

# APPENDICES

F – J

**APPENDIX F  
DENTAL PROCEDURES WHICH ARE THE RESPONSIBILITY OF THE  
HEALTH PLAN**

HCPCS or CDT-5 Procedure Code*	Description
D/07340	Vestibuloplasty-ridge extension
D/07350	Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
	<b>Excision of Tumors</b>
D/07440	Excision of malignant tumor – lesion diameter up to 1.25 cm
D/07441	Excision of malignant tumor – lesion diameter over 1.25 cm
	<b>Removal of Cysts and Neoplasms</b>
D/07450	Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25 cm
D/07451	Removal of benign odontogenic cyst or tumor lesion diameter over 1.25 cm
D/07460	Removal of benign non-odontogenic cyst or tumor lesion diameter up to 1.25 cm
D/07461	Removal of benign non-odontogenic cyst or tumor lesion diameter over 1.25 cm
D/07465	Destruction of lesions by physical methods; electrosurgery, chemotherapy, cryotherapy or laser
	<b>Excision of Bone Tissue</b>
D/07471	Removal of lateral exostosis – mandible or maxilla
D/07472	Removal of torus palatinus
D/07473	Removal of torus mandibularis
D/07490	Radical resection of mandible or maxilla
	<b>Surgical Incision</b>
D/07511	Incision and drainage of abscess-intra oral soft-tissue-complicated
D/07520	Incision and drainage of abscess-extraoral soft tissue
D/07530	Removal of foreign body, skin, or subcutaneous areolar tissue
D/07540	Removal of reaction-producing foreign bodies, musculoskeletal system
D/07550	Sequestrectomy for osteomyelitis
D/07560	Maxillary sinusotomy for removal of tooth fragment or foreign body
	<b>Treatment of Fractures – Simple</b>
D/07610	Maxilla – open reduction (teeth immobilized if present)
D/07620	Maxilla – closed reduction (teeth immobilized if present)
D/07630	Mandible – open reduction (teeth immobilized if present)
D/07640	Mandible closed reduction (teeth immobilized if present)

HCPCS codes will be billed with the “zero” as the first character. CDT-5 codes will be billed with the “D” as the first character.

<b>HCPCS or CDT-5 Procedure Code*</b>	<b>Description</b>
D/07650	Malar and/or zygomatic arch-open reduction
D/07660	Malar and/or zygomatic arch-closed reduction
D/07670	Aveolus – stabilization of teeth, open reduction, splinting
D/07680	Facial bones – complicated reduction with fixation and multiple surgical approaches
	<b>Treatment of fractures – Compound</b>
D/07710	Maxilla – open reduction
D/07720	Maxilla – closed reduction
D/07730	Mandible – open reduction
D/07740	Mandible – closed reduction
D/07750	Malar and/or zygomatic arch-open reduction
D/07760	Malar and/or zygomatic arch-closed reduction
D/07770	Alveolus – complicated reduction with fixation and multiple surgical approaches
D/07780	Facial bones – complicated reduction with fixation and multiple surgical approaches
	<b>Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions</b>
D/07810	Open reduction of dislocation
D/07820	Closed reduction of dislocation
D/07830	Manipulation under anesthesia
D/07840	Condylectomy
D/07850	Surgical disectomy, with/without implant
D/07852	Disc repair
D/07854	Synovectomy
D/07856	Myotomy
D/07858	Joint reconstruction
D/07860	Arthrotomy
D/07870	Arthrocentesis
D/07872	Arthroscopy – diagnosis, with or without biopsy
D/07873	Arthroscopy – surgical: lavage and lysis of adhesions
D/07874	Arthroscopy – surgical: disc repositioning and stabilization
D/07875	Arthroscopy – surgical: synovectomy
D/07876	Arthroscopy – surgical: disectomy
D/07877	Arthroscopy – surgical: dibridement
D/07880	Occlusal – orthotic device, by report
	<b>Other Oral Surgery – Repair of Traumatic Wounds</b>
D/07910	Suture of recent small wounds up to 5 cm
D/07911	Complicated suture up to 5 cm
D/07912	Complicated suture over 5 cm

HCPCS codes will be billed with the “zero” as the first character. CDT-5 codes will be billed with the “D” as the first character.

HCPCS or CDT-5 Procedure Code*	Description
D/07920	Skin grafts (identify defect covered, location and type of graft)
<b>Other Repair Procedures</b>	
D/07940	Osteoplasty for orthognathic deformities
D/07941	Osteotomy – mandibular rami
D/07943	Osteotomy mandibular rami with bone graft; include obtaining the graft
D/07944	Osteotomy, segmented or subapical, per sextant or quadrant
D/07945	Osteotomy, body of mandible
D/07946	Le Fort I (maxilla –total)
D/07947	Le For I (maxilla – segmented)
D/07948	Le Fort II or Le Fort III – (osteoplasty of facial bones for midface hypoplasia retrusion) without bone graft)
D/07949	Le Fort II or Le Fort III – with bone graft
D/07950	Osseous, osteoperiosteal, periosteal, or cartilage graft of the mandible – autogenous or nonautogenous
D/07955	Repair of maxillofacial soft and hard tissue defects
D/07980	Sialolithotomy
D/07981	Excision of salivary gland, by report
D/07982	Closure of salivary fistula
D/07990	Emergency tracheotomy
D/07991	Coronoidectomy
D/07995	Synthetic graft – mandible or facial bones, by report
D/07996	Implant – mandible for augmentation purposes (excluding alveolar ridge), by report
D/07997	Appliance removal (not by dentist who replaced appliance), includes removal of archbar
D/07999	Unspecified oral surgery procedure, by report
<b>Adjunctive General Services</b>	
D/09220	General anesthesia – first 30 minutes (limitation: nitrous oxide for unruly children or highly apprehensive adults; attach report or note)
D/09221	General anesthesia – each additional 15 minutes
D/094220	Hospital calls (limitation: confinement must be approved; only under physician’s request; no routine or follow-up visits)

HCPS codes will be billed with the “zero” as the first character. CDT-5 codes will be billed with the “D” as the first character.

