

Home and Community Based Services Manual

8.00

Appendix 4

GENERAL HEALTH EVALUATION & LEVEL OF CARE RECOMMENDATION INSTRUCTIONS

The General Health Evaluation & Level of Care Recommendation form is to be completed by a nurse from a Home and Community Based Services (HCBS) provider. The intention of the multi-purpose evaluation is to provide uniformity and streamline the documents completed by providers when reporting clinical information to the Division of Senior and Disability Services (DSDS) or its designee. The form also provides a method for provider nurses to communicate the participant's needs, whether those needs are being met, and any changes in the participant's situation that may require intervention by DSDS or its designee.

Providers shall complete the General Health Evaluation & Level of Care Recommendation form for all semi-annual (General Health Evaluation) Authorized Nurse Visits. It may also be completed for participants receiving monthly Authorized Nurse Visits. However, unless there has been a significant change in the participant's condition, the only time it is necessary to upload a copy to the WebTool participant case record is for the semi-annual General Health Evaluation.

The General Health Evaluation & Level of Care Recommendation shall be uploaded to the participant's WebTool case record as soon as possible after the date of completion, but no later than ten (10) working days from the end of the authorization period. However, the REV team should be contacted **immediately** regarding any critical issues identified during the visit. If the provider nurse recommends changes, the form shall be forwarded to the REV team, or its designee. DSDS staff or its designee will review the requested changes; consult with the participant, and discuss any questions with the provider nurse. DSDS staff, or its designee, shall notify the provider regarding any changes made.

The necessary items shall be entered in the appropriate fields:

A: PARTICIPANT INFORMATION

This section shall be completed for each evaluation.

- DATE: Enter the date form is completed.
- PARTICIPANT: Enter the name of the participant (last, first, and middle initial).
- DCN: Enter the participant's Departmental Client Number.
- DATE OF BIRTH: Enter the participant's date of birth.
- DSDS REGION: Enter the region where the participant resides.
- ADDRESS: Enter the participant's street address, city, and zip code.
- COUNTY: Enter name of the participant's county of residence.
- PHONE NUMBER(s): Enter the participant's telephone number.

B: PROVIDER NURSE INFORMATION

This section shall be completed for each evaluation.

- NAME OF PROVIDER NURSE: Enter the name of the nurse completing the evaluation.
- NAME OF PROVIDER: Enter the name of the HCBS provider.
- PROVIDER PHONE NUMBER: Enter the phone number of the HCBS provider.

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C: REASON FOR NURSE VISIT

This section shall be completed for each evaluation.

- Check the appropriate box.

If there has been a significant change in the participant's condition that must be reported to the appropriate HCS Regional Evaluation Team or designee.

D: HEALTH CARE INFORMATION

This section shall be completed for each evaluation.

- **PRIMARY HEALTH CARE PROVIDERS:** List all pertinent health providers currently treating the participant.
- **CURRENT HEALTH DIAGNOSES/CONCERNS:** The nurse shall identify and list all current health diagnoses or health concerns.
- **RECENT HOSPITALIZATIONS, SURGERIES, OR PROCEDURES:** The nurse shall identify and list all recent hospitalizations, surgeries, or procedures.
- **ANY ADDITIONAL HEALTH INFORMATION:** List any additional health information relevant to the participant such as upcoming surgeries or procedures.

E: ALLERGIES AND VITAL SIGNS

This section shall be completed for each evaluation. A1C may not be available for all participants.

F: CARDIOPULMONARY ASSESSMENT

This section shall be completed for each evaluation.

- Check the appropriate boxes

G. INTEGUMENTARY ASSESSMENT

This section shall be completed for each evaluation.

- Check the appropriate box – if there are concerns such as skin tears, abrasions, wounds, or decubitus ulcers, indicate them on the body diagram and [provider nurse assessment chart](#).

H. LEVEL OF CARE

This section shall, at a minimum, be completed during the semi-annual General Health Evaluation and LOC Recommendation, and any time requested by DSDS staff or its designee.

- Provide a score for each of the nine (9) LOC categories and add any additional comments to each corresponding section.
- See [Policy 4.10](#) for additional information regarding LOC scoring.

I: CURRENT AUTHORIZATION REVIEW:

This section shall be completed for each evaluation.

- Check the appropriate boxes and explain if necessary

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J: EMERGENCY BACK-UP PLAN:

This section shall be completed for each evaluation.

- In cases of emergency, the participant should have a back-up plan if services are not available, such as during times of natural or other disasters, (i.e., floods, earthquakes, tornados, bombs and other acts of terrorism). Enter the Emergency Contact person designated by the participant, along with their phone number and relationship to the participant.

K: DIRECTIONS TO LOCATE, SAFETY CONCERNS IN THE HOME, OR ADDITIONAL COMMENTS:

Use this section to provide directions to the participant's home, documentation of safety concerns within the home, or documentation of any issues or concerns not listed on the form itself. (Additional narrative pages may be attached as needed.)

SIGNATURES: Both the participant and the provider nurse shall sign and date the form. If the evaluation is completed by an LPN, the supervisory RN or physician shall sign and date in the appropriate fields.