Date Referral Completed: _____ (Month/Day/Year)
Screening Agency: _____
Screener Name: _____
Assessing Agency: _____
Assessor Name: _____
Provider #: _____
Worker # _____

ULTC 100.2 – INITIAL SCREENING AND INTAKE

Current Living Situation

☐ Alone	☐ With Non-Relatives	☐ Pending Nursing Facility Discharge or Admission
☐ With Spouse/ Others	☐ Alternative Care Facility	☐ Hospital Discharge, Date: _____
☐ With Non-Spouse Relatives	☐ Adult Foster Care	☐ DD Residential Program
☐ With Parents	☐ Nursing Facility	☐ ICF/MR

☐ **URGENT**

Applicant Information

State ID: _____ Primary Language _____ County ID: _____

Last Name: _____ First Name: _____ Middle Initial: _____ SSN: _____

Address: _____ DOB: _____ (Month/Day/Year) Marital Status: S☐ M☐ D☐ W☐

City: _____ State: _____ Zip: _____ Phone: _____

Presenting Problems and Diagnoses

Comments:

Areas of Concern

☐ Bathing	☐ Toileting	☐ Behaviors	☐ Possible Mental Illness
☐ Dressing	☐ Transferring	☐ Memory/Cognition	☐ Possible Developmental Disability
☐ Eating	☐ Mobility		☐ Brain Injury

Potential Community Based Long Term Care Programs

☐ HCBS-Elderly, Blind and Disabled (EBD)	☐ HCBS-Persons Living with HIV/AIDS (PLWA)
☐ Home Care Allowance (HCA)	☐ HCBS-Brain Injury (BI)
☐ Private Case Management	☐ HCBS-Mentally Ill (MI)
☐ Long Term Skilled Home Health	☐ HCBS- DD (Comprehensive Services)
☐ PACE	☐ Consumer Directed Attendant Support(CDAS)
☐ HCBS-Children's Extensive Support (CES)	☐ Children's HCBS
☐ HCBS-Supported Living Services (SLS)	☐ Other Program (specify): _____

☐ Medical information page sent to provider.

Provider Name: _____ Date: _____

Residential Alternatives

- ☐ Adult Foster Care
- ☐ Alternative Care Facility
- ☐ DD Residential Program
- ☐ Nursing Facility
- ☐ Other: _____
- ☐ ICF/MR

Information and Referral Provided

- ☐ Home Health
- ☐ Vocational Rehabilitation
- ☐ Community Centered Board
- ☐ Homeless Shelter
- ☐ Area Agency on Aging
- ☐ Child Protection
- ☐ Hospice
- ☐ Mental Health Services
- ☐ Veterans Affairs
- ☐ Adult Protective Services
- ☐ County Eligibility
- ☐ Community Food Bank
- ☐ Other:

Contact Information

Name: _____ Relationship: _____

Phone #1: _____ Phone #2: _____

Address: _____

City: State: Zip:

Comments:

Referral Information

Name: _____

Phone #: _____

Address: _____

City: State: Zip:

Organization/
Relationship:

Financial Information

Client Income Source(s)		Spouse Income Source(s)	
Source	Amount	Source	Amount
☐ SSA/SSDI ☐ SSI ☐ Pension ☐ Employment ☐ OAP ☐ AND/AB		☐ SSA/SSDI ☐ SSI ☐ Pension ☐ Employment ☐ OAP ☐ AND/AB	
☐ Other: _____		☐ Other: _____	
Gross Monthly Income	$	Gross Monthly Income	$
Assets:	$	Assets:	$

Insurance Information

Client's Insurance Information

- ☐ VA Benefits
- ☐ Medicare Part A
- ☐ Medicare Part B
- ☐ Private Health Insurance: _____
- ☐ Medicaid
- ☐ LTC Medicaid
- ☐ Medicaid Pending
  - ☐ Application in Process
  - ☐ Application Needed
  - ☐ Application Mailed Date: _____

Comments:

Medical Provider Information

Provider Name _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Type of Provider: _____

Contact Person:

Comments:

Case Assigned to: (worker name or number): _____ Date: _____

Long Term Care Professional Medical Information

Dear Medical Provider:

We are conducting a functional assessment of this person for long-term care services. The services will be provided in a skilled nursing facility, alternative care facility or in their own home in the community. Please complete the information below to help with the care planning for this person.

Client:

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address _____ City _____ State _____ Zip _____

Date of Birth _____ Telephone _____ Male ☐ Female ☐

Medical Information Section:

ICD 9 Code	ICD 9 Description	Onset	Medication Name	Dosage	Frequency	Route

Other Services Required for Medical Problems: (oxygen therapy, patient education, monitoring, follow-up care):

Is there a Mental Health Diagnosis? Yes ☐ No ☐
Is there a Developmental Disability Diagnosis? Yes ☐ No ☐
Is there a Traumatic Brain Injury Diagnosis? Yes ☐ No ☐
Diagnosis of dementia must be validated by a neurological exam with documentation by the attending physician.

