NV LOC - FA-19

Level of Care Assessment for Nursing Facilities

Please upload this form through the Provider Web Portal. If you are not an enrolled Nevada Medicaid provider, you may fax this form to **1 (855) 709-6847**

For assistance please contact Nevada Medicaid Customer Service **1 (800) 525-2395**

Screening Type

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

* ***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 FA- 22 is 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	Recipient's Home or Cell Number	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	

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	☐ 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 ◯ Limited Assistance ◯ Extensive Assistance ◯ Total Dependence	◯ No Setup or Help ◯ Setup Help Only ◯ One Person Physical Assist ◯ Two Person Physical Assist
Transferring	◯ Independent ◯ Supervision ◯ Limited Assistance ◯ Extensive Assistance ◯ Total Dependence	◯ No Setup or Help ◯ Setup Help Only ◯ One Person Physical Assist ◯ Two Person Physical Assist
Dressing	◯ Independent ◯ Supervision ◯ Limited Assistance ◯ Extensive Assistance ◯ Total Dependence	◯ No Setup or Help ◯ Setup Help Only ◯ One Person Physical Assist ◯ Two Person Physical Assist
Eating And Feeding	◯ Independent ◯ Supervision ◯ Limited Assistance ◯ Extensive Assistance ◯ Total Dependence	◯ No Setup or Help ◯ Setup Help Only ◯ One Person Physical Assist ◯ Two Person Physical Assist
Hygiene	◯ Independent ◯ Supervision ◯ Limited Assistance ◯ Extensive Assistance ◯ Total Dependence	◯ No Setup or Help ◯ Setup Help Only ◯ One Person Physical Assist ◯ Two Person Physical Assist
Bathing	◯ Independent ◯ Supervision ◯ Limited Assistance ◯ Extensive Assistance ◯ Total Dependence	◯ No Setup or Help ◯ Setup Help Only ◯ One Person Physical Assist ◯ Two Person Physical Assist
Bladder Function	◯ Independent ◯ Supervision ◯ Limited Assistance ◯ Extensive Assistance ◯ Total Dependence	◯ Continent ◯ Incontinent ◯ Catheter
Bowel Function	◯ Independent ◯ Supervision ◯ Limited Assistance ◯ Extensive Assistance ◯ Total Dependence	◯ Continent ◯ Incontinent ◯ Catheter
Locomotion	◯ Independent ◯ Supervision ◯ Limited Assistance ◯ Extensive 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 ◯ Limited Assistance ◯ Extensive Assistance ◯ Total Dependence
Homemaking Services - Related to personal care	◯ Independent ◯ Supervision ◯ Limited Assistance ◯ Extensive 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

Screener Certification (FA-19)

Signature and title of person completing this form: