DHS Office of Medical Review
Request for Level of Care (LOC)

Please fax completed form to the Office of Community Programs (OCP) at the RI Department of Human Services
Fax: 401-462-3496 Phone: 401-462-6393

Today's Date: _____ **Anticipated D/C Date:** _____

Hospital/Nursing Home Name: _____ **Hospital/Nursing Home Rm #** _____

Reason for Hospitalization: _____ **Primary Dx:** _____

Other Dx: _____ **Primary Language:** _____

Does the patient have a serious mental illness or MRDD Diagnosis? ☐ Yes ☐ No

If yes, is a Level II PASRR in process? ☐ Yes ☐ No

Applicant Name: _____
(Last) *(First)* *(M.I.)*

Applicant Address: _____
(*Street Address)* *(Apt/Unit #)* *(City/Town)* *(State)* *(Zip code)*

DOB: _____**Age:** _____ **SS# or MID**: _____

Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Medicaid Recipient: ☐ Yes ☐ No

☐ Active Community MA ☐ Active LTC ☐ New Applicant ☐ Active SSI

Medicare Recipient: ☐ Yes ☐ No If yes, Medicare # _____

If yes, does the applicant have a primary insurance other than Medicaid? ☐ Yes ☐ No

If yes, Name of Insurance: _____ Insurance #: _____

If yes, will this insurance cover any part of the Nursing Home stay or portion of Home Care Services?
☐ Yes ☐ No

What service(s) are being requested? ☐ Nursing Facility ☐ HCBS ☐ Other _____

D/C Planner Signature: _____ **Telephone #:** _____