Neurological Exam Date: _____

If Hospitalized, Reason: _____ Admit Date: _____

Diet Order: _____
Allergies: _____
Prognosis: _____

Medical Provider Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Name of Person Completing this Information Title:

Date Information Completed:

Medical Provider Comments:

Facility/Case Manager Information

Facility/Case Management Agency: _____

Administrator/Case Manager Name (print): _____ Phone Number: _____

Administrator/Case Manager Signature: _____

LONG TERM CARE ELIGIBILITY ASSESSMENT

General Instructions: To qualify for Medicaid long-term care services, the recipient/applicant must have deficits in 2 of 6 Activities of Daily Living, ADLs, (2+ score) or require at least moderate (2+ score) in Behaviors or Memory/Cognition under Supervision.

ACTIVITIES OF DAILY LIVING

I. BATHING

Definition: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene.

ADL SCORING CRITERIA
☐ 0=The client is independent in completing the activity safely.
☐ 1=The client requires oversight help or reminding; can bathe safely without assistance or supervision, but may not be able to get into and out of the tub alone.
☐ 2=The client requires hands on help or standby assistance throughout bathing activities in order to maintain safety, adequate hygiene and skin integrity.
☐ 3=The client is dependent on others to provide a complete bath.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	☐ Open Wound
☐ Pain	☐ Stoma Site
☐ Visually Impaired	**Supervision:**
☐ Limited Range of Motion	☐ Cognitive Impairment
☐ Weakness	☐ Memory Impairment
☐ Balance Problems	☐ Behavior Issues
☐ Shortness of Breath	☐ Lack of Awareness
☐ Decreased Endurance	☐ Difficulty Learning
☐ Falls	☐ Seizures
☐ Paralysis	**Mental Health:**
☐ Neurological Impairment	☐ Lack of Motivation/Apathy
☐ Oxygen Use	☐ Delusional
☐ Muscle Tone	☐ Hallucinations
☐ Amputation	☐ Paranoia

Comments:

II. DRESSING

Definition: The ability to dress and undress as necessary. This includes the ability to put on prostheses, braces, anti-embolism hose or other assistive devices and includes fine motor coordination for buttons and zippers. Includes choice of appropriate clothing for the weather. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit.

ADL SCORE CRITERIA
☐ 0= The client is independent in completing activity safely.
☐ 1=The client can dress and undress, with or without assistive devices, but may need to be reminded or supervised to do so on some days.
☐ 2= The client needs significant verbal or physical assistance to complete dressing or undressing, within a reasonable amount of time.
☐ 3= The client is totally dependent on others for dressing and undressing

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	**Supervision:**
☐ Pain	☐ Cognitive Impairment
☐ Sensory Impairment	☐ Memory Impairment
☐ Limited Range of Motion	☐ Behavior Issues
☐ Weakness	☐ Lack of Awareness
☐ Balance Problems	☐ Difficulty Learning
☐ Shortness of Breath	☐ Seizures
☐ Decreased Endurance	**Mental Health:**
☐ Fine Motor Impairment	☐ Lack of Motivation/Apathy
☐ Paralysis	☐ Delusional
☐ Neurological Impairment	☐ Hallucinations
☐ Bladder Incontinence	☐ Paranoia
☐ Bowel Incontinence	
☐ Amputation	
☐ Oxygen Use	
☐ Muscle Tone	
☐ Open Wound	

Comments:

III. TOILETING

Definition: The ability to use the toilet, commode, bedpan or urinal. This includes transferring on/off the toilet, cleansing of self, changing of apparel, managing an ostomy or catheter and adjusting clothing.

ADL SCORE CRITERIA
☐ 0=The client is independent in completing activity safely.
☐ 1=The client may need minimal assistance, assistive device, or cueing with parts of the task for safety, such as clothing adjustment, changing protective garment, washing hands, wiping and cleansing.
☐ 2=The client needs physical assistance or standby with toileting, including bowel/bladder training, a bowel/bladder program, catheter, ostomy care for safety or is unable to keep self and environment clean.
☐ 3=The client is unable to use the toilet. The client is dependent on continual observation, total cleansing, and changing of garments and linens. This may include total care of catheter or ostomy. The client may or may not be aw are of own needs.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	☐ Ostomy
☐ Pain	☐ Catheter
☐ Visual Impairment	**Supervision Need:**
☐ Limited Range of Motion	☐ Cognitive Impairment
☐ Weakness	☐ Memory Impairment
☐ Shortness of Breath	☐ Behavior Issues
☐ Decreased Endurance	☐ Lack of Awareness
☐ Fine Motor Impairment	☐ Difficulty Learning
☐ Paralysis	☐ Seizures
☐ Neurological Impairment	**Mental Health**:
☐ Bladder Incontinence	☐ Lack of Motivation/Apathy
☐ Bowel Incontinence	☐ Delusional
☐ Amputation	☐ Hallucinations
☐ Oxygen Use	☐ Paranoia
☐ Physiological defect	
☐ Balance	
☐ Muscle Tone	
☐ Impaction	

Comments:

IV. MOBILITY

Definition: The ability to move between locations in the individual's living environment inside and outside the home. Note: Score client's mobility without regard to use of equipment.

