Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MassHealth Chronic Disease and Rehabilitation Hospital Bulletin 83 January 2003

TO: Chronic Disease and Rehabilitation Hospitals Participating in MassHealth

FROM: Wendy E. Warring, Commissioner

RE: **Changes in Clinical Assessment Forms**

Background

The Division determines clinical eligibility for MassHealth long-term-care services based upon documentation submitted by the provider. The Long Term Care Assessment form has been replaced by two new forms in order to facilitate communication between providers and the Division.

New Forms

Attached to this bulletin are copies of the two new forms required for approving referrals for long-term-care services, including, but not limited to, nursing-facility and adult-day-health services.

- Request for Services (RFS-1) (formerly called the MassHealth Long Term Care Assessment form)
- Minimum Data Set – Home Care (MDS-HC)

Chronic disease and rehabilitation hospitals must begin using these new forms by February 1, 2003. Please discard all previous versions of the Long Term Care Assessment form.

Who May Complete the MDS-HC

The MDS-HC must be completed by an assessment coordinator. The assessment coordinator must be a registered nurse who certifies the accuracy and completeness of the MDS-HC.

The following sections of the MDS-HC may be completed by a licensed social worker (LSW, LCSW, or LICSW).

AA – Name and Identification Numbers
BB – Personal Items
CC – Referral Items
B – Cognitive Patterns
C – Communication/Hearing Patterns
E – Mood and Behavior Patterns
F – Social Functioning
G – Informal Support Services
O – Environmental Assessment

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Who May Complete the MDS-HC (cont.)

Each person who completes a portion of the MDS-HC must sign and certify the sections he or she completes in Section R – Assessment Information (Other Signatures, Title, Sections, Date).

Qualifications for Completing the Forms

The registered nurse or social worker must be licensed by the Massachusetts Board of Registration.

ICD-9-CM Codes

The MDS-HC assessment requires the use of the ICD-9-CM codes for medical diagnoses.

Trainings

The Division holds periodic trainings for providers. You will receive notice of trainings when they are scheduled.

Supplies of the Forms

You may photocopy the forms as needed. To obtain supplies of the forms, use the information below to mail or fax your request. Include your provider number, address, telephone number, the exact title of the form, and the desired quantity.

MassHealth Forms Distribution
P.O. Box 9101
Somerville, MA 02145
Fax: 703-917-4087

Questions

If you have any questions about this bulletin, please contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

MINIMUM DATA SET - HOME CARE (MDS-HC)©

• Unless otherwise noted, score for last 3 days

• Examples of exceptions include IADLs/Continence/Services/Treatments where status scored over last 7 days

SECTION AA. NAME AND IDENTIFICATION NUMBERS

1.	NAME OF CLIENT	**a.** (Last/Family Name) **b.** (First Name) **c.** (Middle Initial)
2.	CASE RECORD NO.	
3.	GOVERNMENT PENSION AND HEALTH INSURANCE NUMBERS	**a.** Pension (Social Security) Number ___ — ___ — ____ **b.** Health insurance number (or other comparable insurance number)

SECTION BB. PERSONAL ITEMS *(Complete at Intake Only)*

1.	GENDER	1. Male 2. Female
2.	BIRTHDATE	Month — Day — Year
3.	RACE/ ETHNICITY	(***Check all that apply***) ***RACE*** American Indian/Alaskan Native **a.** Asian **b.** Black or African American **c.** Native Hawaiian or other Pacific Islander **d.** White **e.** ***ETHNICITY***: Hispanic or Latino **f.**
4.	MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced 6. Other
5.	LANGUAGE	Primary Language 0. English 1. Spanish 2. French 3. Other
6.	EDUCATION (*Highest Level Completed*)	1. No schooling 2. 8th grade/less 3. 9-11 grades 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree
7.	RESPONSIBILITY/ ADVANCED DIRECTIVES	(***Code for responsibility/advanced directives***) 0. No 1. Yes **a.** Client has a legal guardian **b.** Client has advanced medical directives in place (for example, a do not hospitalize order)

SECTION CC. REFERRAL ITEMS *(Complete at Intake Only)*

1.	DATE CASE OPENED/ REOPENED	Month — Day — Year
2.	REASON FOR REFERRAL	1. Post hospital care 2. Community chronic care 3. Home placement screen 4. Eligibility for home care 5. Day care 6. Other
3.	GOALS OF CARE	(***Code for client/family understanding of goals of care***) 0. No 1. Yes **a.** Skilled nursing treatments **b.** Monitoring to avoid clinical complications **c.** Rehabilitation **d.** Client/family education **e.** Family respite **f.** Palliative care
4.	TIME SINCE LAST HOSPITAL STAY	Time since discharge from last in-patient setting (***Code for most recent instance in LAST 180 DAYS***) 0. No hospitalization within 180 days 1. Within last week 2. Within 8 to 14 days 3. Within 15 to 30 days 4. More than 30 days ago
5.	WHERE LIVED AT TIME OF REFERRAL	1. Private home/apt. with no home care services 2. Private home/apt. with home care services 3. Board and care/assisted living/group home 4. Nursing home 5. Other
6.	WHO LIVED WITH AT REFERRAL	1. Lived alone 2. Lived with spouse only 3. Lived with spouse and other(s) 4. Lived with child (not spouse) 5. Lived with other(s) (not spouse or children) 6. Lived in group setting with non-relative(s)
7.	PRIOR NH PLACEMENT	Resided in a nursing home at anytime during **5 YEARS** prior to case opening 0. No 1. Yes
8.	RESIDENTIAL HISTORY	Moved to current residence within last two years 0. No 1. Yes

SECTION A. ASSESSMENT INFORMATION

1.	ASSESSMENT REFERENCE DATE	***Date of assessment*** Month — Day — Year
2.	REASONS FOR ASSESSMENT	***Type of assessment*** 1. Initial assessment 2. Follow-up assessment 3. Routine assessment at fixed intervals 4. Review within 30-day period prior to discharge from the program 5. Review at return from hospital 6. Change in status 7. Other

SECTION B. COGNITIVE PATTERNS

1.	MEMORY RECALL ABILITY	(***Code for recall of what was learned or known***) 0. Memory OK 1. Memory problem **a.** Short-term memory OK — seems/appears to recall after 5 minutes **b.** Procedural memory OK—Can perform all or almost all steps in a multitask sequence without cues for initiation
2.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	**a.** How well client made decisions about organizing the day (e.g., when to get up or have meals, which clothes to wear or activities to do) 0. *INDEPENDENT*—Decisions consistent/reasonable/safe 1. *MODIFIED INDEPENDENCE*—Some difficulty in new situations only 2. *MINIMALLY IMPAIRED*—In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times 3. *MODERATELY IMPAIRED*—Decisions consistently poor or unsafe, cues/supervision required at all times 4. *SEVERELY IMPAIRED*—Never/rarely made decisions **b.** Worsening of decision making as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes
3.	INDICATORS OF DELIRIUM	**a.** Sudden or new onset/change in mental function over **LAST 7 DAYS** (including ability to pay attention, awareness of surroundings, being coherent, unpredictable variation over course of day) 0. No 1. Yes **b.** In the **LAST 90 DAYS** (or since last assessment if less than 90 days), client has become agitated or disoriented such that his or her safety is endangered or client requires protection by others 0. No 1. Yes

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	(*With hearing appliance if used*) 0. *HEARS ADEQUATELY*—Normal talk, TV, phone, doorbell 1. *MINIMAL DIFFICULTY*—When not in quiet setting 2. *HEARS IN SPECIAL SITUATIONS ONLY*—Speaker has to adjust tonal quality and speak distinctly 3. *HIGHLY IMPAIRED* —Absence of useful hearing
2.	MAKING SELF UNDERSTOOD (Expression)	(*Expressing information content—however able*) 0. *UNDERSTOOD*—Expresses ideas without difficulty 1. *USUALLY UNDERSTOOD*—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required 2. *OFTEN UNDERSTOOD*—Difficulty finding words or finishing thoughts, prompting usuallly required 3. *SOMETIMES UNDERSTOOD*—Ability is limited to making concrete requests 4. *RARELY/NEVER UNDERSTOOD*
3.	ABILITY TO UNDERSTAND OTHERS (Comprehension)	(*Understands verbal information—however able*) 0. *UNDERSTANDS*—Clear comprehension 1. *USUALLY UNDERSTANDS*—Misses some part/intent of message, BUT comprehends most conversation with little or no prompting 2. *OFTEN UNDERSTANDS*—Misses some part/intent of message; with prompting can often comprehend conversation 3. *SOMETIMES UNDERSTANDS*—Responds adequately to simple, direct communication 4. *RARELY/NEVER UNDERSTANDS*
4.	COMMUNICATION DECLINE	Worsening in communication (making self understood or understanding others) as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes

SECTION D. VISION PATTERNS

1.	VISION	(*Ability to see in adequate light and with glasses if used*) 0. *ADEQUATE*—Sees fine detail, including regular print in newspapers/ books 1. *IMPAIRED*—Sees large print, but not regular print in newspapers/ books 2. *MODERATELY IMPAIRED*—Limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—Object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—No vision or sees only light, colors, or shapes; eyes do not appear to follow objects
2.	VISUAL LIMITATION/ DIFFICULTIES	Saw halos or rings around lights, curtains over eyes, or flashes of lights 0. No 1. Yes
3.	VISION DECLINE	Worsening of vision as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (***Code for observed indicators irrespective of the assumed cause***)

0. Indicator not exhibited in last 3 days
1. Exhibited 1-2 of last 3 days
2. Exhibited on each of last 3 days

- **a. A FEELING OF SADNESS OR BEING DEPRESSED**, that life is not worth living, that nothing matters, that he or she is of no use to anyone or would rather be dead
- **b. PERSISTENT ANGER WITH SELF OR OTHERS**—e.g., easily annoyed, anger at care received
- **c. EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS**—e.g., fear of being abandoned, left alone, being with others
- **d. REPETITIVE HEALTH COMPLAINTS**—e.g., persistently seeks medical attention, obsessive concern with body functions
- **e. REPETITIVE ANXIOUS COMPLAINTS, CONCERNS**—e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues
- **f. SAD, PAINED, WORRIED FACIAL EXPRESSIONS**—e.g., furrowed brows
- **g. RECURRENT CRYING, TEARFULNESS**
- **h. WITHDRAWAL FROM ACTIVITIES OF INTEREST**—e.g., no interest in long standing activities or being with family/friends
- **i. REDUCED SOCIAL INTERACTION**

2. MOOD DECLINE Mood indicators have become worse as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No 1. Yes

3. BEHAVIORAL SYMPTOMS Instances when client exhibited behavioral symptoms. If EXHIBITED, ease of altering the symptom when it occurred.

