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: |  |