ADL SCORE CRITERIA
☐ 0=The client is independent in completing activity safely.
☐ 1=The client is mobile in their own home but may need assistance outside the home.
☐ 2=The client is not safe to ambulate or move between locations alone; needs regular cueing, stand-by assistance, or hands on assistance for safety both in the home and outside the home.
☐ 3=The client is dependent on others for all mobility.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	**Supervision Need:**
☐ Pain	☐ Cognitive Impairment
☐ Sensory Impairment	☐ Memory Impairment
☐ Limited Range of Motion	☐ Behavior Issues
☐ Weakness	☐ Lack of Awareness
☐ Shortness of Breath	☐ Difficulty Learning
☐ Decreased Endurance	☐ Seizures
☐ Fine or Gross Motor Impairment	☐ History of Falls
☐ Paralysis	**Mental Health:**
☐ Neurological Impairment	☐ Lack of Motivation/Apathy
☐ Amputation	☐ Delusional
☐ Oxygen Use	☐ Hallucinations
☐ Balance	☐ Paranoia
☐ Muscle Tone	

Comments:

LONG TERM CARE ELIGIBILITY ASSESSMENT: ADLS (continued)

V. TRANSFERRING

Definition: The physical ability to move between surfaces: from bed/chair to wheelchair, walker or standing position; the ability to get in and out of bed or usual sleeping place; the ability to use assisted devices for transfers. Note: Score client's mobility without regard to use of equipment.

ADL SCORE CRITERIA
☐ 0=The client is independent in completing activity safely.
☐ 1=The client transfers safely without assistance most of the time, but may need standby assistance for cueing or balance; occasional hands on assistance needed.
☐ 2=The client transfer requires standby or hands on assistance for safety; client may bear some weight.
☐ 3=The client requires total assistance for transfers and/or positioning with or without equipment.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	**Supervision Need:**
☐ Pain	☐ Cognitive Impairment
☐ Sensory Impairment	☐ Memory Impairment
☐ Limited Range of Motion	☐ Behavior Issues
☐ Weakness	☐ Lack of Awareness
☐ Balance Problems	☐ Difficulty Learning
☐ Shortness of Breath	☐ Seizures
☐ Falls	**Mental Health:**
☐ Decreased Endurance	☐ Lack of Motivation/Apathy
☐ Paralysis	☐ Delusional
☐ Neurological Impairment	☐ Hallucinations
☐ Amputation	☐ Paranoia
☐ Oxygen Use	

Comments:

VI. EATING

Definition: The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew and swallow food. *Note: If a person is fed via tube feedings or intravenously, check box 0 if they can do independently, or box 1, 2, or 3 if they require another person to assist.*

ADL SCORE CRITERIA
☐ 0=The client is independent in completing activity safely
☐ 1=The client can feed self, chew and swallow foods but may need reminding to maintain adequate intake; may need food cut up; can feed self if food brought to them, with or without adaptive feeding equipment.
☐ 2=The client can feed self but needs standby assistance for frequent gagging, choking, swallowing difficulty; or aspiration resulting in the need for medical intervention. The client needs reminder/assistance with adaptive feeding equipment; or must be fed some or all food by mouth by another person.
☐ 3=The client must be totally fed by another person; must be fed by another person by stomach tube or venous access.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	☐ Tube Feeding
☐ Pain	☐ IV Feeding
☐ Visual Impairment	**Supervision Need:**
☐ Limited Range of Motion	☐ Cognitive Impairment
☐ Weakness	☐ Memory Impairment
☐ Shortness of Breath	☐ Behavior Issues
☐ Decreased Endurance	☐ Lack of Awareness
☐ Paralysis	☐ Difficulty Learning
☐ Neurological Impairment	☐ Seizures
☐ Amputation	**Mental Health:**
☐ Oxygen Use	☐ Lack of Motivation/Apathy
☐ Fine Motor Impairment	☐ Delusional
☐ Poor Dentition	☐ Hallucinations
☐ Tremors	☐ Paranoia
☐ Swallowing Problems	
☐ Choking	
☐ Aspiration	

Comments:

LONG TERM CARE ELIGIBILITY ASSESSMENT: Supervision

VII. SUPERVISION

Definition: The need for supervision is indicated by a significant impairment in Behavior and/or Cognition/Memory.

A. Behaviors (Wandering/Disruptive/Self-Injurious/Resistive to care/*Self-neglect*)

Scoring Criteria:

☐ 0=The client demonstrates appropriate behavior; there is no concern.