0. Did not occur in last 3 days
1. Occurred, easily altered
2. Occurred, not easily altered

- **a. WANDERING**—Moved with no rational purpose, seemingly oblivious to needs or safety
- **b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS**—Threatened, screamed at, cursed at others
- **c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS**—Hit, shoved, scratched, sexually abused others
- **d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS**—Disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smears/throws food/feces, rummaging, repetitive behavior, rises early and causes disruption
- **e. RESISTS CARE**—Resisted taking medications/injections, ADL assistance, eating, or changes in position

4. CHANGES IN BEHAVIOR SYMPTOMS Behavioral symptoms have become worse or are less well tolerated by family as compared to **90 DAYS AGO** (or since last assessment if less than 90 days)
0. No, or no change in behavioral symptoms 1. Yes

SECTION F. SOCIAL FUNCTIONING

1. INVOLVEMENT
- **a.** At ease interacting with others (e.g., likes to spend time with others)
  0. At ease 1. Not at ease
- **b.** Openly expresses conflict or anger with family/friends
  0. No 1. Yes

2. CHANGE IN SOCIAL ACTIVITIES As compared to **90 DAYS AGO** (or since last assessment if less than 90 days ago), decline in the client's level of participation in social, religious, occupational or other preferred activities. IF THERE WAS A DECLINE, client distressed by this fact
0. No decline
1. Decline, not distressed
2. Decline, distressed

3. ISOLATION
- **a.** Length of time client is alone during the day (morning and afternoon)
  0. Never or hardly ever
  1. About one hour
  2. Long periods of time—e.g., all morning
  3. All of the time
- **b.** Client says or indicates that he/she feels lonely
  0. No 1. Yes

SECTION G. INFORMAL SUPPORT SERVICES

1. TWO KEY INFORMAL HELPERS **Primary (A) and Secondary (B)**

NAME OF PRIMARY AND SECONDARY HELPERS

a. (Last/Family Name) **b.** (First)

c. (Last/Family Name) **d.** (First)

	(A) Prim	(B) Secn
e. Lives with client 0. Yes 1. No 2. No such helper [skip other items in the appropriate column]		
f. Relationship to client 0. Child or child-in-law 2. Other Relative 1. Spouse 3. Friend/neighbor		
Areas of help: 0. Yes 1. No		
g. — Advice or emotional support		
h. — IADL care		
i. — ADL care		

1. TWO KEY INFORMAL HELPERS **Primary (A) and Secondary (B)** **(cont)**

	(A) Prim	(B) Secn
If needed, willingness (with ability) to increase help: 0. More than 2 hours 1. 1-2 hours per day 2. No		
j. — Advice or emotional support		
k. — IADL care		
l. — ADL care		

2. CAREGIVER STATUS (***Check all that apply***)

- A caregiver is unable to continue in caring activities—e.g., decline in the health of the caregiver makes it difficult to continue — **a.**
- Primary caregiver is not satisfied with support received from family and friends (e.g., other children of client) — **b.**
- Primary caregiver expresses feelings of distress, anger or depression — **c.**
- *NONE OF ABOVE* — **d.**

3. EXTENT OF INFORMAL HELP (HOURS OF CARE, ROUNDED) For instrumental and personal activities of daily living received over the **LAST 7 DAYS**, indicate extent of help from family, friends, and neighbors

HOURS

- **a.** Sum of time across five weekdays
- **b.** Sum of time across two weekend days

SECTION H. PHYSICAL FUNCTIONING:
• IADL PERFORMANCE IN 7 DAYS
• ADL PERFORMANCE IN 3 DAYS

1. IADL SELF PERFORMANCE—Code for functioning in routine activities around the home or in the community during the **LAST 7 DAYS**,

(A) IADL SELF PERFORMANCE CODE (***Code*** *for client's* ***performance during LAST 7 DAYS***)
0. *INDEPENDENT*—did on own
1. *SOME HELP*—help some of the time
2. *FULL HELP*—performed with help all of the time
3. *BY OTHERS*—performed by others
8. *ACTIVITY DID NOT OCCUR*

(B) IADL DIFFICULTY CODE *How difficult it is (or would it be) for client to do activity on own*
0. *NO DIFFICULTY*
1. *SOME DIFFICULTY*—e.g., needs some help, is very slow, or fatigues
2. *GREAT DIFFICULTY*—e.g., little or no involvement in the activity is possible