**QExA Service Coordinator Responsibilities and Ratios**

	<b>Non-Nursing Facility Level of Care</b>	<b>Nursing Facility Level of Care - Community</b>	<b>Nursing Facility Level of Care -- Institutional Setting</b>	<b>Self-Direction</b>	<b>Optional Delegate to Provider (i.e., NF, CCMA, or hospital)</b>
Conduct initial health and functional assessment (HFA)	X	X	X	X	
Develop plan based on HFA	X	X	X	X	
Coordinate a team of decision-makers to develop the care plan, including the PCP, other providers as appropriate, the member and others as determined by the member including family members, caregivers and significant others		X	X	X	
Update care plan with input from team of decision-makers	Annually	At a minimum, every 90 days	At a minimum, every 90 days	At a minimum, every 90 days	
Conduct functional level of care assessment using DHS form 1147, at a minimum annually		X	X	X	X

## QExA Service Coordinator Responsibilities and Ratios

	Non-Nursing Facility Level of Care	Nursing Facility Level of Care - Community	Nursing Facility Level of Care - Institutional Setting	Self-Direction	Optional Delegate to Provider (i.e., NF, CCMA, or hospital)
Transfer functional level of care assessment results to State for nursing facility determination		X	X	X	X
Provide options counseling regarding institutional placement and HCB services alternatives		X	X	X	X
Assist members in transitioning to and from nursing facilities/residential facilities		X	X	X	
Coordinate services with other providers such as Medicare fee-for-service and MCO providers, Zero-To-Three, Healthy Start, mental health providers at DOH, and DD/MR providers	X	X	X	X	

**QExA Service Coordinator Responsibilities and Ratios**

	<b>Non-Nursing Facility Level of Care</b>	<b>Nursing Facility Level of Care - Community</b>	<b>Nursing Facility Level of Care – Institutional Setting</b>	<b>Self-Direction</b>	<b>Optional Delegate to Provider (i.e., NF, CCMA, or hospital)</b>
Utilize compiled data received from client encounters to assure the services being provided meet client needs		X		X	
Facilitate access to services		X		X	
Seek to resolve any concerns about care delivery or providers	X	X	X	X	
Annual Face-to-Face HFA Reassessment (including an assessment as to the need for a nursing facility evaluation)	X	X	X	X	
Oversight and monitoring of the self-direction delivery process (including assistance in choosing providers, directing providers and provider background checks)				X	

**QExA Service Coordinator Responsibilities and Ratios**

	<b>Non-Nursing Facility Level of Care</b>	<b>Nursing Facility Level of Care - Community</b>	<b>Nursing Facility Level of Care – Institutional Setting</b>	<b>Self-Direction</b>	<b>Optional Delegate to Provider (i.e., NF, CCMA, or hospital)</b>
Oversight and monitoring of the care delivery process		X	X	X	
Referral for SEBD/SMI Evaluation	X	X	X	X	
Referral for preventive and restorative dental care	X	X	X	X	
Referral for termination from self-direction				X	
<b>Service Coordinator Ratios and numbers needed</b>					
	1:750	1:50	1:120	1:40	

## Long Term Care Evaluation Form 1147

### *Submission of Form 1147*

- a. Form 1147 must be completed and submitted to the DHS Consultant or his representative for the following:
  - Admission from residence to a long term care facility,
  - Transfer from an acute hospital to a long term care facility for admission or readmission,
  - Transfer between SNF, ICF and Hospice facilities,
  - Changes in level of care within a facility (includes swing bed),
  - Transfer from a Medicare or other health insurance status at a long term care institution to a Medicaid status, even though Medicaid may have been paying the co-insurance or deductible,
  - Private patients already confined in long term care institutions that apply for medical assistance.
- b. Forms should be submitted prior to admission, transfer or change in status. The use of any other form is not permitted.

### *Action by DHS Consultant or his/her Representative*

- a. This section will be completed by MQD staff or his/her representative when performing medical reviews or an independent professional review.
- b. The Consultant will indicate the determination of level of care and the effective date. Approval, when granted, is for the indicated level of care and medical care. It does not establish eligibility for the Medicaid Program or authorize payment for care. Payment is contingent on the patient being eligible under the Medicaid Program, the services being a benefit of the Program, and the provider of service being Medicaid certified at the time services are rendered.
- c. The DHS Consultant or his representative will sign and date the form. Medical authorization for admission expires thirty (30) days from the date of approval.
- d. Upon completion of the form by the DHS Consultant or his representative, the approved copy will be returned to the sender, or, if the person is in a medical facility, to the long-term care institution, or as requested by an appropriate note on the form.

### *Authorization Period*

Medical authorization for admission expires 30 days from the date of approval. If the 30-day authorization period expires before the patient is admitted or transferred, a new Form 1147 should be submitted to MQD with a copy of the old form. A statement such as "For Updating" should be prominently written on the form to avoid confusion in handling.

### *Payment Requirement*

Approval of the patient's admission or transfer is not an authorization for payment or an approval of charges. All payments by the Medicaid Program are dependent on the following criteria:

- The patient must be eligible under the Medicaid Program at the time services are rendered.
- The provider of the service must be approved for Medicaid participation by DHS to render services to Medicaid recipients.

### *Form Availability*

The Long Term Care Evaluation form 1147 may be obtained from the Medicaid Fiscal Agent.

## INSTRUCTIONS

### DHS FORM 1147

#### SUBACUTE/LONG TERM CARE/HOSPICE LEVEL OF CARE EVALUATION

##### PAGE 1 - APPLICANT INFORMATION

1. **NAME:** *Self-explanatory*
2. **BIRTHDATE:** *Self-explanatory*
3. **AGE:** *Self-explanatory*
4. **SEX:** *Self-explanatory*
5. **MEDICARE STATUS:**  
Answer questions specific to coverage by Medicare. Check Yes or No for Part A coverage. Check Yes or No for Part B Coverage. Enter the Medicare I.D. Number, if the patient is has Part A and B coverage, only Part A, or only Part B.
6. **MEDICAID STATUS:**  
If the person is eligible for Medicaid, check Yes and enter his/her Medicaid I.D. Number. If the patient has applied for Medicaid but has not yet been deemed eligible, check No and enter date applied. **DO NOT COMPLETE THE 1147 FORM UNLESS THE PATIENT HAS APPLIED FOR MEDICAID.** When the person becomes eligible for Medicaid and has a valid number, a 1147a must be generated and approved by Mountain Pacific in order for that facility to be paid.
7. **PRESENT ADDRESS:**  
If Facility, provide name of the facility; if Residence, provide street address, city, and zip code. Check appropriate box, which describes the address given.
8. **ATTENDING PHYSICIAN:**  
Print name of the attending physician and give his/her phone and fax numbers. The attending physician can be the hospital-based physician responsible for the person's inpatient acute care, the nursing facility medical director, or the patient's primary care physician or physician specialist.
9. **RETURN FORM TO:**  
State how you wish the form sent back to you--by mail or fax--and to whose attention this should be directed. The form may not be mailed or faxed back to you with a cover

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 <b>PROVIDER MANUAL: APPENDIX 4</b>	<b>Pages D1 to D44</b>
<b>AUTHORIZATION FORMS</b>	
<b>Subacute/Long Term Care/Hospice Level of Care Evaluation</b>	<b>Pages D21 to D25</b>
<b>DHS 1147 Instructions</b>	<b>H-3</b>

sheet. Therefore, it is critical that this information is accurate. For reimbursement of the level of care, enter your facility's provider number for level of care on effective date. If a facility wants a level of care determination ONLY and will not bill for the services, it must submit the 1147 without a provider number.

**10. REFERRAL INFORMATION:**

**A. Contact person:** \*

**B. Title:** \*

**C. Phone/Fax:** \*

\*The name of the person (also, title, and phone and fax numbers) who should be contacted if DHS or its designee require additional information or clarification of information submitted on the 1147 form.

**D. Source(s) of Information: Self-explanatory**

**Responsible Person:**

The name, relationship, phone and fax numbers, and language spoken of the family member/personal agent who would make decisions for the patient if he/she were not able to act.

**E. Requesting:**

Check the setting which person or his/her agent requests that long term care (LTC) be provided.

**11. ASSESSMENT INFORMATION:**

**A. Assessment Date:**

The date the assessment was completed.

**B. Assessor's Name, Title, Signature, Phone and Fax Numbers:**

A Registered Nurse (RN) or physician must perform the assessment. The name, title signature, and phone and fax numbers of the assessor should be entered.

**C. HCBS Option Counseling provided:**

Enter Yes or No as to whether or not the person was given information about home and community based programs and counseling about how his/her needs could be met in the home and community setting. Provide an explanation if the person did not receive information and/or counseling. If a person did receive information and



counseling, provide the name, title or relationship of the person who provided the information and counseling.

**12. MEDICAL NECESSITY / LEVEL OF CARE ACTION**

Completed by DHS or Designee. Leave Blank. DO NOT COMPLETE.

**DISPOSITION**

Completed by DHS or Designee. Leave Blank. DO NOT COMPLETE.

**PAGE 2 - APPLICANT/CLIENT BACKGROUND INFORMATION**

1. **NAME:** *Self-explanatory*

2. **BIRTHDATE:** *Self-explanatory*

**3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS:**

**I. LIST SIGNIFICANT CURRENT DIAGNOSIS (ES): Primary and Secondary.**

List the main diagnosis (ses) or medical conditions related to person's need for long term care. List the most important diagnosis first.

**II. COMATOSE:**

If the patient is comatose, enter Yes. Do not complete sections III. To XIII. Go directly to section XIV. If the patient is not comatose, enter No and complete entire page.

**III. to XII.**

Circle the description that best describes the person's functional ability in each section. These sections require an assessment of the patient's activities of daily living. To provide accurate information, the assessor should consult the patient or nursing staff, physicians, caregivers, etc. familiar with the patient. Completion of these sections requires direct knowledge of the patient's functional abilities on the date the assessment is done. Therefore, these sections cannot be completed from medical record review alone.

**XIII. TOTAL POINTS:**

Enter the score by totaling the points circled in sections III. To XII.

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 PROVIDER MANUAL: APPENDIX 4	Pages D1 to D44
AUTHORIZATION FORMS	
Subacute/Long Term Care/Hospice Level of Care Evaluation	Pages D23 to D25
DHS 1147 Instructions	

**XIV. MEDICATIONS/TREATMENTS:**

List the significant medications the patient is currently receiving. These are medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term medications (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than five (5) significant medications, attach orders or treatment sheet.

**XV. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS:**

Provide any additional clinical information, which will clarify his/her functional status and support his/her need for long term care.

**PAGE 3**

1. **NAME:** *Self-explanatory*

2. **BIRTHDATE:** *Self-explanatory*

**XVI. SKILLED PROCEDURES:**

If the services listed are provided daily, state the number of times they are performed. Check if they are provided less than daily or never provided. Provide explanation, details when requested.

**XVII. SOCIAL SITUATION:**

**A. Caregiving support system is willing to provide/continue to provide care with assistance:**

Answer Yes or No and then state the help the caregiver needs in order for him/her to continue in the role of caregiver.

**B. Name, Relationship, Address, Phone and Fax Numbers of Caregiver: (Self-explanatory)**

**C. Person currently has a home and can return home:**

Answer Yes or No. If No, answer if, based on his/her clinical status, residential setting is or is not appropriate for the patient.

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 PROVIDER MANUAL: APPENDIX 4 AUTHORIZATION FORMS	Pages D1 to D44
Subacute/Long Term Care/Hospice Level of Care Evaluation DHS 1147 Instructions	Pages D24 to D25

**D. Patient is appropriate for:**

Check all the residential settings in which the patient's needs can be appropriately met.

**XVIII. RECOMMENDATIONS / DISCHARGE PLANS:**

**A. Requested LOC:**

Enter the LOC the assessor feels most appropriate for the patient and is requesting.

**B. Requested Effective Date of Medicaid Coverage:**

This is the date being requested as the start of the Medicaid long-term care benefit. For a patient dually eligible for Medicare and Medicaid, enter the date that Medicare coverage will terminate—assuming that the patient has a continuing need for long term care after the Medicare benefit ends.

**C. Effective Date of LOC:**

This is the date the patient was deemed appropriate for a long term care (LTC) LOC. It does NOT have to be the assessment date provided on Page 1 as the assessment might have been completed while the person was at the acute LOC or after a person who has been at a LTC LOC with Medicare or other health insurance coverage becomes eligible for Medicaid. However, if no date is entered, the assessment date is considered to be the effective date.

**D. Hospice Elected: Self-explanatory**

**E. Appropriate for HCBS: Self-explanatory**

**XIX. PHYSICIAN'S SIGNATURE:**

A physician who has either prepared or reviewed the 1147 should sign and enter the date of signature. The physician's name should be printed.

**Comments:**

Comments by the signing physician, or assessor can be entered here. Additional information which would clarify the requested LOC, explain any discrepancies with effective date of LOC, assessment date, and effective date of Medicaid coverage, contribute to a clearer understanding of the patient's medical or social condition, etc. can be entered.