☐ 1=The client exhibits some inappropriate behaviors but not resulting in injury to self, others and/or property. The client may require redirection. Minimal intervention is needed.

☐ 2=The client exhibits inappropriate behaviors that put self, others or property at risk. The client requires more than verbal redirection to interrupt inappropriate behaviors. The client needs medication assistance, monitoring, supervision or is unable to make safe decisions.

☐ 3=The client exhibits behaviors resulting in physical harm for self or others. The client requires extensive supervision to prevent physical harm to self or others.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	☐ Agitation
☐ Medication Management	☐ Aggressive Behavior
☐ Chronic Medical Condition	☐ Cognitive Impairment
☐ Acute Illness	☐ Difficulty Learning
☐ Pain	☐ Memory Impairment
☐ Neurological Impairment	☐ Verbal Abusiveness
☐ Choking	☐ Constant Vocalization
☐ Sensory Impairment	☐ Sleep Deprivation
☐ Communication Impairment (not inability to speak English)	☐ Self-Injurious Behavior
Mental Health:	☐ Impaired Judgment
☐ Lack of Motivation/Apathy	☐ Disruptive to Others
☐ Delusional	☐ Disassociation
☐ Hallucinations	☐ Wandering
☐ Paranoia	☐ Seizures
☐ Mood Instability	☐ Self Neglect
Supervision needs:	
☐ Short Term Memory Loss	
☐ Long Term Memory Loss	

Comments:

B. Memory/Cognition Deficit

Scoring Criteria:

☐ 0= Independent no concern

☐ 1= The client can make safe decisions in familiar/routine situations, but needs some help with decision making support when faced with new tasks, consistent with individual's values and goals.

☐ 2= The client requires consistent and ongoing reminding and assistance with planning, or requires regular assistance with adjusting to both new and familiar routines, including medication assistance and monitoring or requires ongoing supervision or is unable to make safe decisions, or cannot make his/her basic needs known.

☐ 3= The client needs help most or all of time. Medications must be administered for the client.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	☐ Self-Injurious Behavior
☐ Metabolic Disorder	☐ Impaired Judgment
☐ Medication Reaction	☐ Unable to Follow Directions
☐ Acute Illness	☐ Constant Vocalizations
☐ Pain	☐ Perseveration
☐ Neurological Impairment	☐ Receptive Expressive Aphasia
☐ Alzheimer's/Dementia	☐ Agitation
☐ Sensory Impairment	☐ Disassociation
☐ Chronic Medical Condition	☐ Wandering
☐ Communication Impairment (does not include ability to speak English)	☐ Lack of Awareness
☐ Abnormal Oxygen Saturation	☐ Seizures
☐ Fine Motor Impairment	**Mental Health:**
Supervision Needs:	☐ Lack of Motivation/Apathy
☐ Disorientation	☐ Delusional
☐ Cognitive Impairment	☐ Hallucinations
☐ Difficulty Learning	☐ Paranoia
☐ Memory Impairment	☐ Mood Instability

Comments:

Assessment Demographics:

Location of Assessment:	Present at Interview:
☐ Applicant's private residence/home ☐ Nursing Home ☐ Hospital/other health care facility ☐ Assisted Living ☐ Agency Office ☐ **Relative's home** ☐ Other:_____	☐ Applicant Only ☐ Caregiver(s) only ☐ Applicant and caregiver(s) ☐ Other:_____ ☐ Applicant and others

Most of the interview information was provided by:

☐ Applicant	☐ Medical record
☐ Caregiver	☐ Facility Staff
☐ Applicant and Caregiver equally	☐ Other:_____

Living Environment:

Safe	☐	Services cannot be delivered here	☐
Safe with feasible modifications	☐	Client needs to move so services can be delivered	☐
Services can be delivered here	☐	Client needs to move to a safer environment	☐
		Special home assessment needed	☐

Adult Protective Services Risk:

Person is known to be a current client of Adult Protective Services (APS) Yes☐ No ☐

Risk Evident During Assessment: (Check any that apply.)

☐ No risk factors or evidence of abuse or neglect apparent at this time.
☐ The individual is currently failing or is at high risk of failing to obtain nutrition, self-care, or safety adequate to avoid Significant negative health outcomes.
☐ Risk factors present; however, LTC services may resolve issues. No APS referral being made at this time.
☐ There are statements of, or evidence of, possible abuse, neglect, self-neglect, or financial exploitation.

☐ **Referring to APS now? Yes ☐ No ☐**

Advance Directives and Legal Documents:

☐	Living Will:_____
☐	Power of Attorney Financial Power of Attorney: _____ General Power of Attorney: _____ Medical Power of Attorney:
☐	Conservator: _____
☐	Guardian:_____

Comments/Narrative:

LEVEL I IDENTIFICATION SCREEN FOR MENTAL ILLNESS/MENTAL RETARDATION

Instructions for completing this form are on reverse side of this page. WEB Page www.cdhs.ctate.co.us/ohr/mhs/index.html.

Client Name: _____ Social Security Number: ____-____-____

Current Street Address: _____ Date of Birth: ____/____/____

_____ Current Location: _____

City State ZIP Code

Current Telephone Number: _____ Nursing Facility: _____

SECTION I

PASRR/MI/Level I Screen
(See back of form for definitions)

1. Has a Major Mental Illness Diagnosis as on the back of this form? ☐ Yes ☐ No
2. Has a history of mental illness in the last 2 years? ☐ Yes ☐ No
3. Presents with symptoms of major mental illness (excluding primary dementia, substantiated by a neurological exam)? ☐ Yes ☐ No
4. Has been prescribed or routinely taken antipsychotic or antidepressant medication during the past 2 years? ☐ Yes ☐ No

List medications and diagnosis/es here:

Psychoactive Medications

_____

_____

_____

_____

PASRR/MR-DD/Level I Screen
(See back of form for definitions)

1. MR-DD diagnosis. ☐ Yes ☐ No
2. Any history of mental retardation or developmental disability in the individual's past? ☐ Yes ☐ No
3. Presenting evidence of cognitive or behavioral impairment (before the age of 22) that may indicate that the individual has a developmental disability. ☐ Yes ☐ No
4. Referral by an agency that provides services to persons with mental retardation or developmental disabilities. ☐ Yes ☐ No

Diagnosis/es:

_____

_____

_____

_____

Note: If all responses to SECTION I are NO, skip to SECTION III.

SECTION II

Individual Determinations - You must contact State Utilization Review Contractor and obtain clearance.

The individual meets:	Date Authorized by URC	Confirmation Number provided by State URC: (if applicable)
A. Convalescent Criteria	____/____/____	
B. Severity of Illness Criteria	____/____/____	_____
C. Terminal Illness Criteria	____/____/____	

Comments:

SECTION III

To The Client/Legal Guardian: As a result of one or more "YES" responses on this screen, a more complete assessment may be necessary. This may result in a delay in the processing of your request for a nursing facility placement.

Legal Guardian: ☐ Yes Date of duration ____/____/____ (If yes, please list the name and address below.)

Name: _____

Address: _____

Client / Legal Guardian has received a copy of this form: ☐ Yes ☐ No

To the Preparer of this form: By Federal Law, your signature is verification that a copy has been given to the client.

Printed Name of Preparer: _____ Agency: _____ Date: ____/____/____

Signature of Preparer: _____ Telephone Number: _____

Note: Any "YES" response on this Level I Screen requires review by the Statewide Utilization Review Contractor.

SECTION I

Level I PASRR Screen: Both MI and MR-DD screens are completed if a client is accessing a nursing facility; do not complete for a Continued Stay review or HCBS EBD. All portions must be completed and a signature is required. If the determination by State URC differs from the responses submitted, instructions will be given to indicate the changes. Note that if there are any yes responses, a copy must be provided to the client and to the legal guardian if applicable, and that the required signature verifies that this has been done.

Note that the name and address of the client and legal guardian is required if there are any yes responses; by federal law the legal guardian and client must be notified, in writing, the findings of a Level I failure. Legal guardian definition: Court appointed including medical decision-making, not Power of Attorney (POA).

Level I / MI Instructions

1. Diagnosis of Mental Illness defined as: a diagnosis of a major mental disorder (as defined in the DSM-IV R) limited to **schizophrenia, paranoia, major affective including bipolar, major depression, dysthymia, cyclothymia or schizoaffective disorder or psychosis nos**.
2. Recent (2 year) history of mental illness and includes inpatient psychiatric hospitalization, mental health interventions or symptoms possibly related to mental illness.
3. Presenting evidence of mental illness: patient demonstrates symptomatology and/or behaviors characteristic of mental illness.
4. Use of psychotropic medications without an appropriate psychiatric diagnosis will require a yes response. List all psychotropic medications with corresponding diagnoses.

Any person who has a primary diagnosis of dementia that is based on a neurological examination is exempt from the PASRR process. This dementia exclusion **DOES NOT** apply to individuals with a diagnosis of mental retardation or major mental illness.

Level I / MR-DD

Developmental disability means:

A disability that is manifested before the person reaches twenty-two years of age, which constitutes a substantial handicap to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation.

SECTION II

Individual determinations must be authorized by Statewide Utilization Review Contractor.

A. Convalescent Care Criteria refers to discharge from hospital to NF for a prescribed stay of 60 days or less for rehab/convalescence for a medical or surgical condition that required hospitalization.
B. Severity of Illness Criteria refers to a comatose, vent-dependent, vegetative state.
C. Terminal Illness Criteria refers to physician documentation of life expectancy of less than 6 months.