	(A) Performance	(B) Difficulty
a. MEAL PREPARATION—How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils)		
b. ORDINARY HOUSEWORK—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)		
c. MANAGING FINANCE—How bills are paid, checkbook is balanced, household expenses are balanced		
d. MANAGING MEDICATIONS—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)		
e. PHONE USE—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)		
f. SHOPPING—How shopping is performed for food and household items (e.g., selecting items, managing money)		
g. TRANSPORTATION—How client travels by vehicle (e.g., gets to places beyond walking distance)		

2. ADL SELF-PERFORMANCE—The following address the client's physical functioning in routine personal activities of daily life, for example, dressing, eating, etc. during the **LAST 3 DAYS**, **considering all episodes of these activities**. For clients who performed an activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity [*Note—For bathing, code for most dependent single episode in* ***LAST 7 DAYS***]

0. *INDEPENDENT*—No help, setup, or oversight —OR— Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. *SETUP HELP ONLY*—Article or device provided within reach of client 3 or more times
2. *SUPERVISION*—Oversight, encouragement or cueing provided 3 or more times during last 3 days —OR— Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision)
3. *LIMITED ASSISTANCE*—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help)
4. *EXTENSIVE ASSISTANCE*—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times:
   — Weight-bearing support —OR—
   — Full performance by another during part (but not all) of last 3 days
5. *MAXIMAL ASSISTANCE*—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times
6. *TOTAL DEPENDENCE*—Full performance of activity by another
8. *ACTIVITY DID NOT OCCUR* (regardless of ability)

2.	ADL SELF-PERFORMANCE (cont)	
	a. MOBILITY IN BED—Including moving to and from lying position, turning side to side, and positioning body while in bed.	
	b. TRANSFER—Including moving to and between surfaces—to/from bed, chair, wheelchair, standing position. [*Note—Excludes to/from bath/toilet*]	
	c. LOCOMOTION IN HOME—[Note—If in wheelchair, self-sufficiency once in chair]	
	d. LOCOMOTION OUTSIDE OF HOME—[Note—If in wheelchair, self-sufficiency once in chair]	
	e. DRESSING UPPER BODY—How client dresses and undresses (**street clothes, underwear**) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.	
	f. DRESSING LOWER BODY—How client dresses and undresses (**street clothes, underwear**) from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners	
	g. EATING—Including taking in food by any method, including tube feedings.	
	h. TOILET USE—Including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing any special devices required (ostomy or catheter), and adjusting clothes.	
	i. PERSONAL HYGIENE—Including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (EXCLUDE baths and showers)	
	j. BATHING—How client takes full-body bath/shower or sponge bath (**EXCLUDE** washing of back and hair). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. ***Code for most dependent episode in LAST 7 DAYS***	
3.	**ADL DECLINE** — ADL status has become worse (i.e., now more impaired in self performance) as compared to status **90 days ago** (or since last assessment if less than 90 days) 0. No 1. Yes	
4.	**PRIMARY MODES OF LOCOMOTION** 0. No assistive device 3. Scooter (e.g., Amigo) 1. Cane 4. Wheelchair 2. Walker/crutch 8. ACTIVITY DID NOT OCCUR	
	a. Indoors	
	b. Outdoors	
5.	**STAIR CLIMBING** — In the **last 3 days**, how client went up and down stairs (e.g., single or multiple steps, using handrail as needed) 0. Up and down stairs without help 1. Up and down stairs with help 2. Not go up and down stairs	
6.	**STAMINA** — **a.** In a typical week, during the **LAST 30 DAYS** (or since last assessment), code the number of days client usually went out of the house or building in which client lives (no matter how short a time period) 0. Every day 2. 1 day a week 1. 2-6 days a week 3. No days	
	b. Hours of physical activities in the **last 3 days** (e.g., walking, cleaning house, exercise) 0. Two or more hours 1. Less than two hours	
7.	**FUNCTIONAL POTENTIAL** — Client believes he/she capable of increased functional independence (ADL, IADL, mobility)	a.
	Caregivers believe client is capable of increased functional independence (ADL, IADL, mobility)	b.
	Good prospects of recovery from current disease or conditions, improved health status expected	c.
	NONE OF ABOVE	d.

SECTION I. CONTINENCE IN LAST 7 DAYS

1.	**BLADDER CONTINENCE**	**a. In LAST 7 DAYS** control of urinary bladder function (with appliances such as catheters or incontinence program employed) [Note—if dribbles, volume insufficient to soak through underpants] 0. *CONTINENT*—Complete control; DOES NOT USE any type of catheter or other urinary collection device 1. *CONTINENT WITH CATHETER*—Complete control with use of any type of catheter or urinary collection device that does not leak urine 2. *USUALLY CONTINENT*—Incontinent episodes once a week or less 3. *OCCASIONALLY INCONTINENT*—Incontinent episodes 2 or more times a week but not daily 4. *FREQUENTLY INCONTINENT*—Tends to be incontinent daily, but some control present 5. *INCONTINENT*—Inadequate control, multiple daily episodes 8. *DID NOT OCCUR*—No urine output from bladder
		b. Worsening of bladder incontinence as compared to status **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes
2.	**BLADDER DEVICES**	(***Check all that apply in LAST 7 DAYS***)
		Use of pads or briefs to protect against wetness — a.
		Use of an indwelling urinary catheter — b.
		NONE OF ABOVE — c.