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 PROVIDER MANUAL: APPENDIX 4	Pages D1 to D44
AUTHORIZATION FORMS	
Subacute/Long Term Care/Hospice Level of Care Evaluation	Pages D25 to D25
DHS 1147 Instructions	

Department of Human Services  
 Med-QUEST Division  
 Medical Standards Branch

**STATE OF HAWAII**  
**Level of Care (LOC) Reevaluation**  
**LT**

Mountain Pacific Quality Health Foundation  
 1360 Beretania St., Ste. 500  
 Honolulu, Hawaii 96814

(Please Type)

1. Patient Name (Last, First, M.I.)	2. Medicaid ID Number	3. Date of Birth Month/Day/Year	4. Sex <input type="checkbox"/> F <input type="checkbox"/> M	5. Admission Date Month/Day/Year
6. Present address/facility (Specify facility name when applicable)			7. Medicaid Provider I.D. Number	
8. Attending Physician (PRINT Last, First, M.I.)		9. Contact Person (Last, First AND Title) Phone Number		
10. Return form to: _____		Via Fax: _____		
Attention _____ Phone _____		Via Mail: _____		

Reason(s) – Check all that apply

Admission/Readmission after acute hospitalization to NF – Name: \_\_\_\_\_ Date: \_\_\_\_\_

Admission/Readmission after acute hospitalization to home and community-based program. Date: \_\_\_\_\_

Nursing Home Without Walls (NHWW)  HIV Community Care Program (HCCP)

PACE Program  Other – Name: \_\_\_\_\_

Residential Alternatives Community Care Program (RACCP) (Case Management Agency)

Transfer from NF to NF – Name: \_\_\_\_\_ Date: \_\_\_\_\_

Changes in LOC.

Annual LOC Determination for home and community-based program.

DHS required evaluation (example: Annual LOC Determination for Nursing Facility ICF LOC).

Extension of Acute Waitlisted NF status (date of initial determination) \_\_\_\_\_ Period requested From (mmddyy): \_\_\_\_\_ To (mmddyy): \_\_\_\_\_

At home, waitlisted for NF bed.

At home, waitlisted for home and community-based program.

In Nursing Facility, Requesting Home or Home & Community-Based Program.

Home & Community-Based Program placement not found/not suitable, requesting Nursing Facility.

Approved LOC on most current form – Date: _____	LOC BEING REQUESTED – Effective Date: _____
<input type="checkbox"/> Subacute Level I <input type="checkbox"/> SNF <input type="checkbox"/> ICF	<input type="checkbox"/> Subacute Level I <input type="checkbox"/> SNF <input type="checkbox"/> ICF
<input type="checkbox"/> Subacute Level II <input type="checkbox"/> Acute Waitlisted ICF <input type="checkbox"/> Acute Waitlisted Subacute	<input type="checkbox"/> Subacute Level II <input type="checkbox"/> Acute Waitlisted ICF <input type="checkbox"/> Acute Waitlisted Subacute
<input type="checkbox"/> Acute Waitlisted SNF <input type="checkbox"/> Hospice	<input type="checkbox"/> Acute Waitlisted SNF <input type="checkbox"/> Hospice

Current Status – Check all that apply

No change in diagnoses – Specify primary diagnoses: \_\_\_\_\_

Additional diagnoses – List: \_\_\_\_\_

Functional capabilities  No change  Change(s) – Specify: \_\_\_\_\_

Nursing needs  No change  Change(s) – Specify: \_\_\_\_\_

Change in LOC  No change  Change(s) – Specify: \_\_\_\_\_

Document need for continuing LTC services at level of care being requested: \_\_\_\_\_

Anticipated time needed at LOC being Requested – Dates From: \_\_\_\_\_ To: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's name (PRINT): \_\_\_\_\_

**To Be Completed By State of Hawaii – DHS/DHS Designee Only**

Approved for:  Subacute Length of approval:  1 year

Level 1  Level 2 *Approved LOC effective date*

SNF  6 months

ICF *Approved LOC effective date*

Hospice  Other – Specify: \_\_\_\_\_

Acute Waitlisted ICF (approved dates) \_\_\_\_\_ to \_\_\_\_\_

Acute Waitlisted SNF (approved dates) \_\_\_\_\_ to \_\_\_\_\_

Acute Waitlisted Subacute (approved dates) \_\_\_\_\_ to \_\_\_\_\_

Deferred:  New 1147 needed.

DHS Reviewer's/Designee's Signature: \_\_\_\_\_ **H-8** Date: \_\_\_\_\_

**SUBACUTE/LONG TERM CARE/HOSPICE LEVEL OF CARE EVALUATION**

**APPLICANT INFORMATION:** (Please print or Type)

1. NAME (Last, First, MI)	2. BIRTHDATE MONTH/DAY/YEAR	3. AGE	4. SEX	5. MEDICARE STATUS Part A      Part B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO ID #	6. MEDICAID STATUS <input type="checkbox"/> YES ID# _____ <input type="checkbox"/> NO Date Applied _____
7. PRESENT ADDRESS (Specify Facility Name When Applicable) _____ _____ Present Address is <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> Waitlisted <input type="checkbox"/> Care Home <input type="checkbox"/> Other _____				8. ATTENDING PHYSICIAN _____ Print Last, First, MI Phone: _____ Fax: _____	
9. RETURN FORM TO: <input type="checkbox"/> VIA FAX (Print Fax Number Below) <input type="checkbox"/> BY MAIL (Print Address Below) _____ Attention _____ Phone _____ Provider Medicaid ID # _____ (Enter provider # for level of care on effective date.)					
10. REFERRAL INFORMATION (To Be Completed by Referring Party)			11. (To Be Completed by RN or Physician)		
A. CONTACT PERSON _____ B. TITLE _____ C. PHONE _____ FAX _____ D. SOURCE(S) OF INFORMATION <input type="checkbox"/> CLIENT <input type="checkbox"/> RECORDS <input type="checkbox"/> OTHER _____ <input type="checkbox"/> RESPONSIBLE PERSON  Name _____ Last, First, MI  Relationship _____  PHONE _____ FAX _____  Language <input type="checkbox"/> English <input type="checkbox"/> Other _____  E. Requesting <input type="checkbox"/> Nursing Facility (NF) <input type="checkbox"/> Acute Waitlisted <input type="checkbox"/> PACE Program <input type="checkbox"/> Hospice <input type="checkbox"/> Home & Community Based Services (HCBS) <input type="checkbox"/> NHWW <input type="checkbox"/> RACCP <input type="checkbox"/> HCCP			A. ASSESSMENT DATE ____/____/____ B. ASSESSOR'S NAME _____ Last, First, MI  TITLE _____  SIGNATURE _____  PHONE _____ FAX _____  C. HCBS Option Counseling provided <input type="checkbox"/> Yes <input type="checkbox"/> No  If NO explain _____  If YES, by whom (Name) _____  Title/Relationship _____		
<b>TO BE COMPLETED BY STATE OF HAWAII MEDICAL CONSULTANT OR DESIGNEE ONLY</b>					
<b>12. MEDICAL NECESSITY/LEVEL OF CARE ACTION</b>					
I. <input type="checkbox"/> LOC APPROVED                                      EFFECTIVE DATE _____ <input type="checkbox"/> SUBACUTE <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> HOSPICE <input type="checkbox"/> ACUTE WAITLISTED SNF from _____ to _____ <input type="checkbox"/> ACUTE WAITLISTED ICF from _____ to _____ <input type="checkbox"/> ACUTE WAITLISTED SUB-ACUTE from _____ to _____ Next Review in <input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> Annual (specify mm/yy) _____ <input type="checkbox"/> Other _____ NEXT 1147/1147a due on (date) _____					
II. <input type="checkbox"/> DEFERRED III. <input type="checkbox"/> DENIED Comments _____					
NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE. THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.  DHS REVIEWER'S/DESIGNEE'S SIGNATURE _____ DATE _____					
<b>13. DISPOSITION</b>					
<input type="checkbox"/> Home and Community-Based Services <input type="checkbox"/> Nursing Home Without Walls (NHWW) <input type="checkbox"/> Residential Alternatives Community Care Program (RACCP) <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> HIV Community Care Program (HCCP) <input type="checkbox"/> PACE Program  <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Hospice <input type="checkbox"/> Own Home <input type="checkbox"/> Extended Care ARCH <input type="checkbox"/> Other _____  Comments _____					
Signature _____ Date _____					