SECTION III

If the client fails or client requests a copy, the Level I, the client or legal guardian must receive a copy of this form by the refe rral source (signature verifies that this is done). Name and address must be provided so that a copy can be mailed to them. The above procedures are a requirement per federal regulations. The original copy is sent to the nursing facility. Copies as needed for client, guardian and Statewide Utilization Review Contractor.

Level of Care Determination								
Client Meets Level of Care Yes ☐ No ☐								
Activities of Daily Living Scores:								
	Bathing	Dressing	Toileting	Mobility	Transfers	Eating	Supervision Behaviors	Supervision Memory/Cognition
Scores:								
Is there documented medical information supporting any of the following programs? MI ☐ BI ☐ PLWA ☐							Has Developmental Disability eligibility been determined? Yes ☐ No ☐	
Comments/Supporting documentation:								

Services Requirements	
Waiver Services Needed within 30 Days Yes ☐ No ☐	☐ **Waitlist** **Waiver:**
If Waiver Services are not required within 30 days document referral to community resources: Comments:	

Nursing Facility PASARR Determination
PASARR Level 1 evaluation Completed ☐ Client Passed ☐ Client Failed ☐
☐ Depression Diversion Client Passed ☐ Client Failed ☐
☐ Level II Evaluation Needed Referred to MHASA ☐ Date Referred to CCB ☐ Date:
Comments:

Long Term Care Certification			
☐ Admission ☐ CSR			
SSN: - -		State ID:	
Last Name:	First Name:	MI:	DOB:
County of Residence:		Date of Medicaid Application:	
Facility Name:	Provider #:	Admit Date:	
DO NOT COMPLETE BELOW IF CLIENT IS APPROVED FOR WAITLIST			

Target Group	Program Approval	Certification Information
☐ 1 Developmental Disability/MR ☐ 2 Mental Health ☐ 3 Frail Elderly (65+) ☐ 4 Physically Disabled (18-64) ☐ 5 Physically Disabled (13-17) ☐ 6 Pediatric (<13) ☐ 7 Brain Injury (16-64)	☐ HCBS/DD (Comprehensive) ☐ HCBS/MI ☐ HCBS/EBD ☐ HCBS/PLWA ☐ Children's HCBS ☐ Nursing Home ☐ HCBS/BI ☐ HCBS/CES ☐ HCBS/BI Supported Living ☐ PACE ☐ ICF/MR ☐ LTC- Skilled Home Health ☐ HCBS/SLS ☐ HCA ☐ AFC	Confirmation #: _____ Start Date: _____ End Date: _____ Authorized By: _____ Agency _____ Authorization Date: _____ **Denial Information** Date Denied: _____ Date Denial Letter Mailed: _____ Case Mgr. Initials

LONG TERM CARE ASSESSMENT FOR INSTRUMENTAL ACTIVITIES OF DAILY LIVING

HYGIENE:
Definition: The ability to perform grooming, shaving, nail care, body care, oral care or hair care for the purpose of maintaining adequate hygiene.

IADL SCORE CRITERIA
☐ 0=The client is independent in completing activity safely.
☐ 1=The client can manage their personal hygiene and grooming but must be reminded or supervised at least some of the time.
☐ 2=The client regularly requires verbal and/or hands on assistance with personal hygiene and grooming and cooperates in the process.
☐ 3=The client is dependent on others to provide all personal hygiene or grooming and/or is uncooperative with the process.

Comments:

MEDICATION MANAGEMENT:
Definition: The ability to follow prescribed medication regime.

IADL SCORE CRITERIA
☐ 0=The client is Independent in completing activity safely.
☐ 1=The client is physically able to take medications but requires another person to (a) remind, monitor or observe the taking of medications less than daily; or (b) open a container, lay out or organize medications less than daily.
☐ 2=The client can physically take medications, but requires another person to either remind, monitor, or observe the taking of medications daily, or the client can physically take medications if another person daily opens containers, lays out, organizes medications.
☐ 3=The client cannot physically take medications and requires another person to assist and administer medications.

Comments:

TRANSPORTATION:
Definition: The ability to drive and/or access transportation services in the community.

IADL SCORE CRITERIA
☐ 0=The client is independent in completing activity.
☐ 1=The client cannot drive or can drive but should not; or public transportation is not available.
☐ 2=The client requires assistance or supervision to arrange transportation but can use the transportation without assistance during the trip.
☐ 3=The client is totally dependent on being accompanied or helped by others during the trip and requires assistance to arrange transportation.

Comments:

Instrumental Activities of Daily Living (continued)

MONEY MANAGEMENT:

Definition: The ability to handle money, pay bills, plan, budget, write checks or money orders, exchange currency, handle coins and paper work, i.e. to do financial management for basic necessities (food, clothing, shelter). Do not check if limitation is only cultural (e.g., recent immigrant who has not learned U.S. currency and/or English language).

IADL SCORE CRITERIA

☐ 0=The client is independent in completing activity.
☐ 1=The client requires cueing and/or supervision. May need minimal physical assistance.
☐ 2=The client requires assistance in budgeting, paying bills, planning, writing checks or money orders and related paperwork. Client has the ability to manage small amounts of discretionary money without assistance.
☐ 3=The client is totally dependent on others for all financial transactions and money handling.

Comments:

SHOPPING:

Definition: The ability to run errands and shop; select appropriate items, get around in a store, physically acquire, transport and put away items (money management not considered in this activity).

IADL SCORE CRITERIA

☐ 0=The client is independent in completing activity.
☐ 1=The client is physically able to shop but needs prompts/cueing to initiate task.
☐ 2=The client requires accompaniment and verbal cues, and/or physical assistance during the activity.
☐ 3=The client is totally dependent on others to do essential shopping.

Comments:

MEAL PREPARATION:

Definition: The ability to obtain and prepare routine meals. This includes the ability to independently open containers and use kitchen appliances, with assistive devices if person uses them. If the person is fed via tube feedings or intravenously, treat preparation of the tube feeding as meal preparation and indicate level of help needed.

IADL SCORE CRITERIA

☐ 0=The client is independent in completing activity.
☐ 1=The client requires some instruction or physical assistance to prepare meals.
☐ 2=The client can participate but needs substantial assistance to prepare meals.
☐ 3=The client cannot prepare or participate in preparation of meals.

Comments:

Instrumental Activities of Daily Living (continued)

LAUNDRY:
Definition: The ability to maintain cleanliness of personal clothing and linens.

IADL SCORE CRITERIA
☐ 0=Independent in completing activity.
☐ 1=The client is physically capable of using laundry facilities, but requires cueing and/or supervision.
☐ 2=The client is not able to use laundry facilities without physical assistance.
☐ 3=The client is dependent upon others to do all laundry.

Comments:

ACCESSING RESOURCES:
Definition: The ability to identify needs and locate appropriate resources; is able to complete phone calls, setup and follow through with appointments and to complete paperwork necessary to acquire/participate in service/activity offered by the resource.

IADL SCORE CRITERIA
☐ 0=The client is independent in completing activity.
☐ 1=The client is capable with minimal prompts or cues to complete some of the tasks associated with accessing resources.
☐ 2=The client requires substantial prompts/cues or physical assistance to complete most of the tasks associated with accessing resources.
☐ 3=The client is totally dependent upon others to access resources and follow through with appointments.

Comments:

HOUSEWORK:
Definition: The ability to maintain cleanliness of the living environment.

IADL SCORE CRITERIA
☐ 0=The client is independent in completing activity.
☐ 1=The client is physically capable of performing essential housework tasks but requires minimal prompts/cues or supervision to complete essential housework tasks.
☐ 2=The client requires substantial prompts/cues or supervision and/or physical assistance to complete essential housework tasks. The client may be able to perform some housekeeping tasks but may require another person to complete heavier cleaning tasks.
☐ 3=The client is dependent upon others to do all housework in client use area.

Comments:

Strengths Assessment and Evaluation

Please identify strengths in each domain:

SOCIAL SUPPORTS	PARTICIPATIION IN ACTIVITIES	EXTERNAL RESOURCES	HEALTH AND WELLNESS	PERSONAL ASSETS
☐ Supportive family ☐ Supportive friends ☐ Caring neighbors ☐ Community recognition and respect ☐ Sense of a place in the world ☐ Other:_____ ☐ Other: _____	☐ Creative activities ☐ Church/spiritual activities ☐ Community activities ☐ Clubs, groups, planned meetings ☐ Volunteer service opportunities ☐ Other: _____ ☐ Other: _____	☐ Adequate housing ☐ Financial security ☐ Adequate transportation ☐ Safe environment ☐ Access to safety resources ☐ Medical equipment ☐ Other: _____ ☐ Other:_____	☐ Adequate physical health ☐ Balanced mental health ☐ Self care ability or resources ☐ Adequate medical access ☐ Commitment to health ☐ Knowledge about how choices impact health ☐ Other:_____ ☐ Other:_____	☐ Positive self-image ☐ sense of empowerment ☐ positive view of others ☐ positive view of the future ☐ adequate communication skills ☐ sense of purpose ☐ ability to ask for and accept help ☐ ability to accept personal responsibility ☐ other:_____ ☐ other:_____

LIST STRENGTHS / ASSETS THREATENED OR RECENTLY WEAKENED

STRENGTH / ASSET	WHY WEAKENED OR THREATENED?