3.	**BOWEL CONTINENCE**	In **LAST 7 DAYS**, control of bowel movement (with appliance or bowel continence program if employed) 0. *CONTINENT*—Complete control; DOES NOT USE ostomy device 1. *CONTINENT WITH OSTOMY*—Complete control with use of ostomy device that does not leak stool 2. *USUALLY CONTINENT*—Bowel incontinent episodes less than weekly 3. *OCCASIONALLY INCONTINENT*—Bowel incontinent episode once a week 4. *FREQUENTLY INCONTINENT*—Bowel incontinent episodes 2-3 times a week 5. *INCONTINENT*—Bowel incontinent all (or almost all) of the time 8. *DID NOT OCCUR*—No bowel movement during entire 7 day assessment period

SECTION J. DISEASE DIAGNOSES

Disease/infection that doctor has indicated is present and affects client's status, requires treatment, or symptom management. Also include if disease is monitored by a home care professional or is the reason for a hospitalization in **LAST 90 DAYS** (or since last assessment if less than 90 days)

[blank]. Not present
1. Present—not subject to focused treatment or monitoring by home care professional
2. Present—monitored or treated by home care professional
[If no disease in list, check **J1ac**, *None of Above*]

1.	**DISEASES**				
		HEART/CIRCULATION		**p.** Osteoporosis	
		a. Cerebrovascular accident (stroke)		**SENSES**	
		b. Congestive heart failure		**q.** Cataract	
		c. Coronary artery disease		**r.** Glaucoma	
		d. Hypertension		**PSYCHIATRIC/MOOD**	
		e. Irregularly irregular pulse		**s.** Any psychiatric diagnosis	
		f. Peripheral vascular disease		**INFECTIONS**	
		NEUROLOGICAL		**t.** HIV infection	
		g. Alzheimer's		**u.** Pneumonia	
		h. Dementia other than Alzheimer's disease		**v.** Tuberculosis	
		i. Head trauma		**w.** Urinary tract infection (**in LAST 30 DAYS**)	
		j. Hemiplegia/hemiparesis		**OTHER DISEASES**	
		k. Multiple sclerosis		**x.** Cancer—(in past 5 years) not including skin cancer	
		l. Parkinsonism		**y.** Diabetes	
		MUSCULO-SKELETAL		**z.** Emphysema/COPD/asthma	
		m. Arthritis		**aa.** Renal Failure	
		n. Hip fracture		**ab.** Thyroid disease (hyper or hypo)	
		o. Other fractures (e.g., wrist, vertebral)		**ac.** *NONE OF ABOVE*	ac.
2.	**OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES**	a.			
		b.			
		c.			
		d.			

SECTION K. HEALTH CONDITIONS AND PREVENTIVE HEALTH MEASURES

1.	**PREVENTIVE HEALTH (PAST TWO YEARS)**	(***Check all that apply—in PAST 2 YEARS***)	
		Blood pressure measured	a.
		Received influenza vaccination	b.
		Test for blood in stool or screening endoscopy	c.
		IF FEMALE: Received breast examination or mammography	d.
		NONE OF ABOVE	e.

2.	**PROBLEM CONDITIONS PRESENT ON 2 OR MORE DAYS**	(***Check all that were present on at least 2 of the last 3 days***)			
		Diarrhea	a.	Loss of appetite	d.
		Difficulty urinating or urinating 3 or more times at night	b.	Vomiting	e.
		Fever	c.	*NONE OF ABOVE*	f.

3.	**PROBLEM CONDITIONS**	(***Check all present at any point during last 3 days***)			
		PHYSICAL HEALTH		Shortness of breath	e.
		Chest pain/pressure at rest or on exertion	a.	**MENTAL HEALTH**	
		No bowel movement in 3 days	b.	Delusions	f.
		Dizziness or lightheadedness	c.	Hallucinations	g.
		Edema	d.	*NONE OF ABOVE*	h.

4.	PAIN	**a.** Frequency with which client complains or shows evidence of pain 0. No pain (score b-e as 0) 2. Daily - one period 1. Less than daily 3. Daily - multiple periods (e.g., morning and evening)	
		b. Intensity of pain 0. No pain 2. Moderate 4. Times when pain is horrible 1. Mild 3. Severe or excruciating	
		c. From client's point of view, pain intensity disrupts usual activities 0. No 1. Yes	
		d. Character of pain 0. No pain 1. Localized - single site 2. Multiple sites	
		e. From client's point of view, medications adequately control pain 0. Yes or no pain 1. Medications do not adequately control pain 2. Pain present, medication not taken	
5.	FALLS FREQUENCY	Number of times fell in **LAST 90 DAYS** (or since last assessment if less than 90 days) If none, code "0"; if more than 9, code "9"	
6.	DANGER OF FALL	(***Code for danger of falling***) 0. No 1. Yes	
		a. Unsteady gait	
		b. Client limits going outdoors due to fear of falling (e.g., stopped using bus, goes out only with others)	
7.	LIFE STYLE (Drinking/ Smoking)	(***Code for drinking or smoking***) 0. No 1. Yes	
		a. In the LAST 90 DAYS (or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking, or others were concerned with client's drinking	
		b. In the LAST 90 DAYS (or since last assessment if less than 90 days), client had to have a drink first thing in the morning to steady nerves (i.e., an "eye opener") or has been in trouble because of drinking	
		c. Smoked or chewed tobacco daily	
8.	HEALTH STATUS INDICATORS	(**Check all that apply**)	
		Client feels he/she has poor health (when asked)	a.
		Has conditions or diseases that make cognition, ADL, mood, or behavior patterns unstable (fluctuations, precarious, or deteriorating)	b.
		Experiencing a flare-up of a recurrent or chronic problem	c.
		Treatments changed in **LAST 30 DAYS** (or since last assessment if less than 30 days) because of a new acute episode or condition	d.
		Prognosis of less than six months to live—e.g., physician has told client or client's family that client has end-stage disease	e.
		NONE OF ABOVE	f.
9.	OTHER STATUS INDICATORS	(**Check all that apply**)	
		Fearful of a family member or caregiver	a.
		Unusually poor hygiene	b.
		Unexplained injuries, broken bones, or burns	c.
		Neglected, abused, or mistreated	d.
		Physically restrained (e.g., limbs restrained, used bed rails, constrained to chair when sitting)	e.
		NONE OF ABOVE	f.

SECTION L. NUTRITION/HYDRATION STATUS

1.	WEIGHT	(***Code for weight items***) 0. No 1. Yes	
		a. Unintended weight loss of 5% or more in the **LAST 30 DAYS** [or 10% or more in the **LAST 180 DAYS**]	
		b. Severe malnutrition (cachexia)	
		c. Morbid obesity	
2.	CONSUMPTION	(***Code for consumption***) 0. No 1. Yes	
		a. In at least 2 of the last 3 days, ate one or fewer meals a day	
		b. In last 3 days, noticeable decrease in the amount of food client usually eats or fluids usually consumes	
		c. Insufficient fluid—did not consume all/almost all fluids during last 3 days	
		d. Enteral tube feeding	
3.	SWALLOWING	0. *NORMAL*—Safe and efficient swallowing of all diet consistencies 1. *REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS* (mechanical diet or able to ingest specific foods only) 2. *REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS* (puree, thickened liquids) 3. *COMBINED ORAL AND TUBE FEEDING* 4. *NO ORAL INTAKE* (*NPO*)	

SECTION M. DENTAL STATUS (ORAL HEALTH)

1.	ORAL STATUS	(**Check all that apply**)	
		Problem chewing (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control, pain while eating)	a.
		Mouth is "dry" when eating a meal	b.
		Problem brushing teeth or dentures	c.
		NONE OF ABOVE	d.

SECTION N. SKIN CONDITION

1.	SKIN PROBLEMS	Any troubling skin conditions or changes in skin condition (e.g., burns, bruises, rashes, itchiness, body lice, scabies) 0. No 1. Yes	
2.	ULCERS (Pressure/ Stasis)	Presence of an ulcer anywhere on the body. Ulcers include any area of persistent skin redness (Stage 1); partial loss of skin layers (Stage 2); deep craters in the skin (Stage 3); breaks in skin exposing muscle or bone (Stage 4). [**Code 0 if no ulcer, otherwise record the highest ulcer stage (Stage 1-4)**.]	
		a. Pressure ulcer—any lesion caused by pressure, shear forces, resulting in damage of underlying tissues	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	OTHER SKIN PROBLEMS REQUIRING TREATMENT	(***Check all that apply***)	
		Burns (second or third degree)	a.
		Open lesions other than ulcers, rashes, cuts (e.g., cancer)	b.
		Skin tears or cuts	c.
		Surgical wound	d.
		Corns, calluses, structural problems, infections, fungi	e.
		NONE OF ABOVE	f.
4.	HISTORY OF RESOLVED PRESSURE ULCERS	Client previously had (at any time) or has an ulcer anywhere on the body 0. No 1. Yes	
5.	WOUND/ ULCER CARE	(***Check for formal care in LAST 7 DAYS***)	
		Antibiotics, systemic or topical	a.
		Dressings	b.
		Surgical wound care	c.
		Other wound/ulcer care (e.g., pressure relieving device, nutrition, turning, debridement)	d.
		NONE OF ABOVE	e.

SECTION O. ENVIRONMENTAL ASSESSMENT

1.	HOME ENVIRONMENT **[Check any of following that make home environment hazardous or uninhabitable (if none apply, check *NONE OF ABOVE*; if temporarily in institution, base assessment on home visit)]**	Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)	a.
		Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)	b.
		Bathroom and toiletroom (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)	c.
		Kitchen (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs)	d.
		Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic)	e.
		Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)	f.
		Access to home (e.g., difficulty entering/leaving home)	g.
		Access to rooms in house (e.g., unable to climb stairs)	h.
		NONE OF ABOVE	i.
2.	LIVING ARRANGEMENT	**a.** As compared to **90 DAYS AGO** (or since last assessment), client now lives with other persons—e.g., moved in with another person, other moved in with client 0. No 1. Yes	
		b. Client or primary caregiver feels that client would be better off in another living environment 0. No 1. Client only 2. Caregiver only 3. Client and caregiver	

SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

1.	FORMAL CARE (Minutes rounded to even 10 minutes)	Extent of care or care management in **LAST 7 DAYS** (or since last assessment if less than 7 days) involving	(A) # of Days	(B) Hours	(C) Mins
		a. Home health aides			
		b. Visiting nurses			
		c. Homemaking services			
		d. Meals			
		e. Volunteer services			
		f. Physical therapy			
		g. Occupational therapy			
		h. Speech therapy			
		i. Day care or day hospital			
		j. Social worker in home			

2. SPECIAL TREATMENTS, THERAPIES, PROGRAMS

Special treatments, therapies, and programs received or scheduled during the **LAST 7 DAYS** (or since last assessment if less than 7 days) and adherence to the required schedule. Includes services received in the home or on an outpatient basis.

[Blank]. Not applicable 2. Scheduled, partial adherence
1. Scheduled, full adherence as prescribed 3. Scheduled, not received
[If no treatments provided, check *NONE OF ABOVE* **P2aa**]

RESPIRATORY TREATMENTS
- **a.** Oxygen
- **b.** Respirator for assistive breathing
- **c.** All other respiratory treatments

OTHER TREATMENTS
- **d.** Alcohol/drug treatment program
- **e.** Blood transfusion(s)
- **f.** Chemotherapy
- **g.** Dialysis
- **h.** IV infusion - central
- **i.** IV infusion - peripheral
- **j.** Medication by injection
- **k.** Ostomy care
- **l.** Radiation
- **m.** Tracheostomy care

THERAPIES
- **n.** Exercise therapy
- **o.** Occupational therapy
- **p.** Physical therapy

PROGRAMS
- **q.** Day center
- **r.** Day hospital
- **s.** Hospice care
- **t.** Physician or clinic visit
- **u.** Respite care

SPECIAL PROCEDURES DONE IN HOME
- **v.** Daily nurse monitoring (e.g., EKG, urinary output)
- **w.** Nurse monitoring less than daily
- **x.** Medical alert bracelet or electronic security alert
- **y.** Skin treatment
- **z.** Special diet
- **aa.** *NONE OF ABOVE*

3. MANAGEMENT OF EQUIPMENT (In Last 3 Days)

Management codes:
0. Not used
1. Managed on own
2. Managed on own if laid out or with verbal reminders
3. Partially performed by others
4. Fully performed by others

- **a.** Oxygen
- **b.** IV
- **c.** Catheter
- **d.** Ostomy

4. VISITS IN LAST 90 DAYS OR SINCE LAST ASSESSMENT

Enter 0 if none, if more than 9, code "9"

- **a.** Number of times ADMITTED TO HOSPITAL **with** an overnight stay
- **b.** Number of times VISITED EMERGENCY ROOM **without** an overnight stay
- **c.** EMERGENT CARE—including unscheduled nursing, physician, or therapeutic visits to office or home

5. TREATMENT GOALS

Any treatment goals that have been met in the **LAST 90 DAYS** (or since last assessment if less than 90 days)
0. No 1. Yes

6. OVERALL CHANGE IN CARE NEEDS

Overall self sufficiency has changed significantly as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days)
0. No change 1. Improved—receives fewer supports 2. Deteriorated—receives more support

7. TRADE OFFS

Because of limited funds, during the last month, client made trade-offs among purchasing any of the following: prescribed medications, sufficient home heat, necessary physician care, adequate food, home care
0. No 1. Yes

SECTION Q. MEDICATIONS

1. NUMBER OF MEDICATIONS

Record the number of different medicines (prescriptions and over the counter), including eye drops, taken regularly or on an occasional basis in the **LAST 7 DAYS** (or since last assessment)[*If none, code "0", if more than 9, code "9"*]

2. RECEIPT OF PSYCHOTROPIC MEDICATION

Psychotropic medications taken in the **LAST 7 DAYS** (or since last assesssment) [Note—Review client's medications with the list that applies to the following categories] 0. No 1. Yes

- **a.** Antipsychotic/neuroleptic
- **b.** Anxiolytic
- **c.** Antidepressant
- **d.** Hypnotic

3. MEDICAL OVERSIGHT

Physician reviewed client's medications as a whole in **LAST 180 DAYS** (or since last assessment)
0. Discussed with at least one physician (or no medication taken)
1. No single physician reviewed all medications

4. COMPLIANCE/ ADHERENCE WITH MEDICATIONS

Compliant all or most of time with **medications** prescribed by physician (both during and between therapy visits) in **LAST 7 DAYS**

0. Always compliant
1. Compliant 80% of time or more
2. Compliant less than 80% of time, including failure to purchase prescribed medications
3. *NO MEDICATIONS PRESCRIBED*

5. LIST OF ALL MEDICATIONS

List prescribed and nonprescribed medications taken in **LAST 7 DAYS** (or since last assessment)

a. Name and Dose—Record the name of the medication and dose ordered.

b. Form: Code the route of Administration using the following list:

1. By mouth (PO)
2. Sub lingual (SL)
3. Intramuscular (IM)
4. Intravenous (IV)
5. Subcutaneous (SQ)
6. Rectal (R)
7. Topical
8. Inhalation
9. Enteral tube
10. Other

c. Number taken—Record the amount of medication administered each time the medication is given

d. Freq: Code the number of times per day, week, or month the medication is administered using the following list:

PRN.	As necessary	5D.	Five times daily
QH.	Every hour	QOD.	Every other day
Q2H.	Every two hours	QW.	Once each wk
Q3H.	Every three hours	2W.	Two times every week
Q4H.	Every four hours	3W.	Three times every week
Q6H.	Every six hours	4W.	Four times each week
Q8H.	Every eight hours	5W.	Five times each week
QD.	Once daily	6W.	Six times each week
BID.	Two times daily (includes every 12 hrs)	1M.	Once every month
		2M.	Twice every month
TID.	Three times daily	C.	Continuous
QID.	Four times daily	O.	Other

a. Name and Dose	b. Form	c. Number Taken	d. Freq.
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			

SECTION R. ASSESSMENT INFORMATION

1. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:

a. Signature of Assessment Coordinator

b. Title of Assessment Coordinator

c. Date Assessment Coordinator signed as complete — Month — Day — Year

d. Other Signatures	Title	Sections	Date
e.			Date
f.			Date
g.			Date
h.			Date
i.			Date

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

® Country specific

MassHealth Request for Services

Date _____

Type of clinical eligibility determination all requested services.

Service(s) requested

- ☐ Pre-admission nursing facility (NF)
- ☐ Adult day health (ADH)
- ☐ Adult foster care (AFC)
- ☐ Group adult foster care (GAFC)
- ☐ Home and community based services (HCBS) waiver
- ☐ Program for All-inclusive Care for the Elderly (PACE)
- ☐ Other _____

Nursing facility use only

- ☐ Conversion
- ☐ Continued stay
- ☐ Short term review
- ☐ Transfer NF to NF
- ☐ Retrospective

Member information

Member/applicant

Last name	First name	Telephone	
Address		City	Zip

Check one

- ☐ MassHealth member — MassHealth ID number _____
- ☐ MassHealth application pending — Date application filed _____
- ☐ GAFC/ Assisted living residence — Date SSI-G application filed _____

Next of kin/Responsible party

Last name	First name	Telephone	
Address		City	Zip

Physician

Last name	First name	Telephone	
Address		City	Zip

Screening for mental illness, mental retardation, and developmental disability

Does the member/applicant have any of the following diagnoses/conditions? Check all that apply.

- ☐ Mental illness Specify: _____
- ☐ Mental retardation without related condition
- ☐ Developmental disability with related condition that occurred prior to age 22. **Check all that apply.**
  - ○ Autism
  - ○ Blindness/severe visual impairment
  - ○ Cerebral palsy
  - ○ Cystic fibrosis
  - ○ Deafness/severe hearing impairment
  - ○ Epilepsy/seizure disorder
  - ○ Head/brain injury
  - ○ Major mental illness
  - ○ Multiple sclerosis
  - ○ Muscular dystrophy
  - ○ Orthopedic impairment
  - ○ Speech/language impairment
  - ○ Severe learning disability
  - ○ Spina bifida
  - ○ Spinal cord injury

Name of member/applicant _____

Community services recommended

Check all that apply.

○ Skilled nursing	○ HCBS waiver	○ Rest home	○ Homemaker
○ Physical therapy	○ Personal emergency response system	○ Elderly housing	○ Meals
○ Occupational therapy	○ Adult foster care	○ Adult day health	○ Transportation
○ Speech therapy	○ Group adult foster care	○ PACE	○ Chore service
○ Mental health services	○ Assisted living	○ Home health aide	○ Grocery shopping/delivery
○ Social worker services	○ Congregate housing	○ Personal care/homemaker	○ Other: _____

Additional information

1. Is the home or apartment available for the member or applicant?	○ yes	○ no
2. Is there a caregiver to assist the member in the community?	○ yes	○ no
3. Has the member or applicant experienced unexplained weight gain in the last 30 days?	○ yes	○ no
4. Does the member or applicant receive personal care/homemaker services?	○ yes	○ no

If yes: days per week _____ hours per week _____

5. Has the member or applicant experienced a significant change in condition in the last 30 days?	○ yes	○ no

If yes: ☐ improvement ☐ deterioration

Indicate the changes below. _____

_____

_____

_____

For nursing facility requests only

1. Does the nursing facility member/applicant express an interest to remain in or return to the community?	○ yes	○ no
2. Is the nursing facility stay expected to be short-term (up to 90 days)?	○ yes	○ no
3. Is the nursing facility stay expected to be long-term (more than 90 days)?	○ yes	○ no

Referral source Name of registered nurse completing this form

Signature	Print name	Title	
Name of organization		Telephone	
Address		City	Zip

For community providers: Attach the MDS-HC and Physician's Summary form according to provider's regulations/guidelines.

For nursing facility providers: Attach the most recent comprehensive MDS, current quarterly MDS, and current physician orders.