADMINISTRATION: Circle type of help needed by applicant to complete each activity. Note: Refer to Ohio Administrative Code rules 5101:3-3-05, 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: Check 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 3 if additional information related to Page 3 is included on the trailer sheet or if additional information related to Page 3 is attached to the ODM 03697.

PAGE 4

SECTION XV – SYSTEMS REVIEW: Complete as indicated.

SECTION XVI – MENTAL RETARDATION/ DEVELOPMENTAL DISABILITIES Complete as indicated.

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