LIST STRENGTHS CLIENT WOULD LIKE TO INCREASE OR ADD TO A DOMAIN		
STRENGTH:	**HOW COULD THIS BE INCREASED OR ADDED?**	**WHO WILL TAKE THE FIRST STEP?**

Self Reported Physical Health

Medical Treatments or Therapy Regimes:

Services Needed:					
Skilled	N	R	Freq	D/W/M	Provider Name
Blood sugar monitoring	☐	☐			
Bowel/Bladder program	☐	☐			
Catheter care	☐	☐			
Dialysis	☐	☐			
Foot Care	☐	☐			
Injections	☐	☐			
IV Therapies	☐	☐			
Medication monitor	☐	☐			
Oxygen	☐	☐			
Occupational therapy	☐	☐			
Ostomy care	☐	☐			
Physical therapy regime	☐	☐			
Range of motion	☐	☐			
Respiratory treatment Speech therapy	☐	☐			
regime	☐	☐			
Suctioning	☐	☐			
Tube Feeding	☐	☐			
Ventilator Assistance	☐	☐			
Wound care/Dressing	☐	☐			
Other:_____	☐	☐			

Comments:

Psycho/Social Health:

Support Systems:	Caregiver?	Phone:	Contacted?
☐ Spouse:	☐		☐
☐ Friends:	☐		☐
☐ Family:	☐		☐
☐ Neighbor:	☐		☐
☐ Faith Based Name:	☐		☐
☐ Support Group:	☐		☐
☐ Agency/ Organization:	☐		☐
☐ Community Based:	☐		☐

Psycho/Social Problems:	
☐ Psychological illness present	**Significant Changes**
☐ Psychological illness history	**Losses**
☐ Depression	☐ Death of spouse
☐ Nervousness	☐ Death of friend/family member
☐ Crying	☐ Death of pet
☐ Insomnia	**Changes**
☐ Nightmares	☐ Change in residence ☐ Divorce/separation ☐ Retirement
☐ Loss of appetite ☐ Concerns regarding potential psychosocial situation ☐ Poor eye contact ☐ Alcohol/Substance Abuse	**Threat/Victim** ☐ Financial concern ☐ Safety concerns ☐ Victim of assault/theft ☐ Victim of abuse/neglect

LONG TERM CARE PLAN

Non-Medicaid Services Available to Address Needs			
Service	**Provider**	**Frequency and Duration**	**Availability**

Medicaid Services

Equipment:	Have	Need	Equipment:	Have	Need
Adaptive Seating	☐	☐	Intermittent Catheter	☐	☐
Adaptive Utinsels	☐	☐	IV Equipment	☐	☐
Assistive Technology	☐	☐	Kitchen Access	☐	☐
Augmentative Communication Device	☐	☐	Lift chair Manual Lift	☐	☐
Bath Mat	☐	☐	Mechanical Lift	☐	☐
Bath/Shower Chair	☐	☐	Medication Box	☐	☐
Bathroom Access	☐	☐	Medication Dispenser	☐	☐
Braces	☐	☐	Monitors	☐	☐
Cane	☐	☐	Orthotics	☐	☐
Circulation Stockings	☐	☐	Ostomy Supplies	☐	☐
Cleaning Equipment	☐	☐	Pivot Board	☐	☐
Cleaning Supplies	☐	☐	Plate Guard	☐	☐
Commode	☐	☐	Protheses	☐	☐
Crutches	☐	☐	Ramp	☐	☐
Electric Lift	☐	☐	Reacher	☐	☐
Electronic Monitor	☐	☐	Roll-In Shower	☐	☐
External Catheter	☐	☐	Scooter	☐	☐
Feeding Pump	☐	☐	Sliding Board	☐	☐
Feeding Tubes	☐	☐	Sock Aide	☐	☐
Foley Catheter	☐	☐	Standing Frame	☐	☐
Gait Belt	☐	☐	Transfer Bench	☐	☐
Grab Bars	☐	☐	Urinal	☐	☐
Hand Held Shower	☐	☐	Walker	☐	☐
Handrail	☐	☐	Wheelchair	☐	☐
Hi Riser	☐	☐	Other:_____	☐	☐

N = Needs
R = Receiving
D/W/M = Daily, Weekly, Monthly

Skilled Medicaid Services						
Skilled	N	R	Freq	D/W/M	Provider Name	Task to be completed
CNA	☐	☐				
LPN	☐	☐				
RN	☐	☐				
Psych RN	☐	☐				
Self	☐	☐				
Family	☐	☐				
Unpaid Provider	☐	☐				
Nursing Home	☐	☐				
PT	☐	☐				
OT	☐	☐				
RT	☐	☐				
ST	☐	☐				
Ambulance	☐	☐				

Comments:

Unskilled Medicaid Services						
Unskilled	N	R	Freq	D/W/M	Provider Name	Tasks to be completed
ACF/AFC	☐	☐				
ADC	☐	☐				
Counselor	☐	☐				
EM	☐	☐				
Family	☐	☐				
Home Care Provider	☐	☐				
Home Mod	☐	☐				
Homemaker	☐	☐				
ILST	☐	☐				
Med. Transport.	☐	☐				
Medication Dispense	☐	☐				
Non-Med. Transport.	☐	☐				
PCP	☐	☐				
Pest Control	☐	☐				
Self	☐	☐				
Unpaid	☐	☐				
Voc. Rehab	☐	☐				

Comments: