NV LOC - FA-19

Level of Care Assessment for Nursing Facilities Adult and Pediatric

Please upload this form through the Provider Web Portal.
For assistance, please contact the Gainwell Technologies Help Desk **1 (800) 525-2395**

Screening Type

Reason For Screening (select one)	Service Level (select one)	Date
◯ Initial Placement	◯ Standard	
◯ Retro Eligibility	◯ Pediatric Specialty Care I **	
◯ Service Level Change	◯ Pediatric Specialty Care I I **	
◯ Time Limitation	◯ Ventilator Dependent *	

Recipient Retro Eligibility	Date of Admission to Skilled Nursing Facility

If Ventilator Dependent, you must attach medical records indicating the date the recipient went on/off the ventilator. ** If Pediatric Specialty Care is selected, the Pediatric Specialty Care Services Screening Requis required.

Requesting Facility or Provider Information

Last Name	First Name	Telephone	Fax	Email

Organization ID	Organization Name

Organization Address 1	Organization Address 2

Organization City	Organization State	Organization Zip

Recipient Information

Recipient

Last Name	First Name	Middle Name

Permanent Mailing Address *(where does applicant receive their mail?)*

Street Address	City	State	Zip Code

Personal Details

Social Security Number	Date of Birth	Medicaid ID Number	Medicaid Status	Medicaid County of Residence

Medical History

Diagnoses

Diagnosis (Current / Pertinent / Active)	Diagnosis	If Other Diagnosis, Specify
Diagnosis (Current / Pertinent / Active)	Diagnosis	If Other Diagnosis, Specify
Diagnosis (Current / Pertinent / Active)	Diagnosis	If Other Diagnosis, Specify

Current Medications

Medications

Medication Administration

Can Recipient Safely Self-Administer Medications?	List Barrier
◯ Yes ◯ No	

Recipient Name: Date of Request:

Special Needs ***(please check all that apply)***					
☐ Central Line	☐ Feeding Tube (G, J, NG)	☐ Glucose Monitoring	☐ Insulin Coverage	☐ IV	☐ O2
☐ Ostomy	☐ Pediatric Specialty Care	☐ PICC	☐ Saline Lock	☐ Secured Alzheimer Unit	☐ Specialty Bed
☐ Suctioning	☐ Trach	☐ Ventilator Dependent (minimum 6 hours/day)	☐ Wound Care	☐ DME	☐ Other
Specify Other Special Needs					
For checked items above, list the frequency/duration of treatment, the stage/grade/size/location of wounds and/or any other specific treatments:					

Activities of Daily Living (ADL):

ADLs	Self Performance ***(select one per ADL)***		Support Provided ***(select one per ADL)***	
Bed Mobility	☐ Independent ☐ Supervision ☐ Extensive Assistance	☐ Limited Assistance ☐ Total Dependence	☐ No Setup or Help ☐ One Person Physical Assist ☐ Two Person Physical Assist	☐ Setup Help Only
Transferring	☐ Independent ☐ Supervision ☐ Extensive Assistance	☐ Limited Assistance ☐ Total Dependence	☐ No Setup or Help ☐ One Person Physical Assist ☐ Two Person Physical Assist	☐ Setup Help Only
Dressing	☐ Independent ☐ Supervision ☐ Extensive Assistance	☐ Limited Assistance ☐ Total Dependence	☐ No Setup or Help ☐ One Person Physical Assist ☐ Two Person Physical Assist	☐ Setup Help Only
Eating And Feeding	☐ Independent ☐ Supervision ☐ Extensive Assistance	☐ Limited Assistance ☐ Total Dependence	☐ No Setup or Help ☐ One Person Physical Assist ☐ Two Person Physical Assist	☐ Setup Help Only
Hygiene	☐ Independent ☐ Supervision ☐ Extensive Assistance	☐ Limited Assistance ☐ Total Dependence	☐ No Setup or Help ☐ One Person Physical Assist ☐ Two Person Physical Assist	☐ Setup Help Only
Bathing	☐ Independent ☐ Supervision ☐ Extensive Assistance	☐ Limited Assistance ☐ Total Dependence	☐ No Setup or Help ☐ One Person Physical Assist ☐ Two Person Physical Assist	☐ Setup Help Only
Bladder Function	☐ Independent ☐ Supervision ☐ Extensive Assistance	☐ Limited Assistance ☐ Total Dependence	☐ Continent ☐ Catheter	☐ Incontinent
Bowel Function	☐ Independent ☐ Supervision ☐ Extensive Assistance	☐ Limited Assistance ☐ Total Dependence	☐ Continent ☐ Catheter	☐ Incontinent
Locomotion	☐ Independent ☐ Supervision ☐ Extensive Assistance	☐ Limited Assistance ☐ Total Dependence	What Assistive Devices are Used?	

