DIRECTIONS: Please complete this form when requesting a change in specialized residential level of care and attach any relevant clinical documentation. Please fax to (810) 257-1347.

|  |  |
| --- | --- |
| Consumer Name: |  |

|  |  |
| --- | --- |
| Case Number: |  |

Request made by  Case Manager

LLP

OT

AFC

|  |  |
| --- | --- |
| AFC Name: |  |

|  |  |
| --- | --- |
| Address: |  |
|  |

Rational for Request (include supporting documentation): Click here to enter text.

1. Behavioral:
2. Targeted Behaviors:

Behavior Average Frequency

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | per day per week |
| New  Change in severity  Change in frequency | | | |
|  |  |  | per day per week |
| New  Change in severity  Change in frequency | | | |
|  |  |  | per day per week |
| New  Change in severity  Change in frequency | | | |
|  |  |  | per day per week |
| New  Change in severity  Change in frequency | | | |
|  |  |  | per day per week |
| New  Change in severity  Change in frequency | | | |

1. Describe new behaviors or changes in behavior: Click here to enter text.
2. LLP Treatment Plan updated in CHIP to address new or changed behaviors

* Date of revised LLP Treatment Plan:Click here to enter text.

LLP Treatment will be updated:

* Anticipated Date Treatment Plan will be in CHIP:Click here to enter text.
* Summary of changes to be made:Click here to enter text.

1. Personal Care (DD and DD/MI Only):  
     
   A. Self-Care Deficits

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Self- Care Item | Independent | Need Verbal Prompts and initial set-up | Need verbal prompts and partial physical assistance | Requires 100% physical assistance | Requires 100% dependent and is resistive/combative with assistance | Is this a new deficit or change in deficit? |
| Mobility |  |  |  |  |  | New Change |
| Eating |  |  |  |  |  | New Change |
| Toileting |  |  |  |  |  | New Change |
| Bathing |  |  |  |  |  | New Change |
| Grooming (hair care, nails, shaving) |  |  |  |  |  | New Change |
| Dressing |  |  |  |  |  | New Change |
| Oral Care (tooth brushing) |  |  |  |  |  | New Change |

Any above item mark other than independent must require detailed explanation:

|  |  |  |
| --- | --- | --- |
| Personal Care Item: | Explanation: (additional sheets if necessary) | Average Daily Time to complete task: |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. Does the consumer have any special exercises or Range of Motion:

Yes. Frequency (how many times a day and how long):Click here to enter text.

No

1. Does the consumer have any special diets:

Yes. Describe:

No

1. OT Treatment Plan updated in CHIP to address new or changed personal care   
    needs.

* Date of revised OT Treatment Plan:Click here to enter text.

OT Treatment will be updated:

* Anticipated Date Treatment Plan will be in CHIP:Click here to enter text.
* Summary of changes to be made:Click here to enter text.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |

|  |  |
| --- | --- |
| Name (print): |  |

GHS UM Use Only:

**GHS UTILIZATION MANAGEMENT REVIEW:**

**Reviewed: CHIP Record LLP Completed Form OT Completed Form**

**AFC Completed Form Case Manager/Supports Coordinator   
 Completed Form**

[ ] Approved LOC:Click here to enter text.

[ ] Denied

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |