Georgia Department of Human Services

COMMUNITY CARE SERVICES PROGRAM LEVEL OF CARE AND PLACEMENT INSTRUMENT

Section I - A. Identifying Information	2. Patient's Name (Last, First, Middle Initial):
1. **CCSP ASSESSMENT TEAM NAME ADDRESS**	3. Home Address:
	4. Telephone Number; 5. County: 6. PSA:

7. Medicaid Number	8. Social Security Number				9. Mother's Maiden Name:		
	10. Sex	11. Age	12 Birthday	13. Race	14. Marital Status	15. Type of Recommendation 1. ☐ Initial 2. ☐ Reassessment	16. Referral Source

This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance and the Department of Human Resources with necessary information including medical data.

17. Signed _____ 18. Date_____

(Patient, Spouse, Parent or other Relative or Legal Representative)

B. Physician's Examination Report, Recommendation, and Nursing Care Needed	1. ICD	2. ICD	3. ICD
19. Diagnosis on Admission to Community Care (Hospital Transfer Record May Be Attached) 1. Primary _____ 2. Secondary _____ 3. Other _____ 20. Is Patient free of communicable disease? 1 ☐ Yes 2 ☐ No			

Medications (including OTC)				Diagnostic and Treatment Procedures
21. Name	Dosage	Route	Frequency	22 Type Frequency

23. **COMMUNITY CARE SERVICES ORDERED** :

24. **Diet**	25. **Hours Out of Bed Per Day**	26. **Overall Cond**	27 **Restorative Potential**	28. **Mental and Behavioral Status**		
☐ Regular	☐ Intake ☐ IV	☐ Improving	☐ Good	☐ Agitated	☐ Noisy	☐ Dependent
☐ Diabetic	☐ Output ☐ Bedfast	☐ Stable	☐ Fair	☐Confused	☐ Nonresponsive	☐ Independent
☐ Formula	☐ Catheter Care	☐ Fluctuating	☐ Poor	☐ Cooperative	☐ Vacillating	☐ Anxious
☐ Low Sodium	☐ Colostomy Care	☐	☐ Questionable	☐ Depressed	☐ Violent	☐ Well Adjusted
☐ Tube Feeding	☐ Sterile Dressings	☐ Critical	☐ None	☐ Forgetful	☐ Wanders	☐ Disoriented
☐ Other	☐ Suctioning	☐ Terminal		☐ Alert	☐ Withdrawn	☐ Inappropriate
				Reaction		

29. **Decubiti**	30, **Bowel**	31. **Bladder**	32. **Indicate Frequency** Per Week: **Physical Therapy**	**Occupational Therapy**	**Remotive Therapy**	**Reality Orientation**	**Speech Therapy**	**Bowel Bladder Retrain**	**Activities Program**
☐ Yes	☐ Continent	☐ Continent							
☐ No	☐ Occas, Incontinent	☐ Occas Incontinent							
☐ Infected	☐ Incontinent	☐ Incontinent							
☐ On Admission	☐ Colostomy	☐ Catheter							
☐ Surgery Date									

33 **Record Appropriate**

Legend
1. Severe
2. Moderate
3. Mild
4. None

IMPPAIRMENT

Sight	Hear	Speech	Ltd Motion	Para-lysis
☐	☐	☐	☐	☐

ACTIVITIES OF DAILY LIVING

1. Dependent
2. Needs Asst,
3 Independent
4. Not App

Eats	Wheel-Chair	Trans-fers	Bath	Ambu-lation	Dressing
☐	☐	☐	☐	☐	☐

34.. This patient's condition ☐ could ☐ could not be managed by provision of ☐ Community Care or ☐ Home Health Services.

35. I certify that this patient ☐ requires ☐ does not require the intermediate level of care provided by a nursing facility.

36. I certify that the attached plan of care addresses the client's needs for Community Care.

37. Physician's Signature _____

38. Physician's Name (Print)

39. Physician's Address (Print)

40. Date Signed By Physician	41. Physician's Licensure No.	42. Physician's Phone No.

ASSESSMENT TEAM USE ONLY

43. Nursing Facility Level of Care ☐ Yes ☐ No 44. L.O.S. Certified Through Date

45. Signed by person certifying LOC: Title Date Signe

Instructions
Community Care Services Program

LEVEL OF CARE

Purpose: The Level of Care (LOC) page summarizes the client's physical, mental, social, and environmental status to help determine the client's appropriateness for the Community Care Services Program (CCSP) or other services. In addition, the LOC page represents the physician's order for all waivered services provided by CCSP.

Who Completes Form: Initial assessments are completed by the RN care coordinator. Subsequent reassessments are completed by the RN or LPN. However, the LOC is always certified by the RN care coordinator. The client's physician, nurse practitioner or physician assistant participates in all assessments and reassessments by completing designated sections of the LOC page and signing the form.

When the Form is Completed:
The RN care coordinator completes the LOC page at initial assessments and reassessments.

Instructions:

SECTION I A. IDENTIFYING INFORMATION
Client Information in Section I is completed from information obtained from referral source or individual (patient) being referred.

1. Enter complete name, address & telephone number, including area code, of care coordination team.

2. Enter client's last name, first name, and middle initial, in that order, exactly as it appears on the Medicaid, Medicare, or social security card.

3. Enter home address of client, including street number, name of street, apartment number (if applicable), or rural route and box number, town, state and zip code.

4. Enter client's area code and telephone number.

5. Enter client's county of residence.

6. Enter planning and service area (PSA) number where client resides.

7. Enter client's Medicaid number exactly as it appears on the Medicaid card.

NOTE: Potential Medical Assistance Only (PMAO) applicants do not have a current Medicaid number. For PMAO applicants, please leave this item blank.

8. Enter client's nine-digit social security number.

9. Enter client's mother's maiden name.

10, 11, 12. Enter client's sex ("M" or "F"), age, and date of birth (month/day/year).

13. Enter client's race as follows:
A = Asian/Pacific Islander H = Hispanic W = White
B = Black NA = Native American

14. Enter client's marital status as follows:
S = Single M = Married W = Widowed
D = Divorced SP = Separated

15. Check (✓) appropriate type of recommendation:
1. Initial: First referral to CCSP or re-entry into CCSP after termination
2. Reassessment: Clients requiring annual recertification or reassessment because of change in status.

16. Enter referral source by name and title (if applicable), or agency and type as follows:
MD = Doctor S = Self HHA = Home health agency
NF = Nursing facility FM = Family PCH = Personal Care Home
HOSP = Hospital ADH = Adult Day Health APS= Adult Protective Services
O = Other (Identify fully) DFCS = Division of Family & Children Services

17, 18. Client signs and dates in spaces provided. If client is unable to sign, spouse, parent, other relative, or legal/authorized representative may sign and note relationship to client after signature.

NOTE: This signature gives client's physician permission to release information to care coordinator regarding level of care determination.

SECTION I B. PHYSICIAN'S EXAMINATION REPORT AND DOCUMENTATION
Section B is completed and signed by licensed medical person completing medical report.

19. The licensed physician/nurse practitioner/physician assistant enters client's primary, secondary, and other (if applicable) diagnoses. CCRN may pre fill Line 19 based on client self report when physical impairments and/or medication(s) indications support the self reported diagnosis. In situations where the CCRN completes the primary diagnosis; a cover letter to the physician which clarifies the nurses completion of Line 19 must

accompany the assessment documents.

* The primary diagnosis should support CCSP eligibility.

NOTE: After the physician/ nurse practitioner returns signed LOC page, care coordination team indicates ICD codes. Enter ICD codes for "primary diagnosis", "secondary diagnosis" or "third diagnosis" in the appropriate box. Care coordination teams secure codes from ICD code book, local hospitals or client's physician.

20. The physician/nurse practitioner (RNP)/physician assistant (PA) checks appropriate box to indicate if client is free of communicable diseases.

21. List all medications, including over-the-counter (OTC) medications and state dosage, how the medications are dispensed, frequency, and reason for medication. Attach additional sheets if necessary and reference.

22. List all diagnostic and treatment procedures the client is receiving.

23. List all waivered services ordered by care coordination team.

    NOTE: Waivered services ordered by care coordination and approved by the physician/ nurse practitioner/physician assistant are considered physician's orders for CCSP waivered services.

24. Enter appropriate diet for client. If "other" is checked (√), please specify type. Completion of this item is important as this information may serve as the service order for home delivered meals. (Nutrition Screening Initiative (NSI), Appendix 100, is to be completed in conjunction with the LOC page, MDS-HC and CCP.)

25. Enter number of hours out of bed per day if client is not bedfast. Check (√) intake if client can take fluids orally. Check (√) output if client's bladder function is normal without catheter. Check (√) all appropriate boxes.

26. Check (√) appropriate box to indicate client's overall condition.

27. Check (√) appropriate box to indicate client's restorative potential.

28. Check (√) *all* appropriate boxes to indicate client's mental and behavioral status. Document on additional sheet any behavior that indicates need for a psychological or psychiatric evaluation.

29. Check (√) appropriate box to indicate if client has decubiti. If "Yes" is checked and surgery did occur, indicate date of surgery.

30. Check (√) appropriate box.

31. Check (√) appropriate box.

32. If applicable, enter number of treatment or therapy sessions per week that client receives or needs.

33. Enter appropriate numbers in boxes provided to indicate level of impairment or assistance needed.

    NOTE: Information on the MDS-HC must match the LOC form.

34. Care coordination team or the admitting/attending physician/nurse practitioner/physician assistant indicates whether client's condition could or could not be managed by provision of Community Care or Home Health Services by checking (√) appropriate box.

NOTE: If physician/nurse practitioner/physician assistant indicates that client's condition cannot be managed by provision of Community Care and/or Home Health Services, the physician may complete and sign a DMA-6

35. Care coordination team or the admitting/attending physician/nurse practitioner/physician assistant certifies that client requires level of care provided by an intermediate care facility.

36. Admitting/attending physician (RNP or PA) certifies that CCP, plan of care addresses patient's needs for Community Care. If client's needs cannot be addressed in CCSP and nursing facility placement is recommended, the physician may complete and sign a DMA-6.

37. This space is provided for signature of admitting/attending physician/ nurse practitioner/ physician assistant indicating his certification that client needs can or cannot be met in a community setting. **Only a licensed physician (MD or DO), nurse practitioner or physician assistant may sign the LOC page.**

    NOTE: MD, DO, RNP or PA signs within 60 days of care coordinator's completion of form. Physician/nurse practitioner's signature must be original. Signature stamps are not acceptable. Electronic signatures are acceptable when Medicaid criteria for electronic signatures is met. See Policies and Procedures for Medicaid/PeachCare for Kids Part I – Definitions and Part I/Section 106 (R). UR will recover payments made to the provider if there is no physician/RNP/PA signature. "Faxed" copies of LOC page are acceptable.

38, 39, 40, 41, 42. Enter admitting/attending physician's name, address, date of signature, licensure number, and telephone number, including area code, in spaces provided. If nurse practitioner or physician assistant is completing the document, he or she will provide information relative to his/her license and contact information. LOC cover letter will reference instructions for RNP and PA.

NOTE: The date the physician signs the form is the service order for CCSP services to begin. UR will recover money from the provider if date is not recorded.

43, 44, 45. REGISTERED NURSE (RN) USE ONLY

43. The registered nurse checks (√) the appropriate box regarding Nursing Facility Level of Care (LOC). When RN denies a level of care, the nurse signs the form after the "No" item in this space. The RN does not use the customized "Approved" or "Denied" stamp.

44. LOS - Indicate time frame for certification, i.e., 3, 6, 12 months. LOS cannot exceed 12 months. Certified Through Date - Enter the last day of the month in which the length of stay (LOS) expires.

45. Licensed person certifying level of care signs in this space and indicates title (R.N.) and date of signature.

NOTE: Date of signature must be within 60 days of date care coordinator completed assessment as indicated in Number 18. Length of stay is calculated from date shown in Number 44. The RN completes a recertification of a level of care prior to expiration of length of stay.

Distribution: The original is filed in the case record. Attach a copy with the CCC to DFCS at initial assessment and reassessment. Include a copy with the provider referral packet.