LOUISIANA DEPARTMENT OF HEALTH

interRAI HC Assessment Corrections Request Form

Select iHC Status:

Participant Name:

Participant ID: **SSN:**

Date of Birth: **iHC Id:**

Assessor's Name: **Assessor's Number:**

Supervisor's Name: **Supervisor's Number:**

iHC LOC Item(s) Request:

*Supervisors must verify that the iHC notebook documentation aligns with the coding change request.

Explain justification for each LOC item. Include iHC item and code change from/to below:

Note: Corrections CANNOT be made on an iHC assessment that has been approved or is more than 90 days old.
SCA's Only: Corrections CANNOT be made if the plan of care associated with the iHC has been approved.