DPHHS-SLTC-85
(New 1/06)

STATE OF MONTANA
Department of Public Health and Human Services

REQUEST FOR LEVEL OF CARE

Program Requested: ☐ **Nursing Facility** ☐ **Home and Community Based Services**
Fax to: 1-800-413-3890 ☐ **Unknown** ☐ **Modified**

Requestor Information

Date of Request: _____ Phone: _____ Fax: _____

Screen Requested By: _____

Agency: _____

Applicant's Name: _____ SSN: _____

Physical Address: _____ Phone: _____

Mailing Address: _____ City/State/Zip: _____

County of Application: _____

D.O.B. _____ Age: _____ Sex: _____ Veteran: ☐ Yes ☐ No

Medicaid Status: _____

Residential Status: (i.e., home, nursing facility, retirement home) _____

Name of Facility: _____

Nursing Facility Admit Date: _____ Anticipated LOS: _____

Medicare Skilled? _____ Date _____

Previous Medicaid Screen? _____ Date _____

Health Care Professional: _____ Phone: _____

Primary Contact:

Name: _____ Relationship: _____

Phone: _____ Phone: _____

Address: _____ City/St/Zip: _____

Name: _____ Relationship: _____

Phone: _____ Phone: _____

Address: _____ City/St/Zip: _____

Name: _____ Relationship: _____

Phone: _____ Phone: _____

Address: _____ City/St/Zip: _____

Name: _____ Relationship: _____

Phone: _____ Phone: _____

Address: _____ City/St/Zip: _____

Dementia: Γ Yes Γ No Traumatic Brain Injury: Γ Yes Γ No Communication Deficit: Γ Yes Γ No