Instrumental Activities of Daily Living (IADL)

IADL	Self Performance ***(select one per IADL)***	
Meal Preparation	☐ Independent ☐ Supervision ☐ Extensive Assistance	☐ Limited Assistance ☐ Total Dependence
Homemaking Services - Related to personal care	☐ Independent ☐ Supervision ☐ Extensive Assistance	☐ Limited Assistance ☐ Total Dependence

Recipient's Need for Supervision ***(select all that apply)***

☐ Behavior Problem	☐ Resists Care	☐ Socially Inappropriate	☐ Wandering	☐ Physically Abusive	☐ Verbally Abusive	☐ Safety Risk

Recipient Name: Date of Request:

Pediatric Specialty Care Services Screening Request

Nursing Service Information (Only fill out for individuals below 21 years of age)

The recipient's condition requires 24-hour access to care from a registered nurse **and** there is documentation to support that the recipient has at least one of the following:

◯ Yes ◯ No

☐ A tracheostomy requiring mechanical ventilation a minimum of 6 hours per day, or the recipient is on a ventilator weaning program (time limited)

☐ Dependence on Total Parenteral Nutrition (TPN) or other intravenous (IV) nutritional support and at least one treatment procedure listed in the next section

☐ A tracheostomy requiring suctioning, mist or oxygen and at least one treatment procedure listed in the next section

☐ Administration of at least two treatment procedures listed in the next section

TREATMENT PROCEDURES *(check all that apply)*

☐ Central or peripherally inserted central catheter (PICC) line management

☐ Complex wound care (including stage III or IV decubitus wound or recent surgical or other recent wound) requiring extensive dressing or packing (time limited)

☐ Daily respiratory care (60 minutes or more per day or continuous oxygen and saturation monitoring or percussion therapy)

☐ Intermittent suctioning at least every eight hours and mist or oxygen as needed

Is there an IV therapy:

◯ Yes ◯ No

Select one that applies:

◯ Administration of continuous therapeutic agents ◯ Hydration ◯ Intermittent IV drug administration of more than one agent

☐ Maximum assist required (quadriplegia or Hoyer lift)

☐ Peritoneal dialysis treatments requiring at least 4 exchanges every 24 hours

☐ Seizure Precautions

☐ Tube utilization (nasogastric or gastrostomy); foley, intermittent catheterization, PEG, rectal tube

☐ Moderate behavior issues (including self-abuse) - Describe the problem behavior, frequency and severity:

☐ Other special treatment(s) not listed above - Describe in detail:

DISCHARGE POTENTIAL

Describe the recipient's potential for discharge from the pediatric unit to a lower level of care or home:

JUSTIFICATION

Enter additional comments to support medical necessity of Pediatric Specialty Care Services (attach supporting documentation):

Screener Certification

Supplier Of Information

Applicant Family
Member Friend
Medical Record
Doctor
Nurse
Case Manager
Social Worker
Other

By checking the box below, I certify that I have completed the above screening of the applicant to the best of my knowledge. I also certify that the individual being screened or their appropriate family member or guardian has been informed that Nursing Facility placement is being considered.

I understand falsification as: an individual who certifies a material and false statement in this screening will be subject to investigation for Medicaid fraud and will be referred to the appropriate state agency for investigation. This screening is NOT physician's orders. There is no physician's signature on the form.

☐ Screener Certification