**APPLICANT/CLIENT BACKGROUND INFORMATION (Please print or Type)**

<b>1. NAME (PRINT Last, First, MI)</b>	<b>2. BIRTHDATE</b>																								
<b>3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS</b>																									
<b>I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):</b>	<b>VIII. MOBILITY/AMBULATION (check a maximum of 2 for a through d)</b>																								
PRIMARY: _____ _____	[0] a. Independently mobile with or without device. [1] b. Ambulates with or without device but unsteady/subject to falls. [2] c. Able to walk/be mobile with minimal assistance. [3] d. Able to walk/be mobile with one assist. [4] e. Able to walk/be mobile with more than one assist. [5] f. Unable to walk.																								
SECONDARY: _____ _____	<b>IX. BOWEL FUNCTION/CONTINENCE</b>																								
<b>II. COMATOSE</b> <input type="checkbox"/> No <input type="checkbox"/> Yes if "Yes," go to XIV.	[0] a. Continent. [1] b. Continent with cues. [2] c. Incontinent (at least once daily). [3] d. Incontinent (more than once daily, # of times _____).																								
<b>III. VISION/HEARING/SPEECH</b>	<b>X. BLADDER FUNCTION/CONTINENCE</b>																								
[0] a. Individual has normal or minimal impairment (with/without corrective device) of: <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech [1] b. Individual has impairment (with/without corrective device) of: <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech [2] c. Individual has complete absence of: <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech	[0] a. Continent. [1] b. Continent with cues. [2] c. Incontinent (at least once daily). [3] d. Incontinent (more than once daily, # of times _____).																								
<b>IV. COMMUNICATION</b>	<b>XI. BATHING</b>																								
[0] a. Adequately communicates needs/wants. [1] b. Has difficulty communicating needs/wants. [2] c. Unable to communicate needs/wants.	[0] a. Independent bathing. [1] b. Unable to safely bathe without minimal assistance and supervision. [3] c. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).																								
<b>V. MENTAL BEHAVIOR (circle all that apply)</b>	<b>XII. DRESSING AND PERSONAL GROOMING</b>																								
[0] a. Oriented (mentally alert and aware of surroundings). [1] c. Disoriented (partially or intermittently; requires supervision). [2] d. Disoriented and/or disruptive. [3] f. Aggressive and/or abusive. [4] g. Wanders at <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Both, or in danger of self-inflicted harm or self-neglect.	[0] a. Appropriate and independent dressing, undressing and grooming. [1] b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes.) [2] c. Physical assistance needed on a regular basis. [3] d. Requires total help in dressing, undressing and grooming.																								
<b>VI. FEEDING/MEAL PREPARATION</b>	<b>XIII. TOTAL POINTS</b>																								
[0] a. Independent with or without an assistive device. [1] b. Feeds self but needs help with meal preparation. [2] c. Needs supervision or assistance with feeding. [4] d. Is spoon/syringe/tub fed, does not participate.	Total Points Indicated _____																								
<b>VII. TRANSFERRING</b>	<b>XIV. MEDICATIONS/TREATMENTS</b>																								
[0] a. Independent with or without a device. [2] b. Transfers with minimal/stand-by help of another person. [3] c. Transfers with supervision and physical assistance of another person. [4] d. Does not assist in transfer or is bedfast.	<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;"></th> <th style="width:10%; text-align: center;">Requires Supervision</th> <th style="width:20%; text-align: center;">PRNs Only Actual</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">(List all Significant Medications, Dosage, Frequency and mode/ Freq. Attach Treatment sheet if more space is needed.)</td> <td></td> <td></td> </tr> <tr> <td style="padding: 2px;"></td> <td style="text-align: center;">and/or monitoring</td> <td></td> </tr> <tr> <td style="padding: 2px;">_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 2px;">_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 2px;">_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 2px;">_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 2px;">_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		Requires Supervision	PRNs Only Actual	(List all Significant Medications, Dosage, Frequency and mode/ Freq. Attach Treatment sheet if more space is needed.)				and/or monitoring		_____	<input type="checkbox"/>	_____												
	Requires Supervision	PRNs Only Actual																							
(List all Significant Medications, Dosage, Frequency and mode/ Freq. Attach Treatment sheet if more space is needed.)																									
	and/or monitoring																								
_____	<input type="checkbox"/>	_____																							
_____	<input type="checkbox"/>	_____																							
_____	<input type="checkbox"/>	_____																							
_____	<input type="checkbox"/>	_____																							
_____	<input type="checkbox"/>	_____																							
<b>XV. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS</b>																									
_____ _____ _____ _____ _____																									

1. NAME (PRINT Last, First, MI)		2. BIRTHDATE	
<b>XVI. SKILLED PROCEDURES</b> D=Indicate number of times per day    (Check L or N if appropriate)    L=Less than once per day    N=Not applicable/Never			
D(#)	L	N	PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:
_____	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy care/suctioning in ventilator dependent person.
_____	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy care/suctioning in non-ventilator dependent person.
_____	<input type="checkbox"/>	<input type="checkbox"/>	Nasopharyngeal suctioning in persons with no tracheostomy.
_____	<input type="checkbox"/>	<input type="checkbox"/>	Total Parenteral Nutrition (TPN) Specify number of hours per day. _____
_____	<input type="checkbox"/>	<input type="checkbox"/>	Maintenance of peripheral/central IV lines.
_____	<input type="checkbox"/>	<input type="checkbox"/>	IV Therapy – Specify agent & frequency. _____
_____	<input type="checkbox"/>	<input type="checkbox"/>	Decubitus ulcers – Stage III and above.
_____	<input type="checkbox"/>	<input type="checkbox"/>	Decubitus ulcers – Less than Stage III; Wound care – Specify nature of ulcer/wound and care prescribed.
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	Instillation of medications via indwelling urinary catheters – Specify agent.
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	Intermittent urinary catheterization.
_____	<input type="checkbox"/>	<input type="checkbox"/>	IM/SQ Medications – Specify agent. _____
_____	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with administration of oral medications – Explain.
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing difficulties and/or choking.
_____	<input type="checkbox"/>	<input type="checkbox"/>	Stable Gastrostomy/Nasogastric/Jejunostomy tub feedings; Enteral Pump? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/>	<input type="checkbox"/>	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration. Specify reason person at risk for aspiration.
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	Initial phase of Oxygen therapy; Oxygen therapy requiring bronchodilators.
_____	<input type="checkbox"/>	<input type="checkbox"/>	Complicating problems of patients on renal dialysis, chemotherapy, radiation therapy, with orthopedic traction. Circle problem(s) and describe.
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral problems related to neurological impairment. Describe.
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	Other – Specify condition and describe nursing intervention.
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Yes		Therapeutic Diet – Describe.
_____			_____
<input type="checkbox"/>	Yes		Restorative Therapy: PT/OT/Speech – Circle therapy and submit/attach evaluation and treatment plan.
_____			_____
<b>XVII. SOCIAL SITUATION</b>			
A. Caregiving support system is willing to provide/continue to provide care with assistance. <input type="checkbox"/> Yes <input type="checkbox"/> No			
State assistance needed by Caregiver _____			
If YES, complete B & C.    If NO, go to D.			
B. Name _____		Relationship _____	
Last, First, MI			
Address _____		Phone _____	
		Fax _____	
C. Person currently has a home and can return home <input type="checkbox"/> Yes <input type="checkbox"/> No    Residential setting can be considered as an alternative to facility. <input type="checkbox"/> Yes <input type="checkbox"/> No			
D. Patient is appropriate for <input type="checkbox"/> Care Home <input type="checkbox"/> Assisted Living <input type="checkbox"/> Hospice Residence			
Check all appropriate site(s) <input type="checkbox"/> Foster Care <input type="checkbox"/> Shelter <input type="checkbox"/> Other _____			
<b>XVIII. RECOMMENDATIONS/DISCHARGE PLANS</b>			
A. Requested LOC _____		D. Hospice Elected <input type="checkbox"/> Yes <input type="checkbox"/> No	
B. Requested Effective Date of Medicaid Coverage. _____		E. Appropriate for HCBS <input type="checkbox"/> Yes <input type="checkbox"/> No	
C. Effective Date of LOC _____			
XIX. PHYSICIAN'S SIGNATURE _____			DATE _____
Physician's Name _____			
Please Print			
Comments _____			
_____			

**INSTRUCTIONS**  
**DHS 1147a**

**LEVEL OF CARE (LOC) REEVALUATION**

**APPLICANT INFORMATION**

1. **Patient Name:** *Self-explanatory*
2. **Medicaid I.D. Number:**  
The Medicaid I.D. Number and check digit should be entered; if the patient has applied for Medicaid but has not yet been deemed eligible please write in "Pending."
3. **Birthdate:** *Self-explanatory*
4. **Sex:** *Self-explanatory*
5. **Admission Date:**  
Date of admission to the current level of care (LOC).
6. **Present Address/Facility:**  
If Facility, provide name of the facility; if Residence, provide street address, city, and zip code.
7. **Medicaid Provider ID:**  
Medicaid Provider I.D. number specific to the LOC (example, if waitlisted in an acute hospital, provide the appropriate waitlisted number)--if unknown, state "waitlisted SNF.")
8. **Attending Physician:** *Self-explanatory*
9. **Contact Person: and Phone Number:**  
The name and phone number of the person able to provide additional information about the patient if needed.
10. **Return Form:**  
State how you wish the form sent back to you--by mail or fax and to whose attention this should be directed. The form will not be mailed or faxed back to you with a cover sheet. Therefore, it is critical that this information is accurate.

**REASON(S):** (Check all that apply) *Self-explanatory; except, as follows:*

***Change in LOC***

Check this if a LOC change is being requested. The blocks “Approved LOC on Most Current Form” and “LOC Being Requested” specify the specific LOC change being requested.

***In Nursing Facility, Requesting Home and Community Based Program***

Do not check this unless the patient needs information on home and community based options. A direct referral to the Home and Community Based Program in which the patient is interested should be done.

**APPROVED LOC ON MOST CURRENT FORM** (date): The LOC approved in Section 12, Page 1 of the most current 1147 form or on the most current 1147a should be checked and the effective date of the LOC should be entered.

**LOC BEING REQUESTED** (effective date). The LOC being requested should be checked and the requested effective date should be entered.

**CURRENT STATUS:** (Check all that apply)

***No change in diagnoses:*** (List diagnoses)

Diagnoses should be taken from the most current 1147 Form (page 2), or on the most current 1147a. The primary diagnosis should be listed first.

***Additional Diagnoses:*** (List diagnoses)

Any new diagnosis (ses) which affect(s) the medical care and NOT listed on the most current 1147/1147a Form should be entered. If more than one, the most important diagnosis should be listed first.

***Changes in Functional Capabilities:*** (Specify)

These refer to increases/decreases/ in ADLs, behavioral, and cognitive functioning.

***Changes in Nursing Needs:*** (Specify)

These refer to increases/decreases in skilled nursing needs

***Changes in LOC:*** (Specify current LOC and explain the change)

These refer to increases/decreases in functional capabilities or skilled nursing needs sufficient to change a person’s LOC.

**DOCUMENT NEED FOR CONTINUING LTC SERVICES:**

This is an assessment of the individual and his/her current status and why LTC services need to be continued. If the answers to “current status” are sufficient to document the need, you may enter “see above.”

**ANTICIPATED TIME NEEDED AT CURRENT LOC:** *Self-explanatory*

**EFFECTIVE DATE:**

This is the effective date of the LOC being requested.

**PHYSICIAN’S SIGNATURE:** *Self-explanatory*

**DATE** is the date the physician signature was obtained.

**PHYSICIAN’S NAME:** *Self-explanatory*

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 PROVIDER MANUAL: APPENDIX R	Pages D1 to D44
AUTHORIZATION FORMS	
Level of Care (LOC) Reevaluation	Pages D29 of D29
DHS 1147a Instructions	

## Hawaii Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exam

PATIENT INFORMATION																																		
Health Plan						Island of Residence						Indicate the EPSDT periodic screening age being reported														Type								
A	H	K	S	M	O	H	K	L	M	O	1	3	2	4	6	9	12	1	1	2	3	4	5	6	8	1	1	1	1	1	2	N	E	
C	Q	Q	U	A	T	I	A	A	A	O	d	d	m	m	m	m	m	m	m	m	y	y	y	y	y	y	y	y	y	y	y	y	W	S
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Today's Date (MMDDYY)						Name (Last, First, Middle Initial)						Medicaid/QUEST ID						Birthdate (MMDDYY)						M	F									
												0 0 0												<input type="checkbox"/>	<input type="checkbox"/>									
HISTORY FOR INFANTS (FIRST YEAR OF LIFE)														List any birth/newborn complications, including abnormal NB Screens, significant illnesses, injuries, surgery, and hospitalizations. (APGAR, Birth Weight are optional after 1 year of age)																				
APGAR	BIRTH WEIGHT - g					Mother's Medicaid/QUEST ID#					#																							
HISTORY FOR CHILDREN OLDER THAN 1 YEAR OF AGE: List below any significant illnesses, injuries, surgery, hospitalization, or applicable family history																																		
MEASUREMENTS																										Allergies		Medications						
Temperature-C or F						Blood Pressure						Height-cm						Weight-kg						BMI	Head Circ.	<input type="checkbox"/>	<input type="checkbox"/>							
						/																				<input type="checkbox"/>	<input type="checkbox"/>							
<b>PHYSICAL EXAMINATION</b> normal except as noted <b>SURVEILLANCE</b> normal except as noted Vision/Hearing/Dental/Oral/ Development and Behavior, Lead & TB Assessment, Health Education, Counseling & Age Appropriate Anticipatory Guidance														List all abnormal findings and/or concerns noted in Measurements, Physical Exam, Surveillance and/or Screening (Also list other screening tools used). Use this space for additional comments on the exam.																				
SCREENING done today														Y		N																		
Snellen/Allen <sup>3y</sup> , 4y, 5y, 6y, 10y, 12y, 14y, 16y, 18y, 20y														<input type="checkbox"/>	<input type="checkbox"/>																			
Audiogram (20-25 db screen) <sup>4y-6y</sup>														<input type="checkbox"/>	<input type="checkbox"/>																			
Blood Lead Level <sup>9m-12m, 2y</sup>														<input type="checkbox"/>	<input type="checkbox"/>																			
Hgb/Hct <sup>9m-12m, Females-12y-14y</sup>														<input type="checkbox"/>	<input type="checkbox"/>																			
PPD <sup>12m, 2-6y, 12-14y</sup>														<input type="checkbox"/>	<input type="checkbox"/>																			
Dev: PEDS/ASQ <sup>9m, 12m, 18m, 2y, 3y, 4y, 5y</sup>														<input type="checkbox"/>	<input type="checkbox"/>																			
Other Dev/Beh - List														<input type="checkbox"/>	<input type="checkbox"/>																			
DIAGNOSIS/STATUS																																		
<input type="checkbox"/>	Well child					<input type="checkbox"/>	Acute Illness					<input type="checkbox"/>	CSHCN					List ICD-9 Codes of CSHCN																
List Acute illness(es):																																		
REFERRALS MADE TODAY														Y - indicate below		N		Print names of specialists to whom referrals were made today																
<input type="checkbox"/>	H-KISS					<input type="checkbox"/>	DDD					<input type="checkbox"/>	Cardiology					<input type="checkbox"/>	Neurology					<input type="checkbox"/>	Ophthalmology									
<input type="checkbox"/>	PHN					<input type="checkbox"/>	Child Welfare					<input type="checkbox"/>	Psychiatry or Psychology					<input type="checkbox"/>	Otolaryngology					<input type="checkbox"/>	Nephrology									
<input type="checkbox"/>	CAMHD					<input type="checkbox"/>	DOE					<input type="checkbox"/>	Orthopedics					<input type="checkbox"/>	Gastroenterology					<input type="checkbox"/>	Urology									
<input type="checkbox"/>	Developmental/Behavioral					<input type="checkbox"/>	Dentistry					<input type="checkbox"/>	Other(s)-list																					
CARE COORDINATION ASSISTANCE NEEDED																																		
<input type="checkbox"/> Arranging transportation														<input type="checkbox"/> Y - indicate below		<input type="checkbox"/> N		List additional information or other assistance needed																
<input type="checkbox"/> Managing medical condition and/or medications																																		
<input type="checkbox"/> Scheduling/Keeping appointments																																		
<input type="checkbox"/> Obtaining dental care																																		
<input type="checkbox"/> Obtaining foreign language translation																																		
<input type="checkbox"/> Written plan of care (POC) has been given to the family																		If assistance is needed, please provide parent's/caregiver's telephone no. to facilitate coordination																
IMMUNIZATIONS GIVEN TODAY AND STATUS																																		
<input type="checkbox"/> HepB						<input type="checkbox"/> DTaP						<input type="checkbox"/> IPV						<input type="checkbox"/> Hib						<input type="checkbox"/> Rotav						<input type="checkbox"/> PCV		<input type="checkbox"/> MMR		
<input type="checkbox"/> Influenza						<input type="checkbox"/> Varicella						<input type="checkbox"/> HPV						<input type="checkbox"/> MCV4/MPSV4						<input type="checkbox"/> Tdap						<input type="checkbox"/> HepA		<input type="checkbox"/> Other(s)		
List Other(s)														<input type="checkbox"/>		<input type="checkbox"/>		Immunizations up to date										<input type="checkbox"/>		<input type="checkbox"/>				
PROVIDER INFORMATION: By signing below, I attest that the services indicated above were performed today by me or my staff under my supervision.																																		
PCP		Provider Name (Print)								Signature								NPI #				Phone #												
<input type="checkbox"/>	<input type="checkbox"/>																																	
<input type="checkbox"/>	<input type="checkbox"/>																																	

Hawai'i Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exam  
ADDITIONAL INFORMATION

Today's Date (MMDDYY)	Name (Last, First, Middle Initial)	Provider Name (Print)

**Additional information, comments, concerns, and/or clarification pertaining to HISTORY:**

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**Additional information, comments, concerns, and/or clarification pertaining to PHYSICAL EXAMINATION, MEDICATIONS, ALLERGIES**

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**Additional information, comments, concerns, and/or clarification pertaining to SURVEILLANCE, SCREENING, and DIAGNOSIS/STATUS**

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**Additional information, comments, concerns, and/or clarification pertaining to REFERRALS AND CARE COORDINATION**

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**Additional information, comments, concerns, and/or clarification pertaining to IMMUNIZATIONS:**

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**Additional information, comments, concerns, and/or clarification pertaining to OVERALL HEALTH STATUS**

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PROVIDER INFORMATION: By signing below, I attest that the services indicated above were performed today by me or my staff under my supervision.

## Hawaii Early And Periodic Screening, Diagnosis, and Treatment (EPSDT) IMMUNIZATION CATCH-UP & FOLLOW-UP Form

PATIENT INFORMATION																				
<b>Health Plan</b>						<b>Island of Residence</b>														
AlohaCare	HMSA QUEST	Kaiser QUEST	Summerlin	Medicaid Fee-For Service	Other	Hawaii	Kauai	Lanai	Maui	Molokai	Oahu									
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Today's Date (MMDDYY)		Name (Last, First, Middle Initial)				Medicaid ID#				Birthdate (MMDDYY)		M	F							
												<input type="radio"/>	<input type="radio"/>							
IMMUNIZATIONS GIVEN TODAY <input type="radio"/> Y-mark below <input type="radio"/> N																				
<input type="radio"/> HepB (Hepatitis B)	<input type="radio"/> DTaP (Diphtheria, Tetanus, Acellular Pertussis)	<input type="radio"/> IPV (Inactivated Poliovirus)	<input type="radio"/> Hib (Haemophilus Influenza Type B)	<input type="radio"/> Rotav (Rotavirus)	<input type="radio"/> PCV (Pneumococcal)															
<input type="radio"/> MMR (Measles, Mumps, Rubella)	<input type="radio"/> Tdap (Tetanus, Diphtheria, Acellular Pertussis)	<input type="radio"/> Varicella	<input type="radio"/> HPV (Human Papillomavirus)	<input type="radio"/> MCV4/MPSV4 (Meningococcal)	<input type="radio"/> Influenza															
<input type="radio"/> HepA (Hepatitis A)	<input type="radio"/> Other(s)	List other(s)																		
<input type="radio"/> Up to date	<input type="radio"/> Additional catch-up needed	Comments on catch up or immunization status																		
SCREENING DONE OR REPEATED TODAY			List abnormalities and/or concerns related to the screenings performed today and or abnormalities in Hgb/Hct, PPD, blood lead or screening results not previously noted during an EPSDT exam																	
Screening	Y	N																		
Snellen/Alien	<input type="radio"/>	<input type="radio"/>																		
Audio (20-25 db screen)	<input type="radio"/>	<input type="radio"/>																		
Blood Lead Level	<input type="radio"/>	<input type="radio"/>																		
Hgb/Hct	<input type="radio"/>	<input type="radio"/>																		
PPD	<input type="radio"/>	<input type="radio"/>																		
Dev: PDS/ASQ	<input type="radio"/>	<input type="radio"/>																		
Other Dev/Beh - List	<input type="radio"/>	<input type="radio"/>																		
FOLLOW-UP ON DIAGNOSIS(SES) AND TREATMENT <input type="radio"/> Y - indicate below <input type="radio"/> N																				
<input type="radio"/> Well child	<input type="radio"/> Acute Illness	<input type="radio"/> CSHCN	If "Y" list condition(s) and/or treatment follow-up provided today and/or new condition(s) identified today																	
List ICD-9 Codes of CSHCN																				
FOLLOW UP AND/OR REFERRALS MADE TODAY <input type="radio"/> Y - indicate below <input type="radio"/> N																				
Agency(ies)	<input type="radio"/>	<input type="radio"/>	If "Y" list agency(ies) and specialist(s). For follow-up, list results from previous referral(s)																	
Specialist(s)	<input type="radio"/>	<input type="radio"/>																		
CARE COORDINATION ASSISTANCE NEEDED <input type="radio"/> Y - indicate below <input type="radio"/> N																				
<input type="radio"/> Bringing immunizations up to date	List additional information or other assistance needed																			
<input type="radio"/> Arranging transportation																				
<input type="radio"/> Scheduling/Keeping appointments																				
<input type="radio"/> Obtaining foreign/sign language translation																				
<input type="radio"/> Other	If assistance is needed, please provide parent's/caregiver's telephone no. to facilitate coordination																			
PROVIDER INFORMATION: By signing below I attest that the immunizations and screenings indicated above were given today by me or my staff under my supervision																				
Provider Name (Print)				Signature				NPI #				Phone #								

**FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT**

State	FY	Total	Age Groups								
			<1	1-2*	3-5	6-9	10-14	15-18	19-20		
1. Total Individuals Eligible for EPSDT	CN										
	MIN										
	TOTAL										
2a. State Periodicity Schedule											
2b. Number of Years in Age Group			1	2	3	4	4	5	4	2	
2c. Annualized State Periodicity Schedule											
3a. Total Months of Eligibility	CN										
	MIN										
	TOTAL										
3b. Average Period of Eligibility	CN										
	MIN										
	TOTAL										
4. Expected Number of Screenings per Eligible	CN										
	MIN										
	TOTAL										
5. Expected Number of Screenings	CN										
	MIN										
	TOTAL										
6. Total Screens Received	CN										
	MIN										
	TOTAL										
7. Screening Ratio	CN										
	MIN										
	TOTAL										

\* Includes 12-month visit  
Note: "CN" - Categorically Needy, "MN" = Medically Needy

State	FY	Age Groups									
		Total	<1	1-2*	3-5	6-9	10-14	15-18	19-20		
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN										
	MN										
	TOTAL										
9. Total Eligibles Receiving at Least One Initial or Periodic Screen	CN										
	MN										
	TOTAL										
10. Participant Ratio	CN										
	MN										
	TOTAL										
11. Total Eligibles Referred for Corrective Treatment	CN										
	MN										
	TOTAL										
12a. Total Eligibles Receiving Any Dental Services	CN										
	MN										
	TOTAL										
12b. Total Eligibles Receiving Preventive Dental Services	CN										
	MN										
	TOTAL										
12c. Total Eligibles Receiving Dental Treatment Services	CN										
	MN										
	TOTAL										
13. Total Eligibles Enrolled in Managed Care	CN										
	MN										
	TOTAL										
14. Total Number of Screening Blood Lead Tests	CN										
	MN										
	TOTAL										

\* Includes 12-month visit

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0354. The time required to complete this information collection is estimated to average 19 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.