

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

### ULTC 100.2 – INITIAL SCREENING AND INTAKE

#### Current Living Situation

<input type="checkbox"/> Alone	<input type="checkbox"/> With Non-Relatives	<input type="checkbox"/> Pending Nursing Facility Discharge or Admission
<input type="checkbox"/> With Spouse/ Others	<input type="checkbox"/> Alternative Care Facility	<input type="checkbox"/> Hospital Discharge, Date: _____
<input type="checkbox"/> With Non-Spouse Relatives	<input type="checkbox"/> Adult Foster Care	<input type="checkbox"/> DD Residential Program
<input type="checkbox"/> With Parents	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>
City: _____	State: _____	Zip: _____ Phone: _____

#### Presenting Problems and Diagnoses

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### Areas of Concern

<input type="checkbox"/> Bathing	<input type="checkbox"/> Toileting	<input type="checkbox"/> Behaviors	<input type="checkbox"/> Possible Mental Illness
<input type="checkbox"/> Dressing	<input type="checkbox"/> Transferring	<input type="checkbox"/> Memory/Cognition	<input type="checkbox"/> Possible Developmental Disability
<input type="checkbox"/> Eating	<input type="checkbox"/> Mobility		<input type="checkbox"/> Brain Injury

#### Potential Community Based Long Term Care Programs

<input type="checkbox"/> HCBS-Elderly, Blind and Disabled (EBD)	<input type="checkbox"/> HCBS-Persons Living with HIV/AIDS (PLWA)
<input type="checkbox"/> Home Care Allowance (HCA)	<input type="checkbox"/> HCBS-Brain Injury (BI)
<input type="checkbox"/> Private Case Management	<input type="checkbox"/> HCBS-Mentally Ill (MI)
<input type="checkbox"/> Long Term Skilled Home Health	<input type="checkbox"/> HCBS- DD (Comprehensive Services)
<input type="checkbox"/> PACE	<input type="checkbox"/> Consumer Directed Attendant Support(CDAS)
<input type="checkbox"/> HCBS-Children's Extensive Support (CES)	<input type="checkbox"/> Children's HCBS
<input type="checkbox"/> HCBS-Supported Living Services (SLS)	<input type="checkbox"/> 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: \_\_\_\_\_

#### Referral Information

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Comments: \_\_\_\_\_

Organization/  
Relationship: \_\_\_\_\_

### Financial Information

Client Income Source(s)		Spouse Income Source(s)	
Source	Amount	Source	Amount
<input type="checkbox"/> SSA/SSDI <input type="checkbox"/> SSI <input type="checkbox"/> Pension <input type="checkbox"/> Employment <input type="checkbox"/> OAP <input type="checkbox"/> AND/AB <input type="checkbox"/> Other: _____	\$ _____	<input type="checkbox"/> SSA/SSDI <input type="checkbox"/> SSI <input type="checkbox"/> Pension <input type="checkbox"/> Employment <input type="checkbox"/> OAP <input type="checkbox"/> AND/AB <input type="checkbox"/> 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 <input type="checkbox"/> Female <input type="checkbox"/>

**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 )**

<p><b>Physical Impairments:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Visually Impaired</li> <li><input type="checkbox"/> Limited Range of Motion</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Balance Problems</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Decreased Endurance</li> <li><input type="checkbox"/> Falls</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Neurological Impairment</li> <li><input type="checkbox"/> Oxygen Use</li> <li><input type="checkbox"/> Muscle Tone</li> <li><input type="checkbox"/> Amputation</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Open Wound</li> <li><input type="checkbox"/> Stoma Site</li> </ul> <p><b>Supervision:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cognitive Impairment</li> <li><input type="checkbox"/> Memory Impairment</li> <li><input type="checkbox"/> Behavior Issues</li> <li><input type="checkbox"/> Lack of Awareness</li> <li><input type="checkbox"/> Difficulty Learning</li> <li><input type="checkbox"/> Seizures</li> </ul> <p><b>Mental Health:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lack of Motivation/Apathy</li> <li><input type="checkbox"/> Delusional</li> <li><input type="checkbox"/> Hallucinations</li> <li><input type="checkbox"/> Paranoia</li> </ul>
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**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)**

<p><b>Physical Impairments:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Sensory Impairment</li> <li><input type="checkbox"/> Limited Range of Motion</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Balance Problems</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Decreased Endurance</li> <li><input type="checkbox"/> Fine Motor Impairment</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Neurological Impairment</li> <li><input type="checkbox"/> Bladder Incontinence</li> <li><input type="checkbox"/> Bowel Incontinence</li> <li><input type="checkbox"/> Amputation</li> <li><input type="checkbox"/> Oxygen Use</li> <li><input type="checkbox"/> Muscle Tone</li> <li><input type="checkbox"/> Open Wound</li> </ul>	<p><b>Supervision:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cognitive Impairment</li> <li><input type="checkbox"/> Memory Impairment</li> <li><input type="checkbox"/> Behavior Issues</li> <li><input type="checkbox"/> Lack of Awareness</li> <li><input type="checkbox"/> Difficulty Learning</li> <li><input type="checkbox"/> Seizures</li> </ul> <p><b>Mental Health:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lack of Motivation/Apathy</li> <li><input type="checkbox"/> Delusional</li> <li><input type="checkbox"/> Hallucinations</li> <li><input type="checkbox"/> Paranoia</li> </ul>
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**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 aware of own needs.

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

<p><b>Physical Impairments:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Visual Impairment</li> <li><input type="checkbox"/> Limited Range of Motion</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Decreased Endurance</li> <li><input type="checkbox"/> Fine Motor Impairment</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Neurological Impairment</li> <li><input type="checkbox"/> Bladder Incontinence</li> <li><input type="checkbox"/> Bowel Incontinence</li> <li><input type="checkbox"/> Amputation</li> <li><input type="checkbox"/> Oxygen Use</li> <li><input type="checkbox"/> Physiological defect</li> <li><input type="checkbox"/> Balance</li> <li><input type="checkbox"/> Muscle Tone</li> <li><input type="checkbox"/> Impaction</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Ostomy</li> <li><input type="checkbox"/> Catheter</li> </ul> <p><b>Supervision Need:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cognitive Impairment</li> <li><input type="checkbox"/> Memory Impairment</li> <li><input type="checkbox"/> Behavior Issues</li> <li><input type="checkbox"/> Lack of Awareness</li> <li><input type="checkbox"/> Difficulty Learning</li> <li><input type="checkbox"/> Seizures</li> </ul> <p><b>Mental Health:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lack of Motivation/Apathy</li> <li><input type="checkbox"/> Delusional</li> <li><input type="checkbox"/> Hallucinations</li> <li><input type="checkbox"/> Paranoia</li> </ul>
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**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)**

<p><b>Physical Impairments:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Sensory Impairment</li> <li><input type="checkbox"/> Limited Range of Motion</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Decreased Endurance</li> <li><input type="checkbox"/> Fine or Gross Motor Impairment</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Neurological Impairment</li> <li><input type="checkbox"/> Amputation</li> <li><input type="checkbox"/> Oxygen Use</li> <li><input type="checkbox"/> Balance</li> <li><input type="checkbox"/> Muscle Tone</li> </ul>	<p><b>Supervision Need:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cognitive Impairment</li> <li><input type="checkbox"/> Memory Impairment</li> <li><input type="checkbox"/> Behavior Issues</li> <li><input type="checkbox"/> Lack of Awareness</li> <li><input type="checkbox"/> Difficulty Learning</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> History of Falls</li> </ul> <p><b>Mental Health:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lack of Motivation/Apathy</li> <li><input type="checkbox"/> Delusional</li> <li><input type="checkbox"/> Hallucinations</li> <li><input type="checkbox"/> Paranoia</li> </ul>
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**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)

<p><b>Physical Impairments:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Sensory Impairment</li> <li><input type="checkbox"/> Limited Range of Motion</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Balance Problems</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Falls</li> <li><input type="checkbox"/> Decreased Endurance</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Neurological Impairment</li> <li><input type="checkbox"/> Amputation</li> <li><input type="checkbox"/> Oxygen Use</li> </ul>	<p><b>Supervision Need:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cognitive Impairment</li> <li><input type="checkbox"/> Memory Impairment</li> <li><input type="checkbox"/> Behavior Issues</li> <li><input type="checkbox"/> Lack of Awareness</li> <li><input type="checkbox"/> Difficulty Learning</li> <li><input type="checkbox"/> Seizures</li> </ul> <p><b>Mental Health:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lack of Motivation/Apathy</li> <li><input type="checkbox"/> Delusional</li> <li><input type="checkbox"/> Hallucinations</li> <li><input type="checkbox"/> Paranoia</li> </ul>
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#### 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)

<p><b>Physical Impairments:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Visual Impairment</li> <li><input type="checkbox"/> Limited Range of Motion</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Decreased Endurance</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Neurological Impairment</li> <li><input type="checkbox"/> Amputation</li> <li><input type="checkbox"/> Oxygen Use</li> <li><input type="checkbox"/> Fine Motor Impairment</li> <li><input type="checkbox"/> Poor Dentition</li> <li><input type="checkbox"/> Tremors</li> <li><input type="checkbox"/> Swallowing Problems</li> <li><input type="checkbox"/> Choking</li> <li><input type="checkbox"/> Aspiration</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Tube Feeding</li> <li><input type="checkbox"/> IV Feeding</li> </ul> <p><b>Supervision Need:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cognitive Impairment</li> <li><input type="checkbox"/> Memory Impairment</li> <li><input type="checkbox"/> Behavior Issues</li> <li><input type="checkbox"/> Lack of Awareness</li> <li><input type="checkbox"/> Difficulty Learning</li> <li><input type="checkbox"/> Seizures</li> </ul> <p><b>Mental Health:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lack of Motivation/Apathy</li> <li><input type="checkbox"/> Delusional</li> <li><input type="checkbox"/> Hallucinations</li> <li><input type="checkbox"/> Paranoia</li> </ul>
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#### 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)**

<p><b>Physical Impairments:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Medication Management</li> <li><input type="checkbox"/> Chronic Medical Condition</li> <li><input type="checkbox"/> Acute Illness</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Neurological Impairment</li> <li><input type="checkbox"/> Choking</li> <li><input type="checkbox"/> Sensory Impairment</li> <li><input type="checkbox"/> Communication Impairment (not inability to speak English)</li> </ul> <p><b>Mental Health:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lack of Motivation/Apathy</li> <li><input type="checkbox"/> Delusional</li> <li><input type="checkbox"/> Hallucinations</li> <li><input type="checkbox"/> Paranoia</li> <li><input type="checkbox"/> Mood Instability</li> </ul> <p><b>Supervision needs:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Short Term Memory Loss</li> <li><input type="checkbox"/> Long Term Memory Loss</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Agitation</li> <li><input type="checkbox"/> Aggressive Behavior</li> <li><input type="checkbox"/> Cognitive Impairment</li> <li><input type="checkbox"/> Difficulty Learning</li> <li><input type="checkbox"/> Memory Impairment</li> <li><input type="checkbox"/> Verbal Abusiveness</li> <li><input type="checkbox"/> Constant Vocalization</li> <li><input type="checkbox"/> Sleep Deprivation</li> <li><input type="checkbox"/> Self-Injurious Behavior</li> <li><input type="checkbox"/> Impaired Judgment</li> <li><input type="checkbox"/> Disruptive to Others</li> <li><input type="checkbox"/> Disassociation</li> <li><input type="checkbox"/> Wandering</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Self Neglect</li> </ul>
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**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)**

<p><b>Physical Impairments:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Metabolic Disorder</li> <li><input type="checkbox"/> Medication Reaction</li> <li><input type="checkbox"/> Acute Illness</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Neurological Impairment</li> <li><input type="checkbox"/> Alzheimer's/Dementia</li> <li><input type="checkbox"/> Sensory Impairment</li> <li><input type="checkbox"/> Chronic Medical Condition</li> <li><input type="checkbox"/> Communication Impairment (does not include ability to speak English)</li> <li><input type="checkbox"/> Abnormal Oxygen Saturation</li> <li><input type="checkbox"/> Fine Motor Impairment</li> </ul> <p><b>Supervision Needs:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Disorientation</li> <li><input type="checkbox"/> Cognitive Impairment</li> <li><input type="checkbox"/> Difficulty Learning</li> <li><input type="checkbox"/> Memory Impairment</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Self-Injurious Behavior</li> <li><input type="checkbox"/> Impaired Judgment</li> <li><input type="checkbox"/> Unable to Follow Directions</li> <li><input type="checkbox"/> Constant Vocalizations</li> <li><input type="checkbox"/> Perseveration</li> <li><input type="checkbox"/> Receptive Expressive Aphasia</li> <li><input type="checkbox"/> Agitation</li> <li><input type="checkbox"/> Disassociation</li> <li><input type="checkbox"/> Wandering</li> <li><input type="checkbox"/> Lack of Awareness</li> <li><input type="checkbox"/> Seizures</li> </ul> <p><b>Mental Health:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lack of Motivation/Apathy</li> <li><input type="checkbox"/> Delusional</li> <li><input type="checkbox"/> Hallucinations</li> <li><input type="checkbox"/> Paranoia</li> <li><input type="checkbox"/> Mood Instability</li> </ul>
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**Comments:**

## Assessment Demographics:

Location of Assessment:	Present at Interview:
<input type="checkbox"/> Applicant's private residence/home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Hospital/other health care facility <input type="checkbox"/> Assisted Living <input type="checkbox"/> Agency Office <input type="checkbox"/> <b>Relative's home</b> <input type="checkbox"/> Other: _____	<input type="checkbox"/> Applicant Only <input type="checkbox"/> Caregiver(s) only <input type="checkbox"/> Applicant and caregiver(s) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Applicant and others

### Most of the interview information was provided by:

<input type="checkbox"/> Applicant <input type="checkbox"/> Caregiver <input type="checkbox"/> Applicant and Caregiver equally	<input type="checkbox"/> Medical record <input type="checkbox"/> Facility Staff <input type="checkbox"/> Other: _____
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## Living Environment:

Safe	<input type="checkbox"/>	Services cannot be delivered here	<input type="checkbox"/>
Safe with feasible modifications	<input type="checkbox"/>	Client needs to move so services can be delivered	<input type="checkbox"/>
Services can be delivered here	<input type="checkbox"/>	Client needs to move to a safer environment	<input type="checkbox"/>
		Special home assessment needed	<input type="checkbox"/>

## 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.)

<input type="checkbox"/> No risk factors or evidence of abuse or neglect apparent at this time. <input type="checkbox"/> 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. <input type="checkbox"/> Risk factors present; however, LTC services may resolve issues. No APS referral being made at this time. <input type="checkbox"/> There are <u>statements of, or evidence of,</u> possible abuse, neglect, self-neglect, or financial exploitation.
--

Referring to APS now? Yes  No

## Advance Directives and Legal Documents:

<input type="checkbox"/>	Living Will: _____
<input type="checkbox"/>	Power of Attorney Financial Power of Attorney: _____ General Power of Attorney: _____ Medical Power of Attorney: _____
<input type="checkbox"/>	Conservator: _____
<input type="checkbox"/>	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](http://www.cdhs.ctate.co.us/ohr/mhs/index.html).**

Client Name: \_\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Current Street Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_  
City State ZIP Code Current Location: \_\_\_\_\_  
Current Telephone Number: \_\_\_\_\_ Nursing Facility: \_\_\_\_\_

**SECTION I**

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

**PASRR/MR-DD/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

- 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

List medications and diagnosis/es here:

**Psychoactive Medications**

**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 referral 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 <input type="checkbox"/> No <input type="checkbox"/>		
<b>Activities of Daily Living Scores:</b>								
	Bathing	Dressing	Toileting	Mobility	Transfers	Eating	Supervision Behaviors	Supervision Memory/Cognition
Scores:								
Is there documented medical information supporting any of the following programs? MI <input type="checkbox"/> BI <input type="checkbox"/> PLWA <input type="checkbox"/>							Has Developmental Disability eligibility been determined? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Comments/Supporting documentation:								

Services Requirements	
Waiver Services Needed within 30 Days	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> 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 <input type="checkbox"/>	Client Passed <input type="checkbox"/> Client Failed <input type="checkbox"/>
<input type="checkbox"/> Depression Diversion	Client Passed <input type="checkbox"/> Client Failed <input type="checkbox"/>
<input type="checkbox"/> Level II Evaluation Needed	Referred to MHASA <input type="checkbox"/> Date _____ Referred to CCB <input type="checkbox"/> Date: _____
Comments:	

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

# 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.

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

<u>Physical Deficits:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Balance Problems <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Falls <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Deficit <input type="checkbox"/> O2 Use	<u>Supervision:</u> <input type="checkbox"/> Cognitive Deficits <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Sensory Integration <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
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**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.

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

<u>Physical Deficits:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Deficit <input type="checkbox"/> Fine Motor Deficit <input type="checkbox"/> Communication Impairment (not inability to speak English) <input type="checkbox"/> Swallowing <input type="checkbox"/> Choking <u>Skilled Care:</u> <input type="checkbox"/> Skilled Medication Administration (oral) <input type="checkbox"/> Skilled Medication Administration (IV, parenteral, G tube) <input type="checkbox"/> Skilled Medication Setup <input type="checkbox"/> Medication Teaching <input type="checkbox"/> Assess for side effects/ drug interactions <input type="checkbox"/> Assess Medication Compliance	<u>Supervision:</u> <input type="checkbox"/> Cognitive Deficits <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Sensory Integration <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
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**Comments:**

## Instrumental Activities of Daily Living (continued)

### 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.

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

<u>Physical Deficits:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Deficit <input type="checkbox"/> Fine Motor Deficit <input type="checkbox"/> Communication Impairment (not inability to speak English) <u>Skilled Care:</u> <input type="checkbox"/> Skilled Medical Accompaniment/Supervision	<u>Supervision:</u> <input type="checkbox"/> Cognitive Deficits <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
--	---

**Comments:**

### 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.

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

<u>Physical Deficits:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Deficit <input type="checkbox"/> Fine Motor Deficit <input type="checkbox"/> Communication Impairment (not inability to speak English)	<u>Supervision:</u> <input type="checkbox"/> Cognitive Deficits <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Impaired Judgment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
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**Comments:**

## Instrumental Activities of Daily Living (continued)

### 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.

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

<u>Physical Deficits:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Falls <input type="checkbox"/> Balance <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Deficit <input type="checkbox"/> Fine Motor Deficit <input type="checkbox"/> Communication Impairment (not inability to speak English)	<u>Supervision:</u> <input type="checkbox"/> Cognitive Deficits <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Impaired Judgment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
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**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.

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

<u>Physical Deficits:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Falls <input type="checkbox"/> Balance <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Deficit <input type="checkbox"/> Fine Motor Deficit <input type="checkbox"/> Communication Impairment (not inability to speak English)	<u>Supervision:</u> <input type="checkbox"/> Cognitive Deficits <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Impaired Judgment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
--	---

**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.

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

<u>Physical Deficits:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Falls <input type="checkbox"/> Balance <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Deficit <input type="checkbox"/> Fine Motor Deficit <input type="checkbox"/> Communication Impairment (not inability to speak English)	<u>Supervision:</u> <input type="checkbox"/> Cognitive Deficits <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Impaired Judgment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
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**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.

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

<u>Physical Deficits:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Falls <input type="checkbox"/> Balance <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Deficit <input type="checkbox"/> Fine Motor Deficit <input type="checkbox"/> Communication Impairment (not inability to speak English)	<u>Supervision:</u> <input type="checkbox"/> Cognitive Deficits <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Impaired Judgment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
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**Comments:**

## Instrumental Activities of Daily Living (continued)

### 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.

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

<p><u>Physical Deficits:</u></p> <ul style="list-style-type: none"><li><input type="checkbox"/>Pain</li><li><input type="checkbox"/>Visually Impaired</li><li><input type="checkbox"/>Hearing Impaired</li><li><input type="checkbox"/>Limited ROM</li><li><input type="checkbox"/>Decreased Endurance</li><li><input type="checkbox"/>Falls</li><li><input type="checkbox"/>Balance</li><li><input type="checkbox"/>Weakness</li><li><input type="checkbox"/>Paralysis</li><li><input type="checkbox"/>Neurological Deficit</li><li><input type="checkbox"/>Fine Motor Deficit</li><li><input type="checkbox"/>Communication Impairment (not inability to speak English)</li></ul>	<p><u>Supervision:</u></p> <ul style="list-style-type: none"><li><input type="checkbox"/>Cognitive Deficits</li><li><input type="checkbox"/>Memory Impairment</li><li><input type="checkbox"/>Impaired Judgment</li><li><input type="checkbox"/>Behavior Issues</li><li><input type="checkbox"/>Lack of Awareness</li><li><input type="checkbox"/>Difficulty Learning</li></ul> <p><u>Mental Health:</u></p> <ul style="list-style-type: none"><li><input type="checkbox"/>Lack of Motivation/Apathy</li><li><input type="checkbox"/>Delusional</li><li><input type="checkbox"/>Hallucinations</li><li><input type="checkbox"/>Paranoia</li><li><input type="checkbox"/>Mood Instability</li></ul>
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**Comments:**

## Strengths Assessment and Evaluation

**Please identify strengths in each domain:**

SOCIAL SUPPORTS	PARTICIPATION IN ACTIVITIES	EXTERNAL RESOURCES	HEALTH AND WELLNESS	PERSONAL ASSETS
<input type="checkbox"/> Supportive family <input type="checkbox"/> Supportive friends <input type="checkbox"/> Caring neighbors <input type="checkbox"/> Community recognition and respect <input type="checkbox"/> Sense of a place in the world <input type="checkbox"/> Other: _____  <input type="checkbox"/> Other: _____	<input type="checkbox"/> Creative activities <input type="checkbox"/> Church/spiritual activities <input type="checkbox"/> Community activities <input type="checkbox"/> Clubs, groups, planned meetings <input type="checkbox"/> Volunteer service opportunities <input type="checkbox"/> Other: _____  <input type="checkbox"/> Other: _____	<input type="checkbox"/> Adequate housing <input type="checkbox"/> Financial security <input type="checkbox"/> Adequate transportation <input type="checkbox"/> Safe environment <input type="checkbox"/> Access to safety resources <input type="checkbox"/> Medical equipment <input type="checkbox"/> Other: _____  <input type="checkbox"/> Other: _____	<input type="checkbox"/> Adequate physical health <input type="checkbox"/> Balanced mental health <input type="checkbox"/> Self care ability or resources <input type="checkbox"/> Adequate medical access <input type="checkbox"/> Commitment to health <input type="checkbox"/> Knowledge about how choices impact health  <input type="checkbox"/> Other: _____  <input type="checkbox"/> Other: _____	<input type="checkbox"/> Positive self-image <input type="checkbox"/> sense of empowerment <input type="checkbox"/> positive view of others <input type="checkbox"/> positive view of the future <input type="checkbox"/> adequate communication skills <input type="checkbox"/> sense of purpose <input type="checkbox"/> ability to ask for and accept help <input type="checkbox"/> ability to accept personal responsibility <input type="checkbox"/> other: _____  <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>			
Bowel/Bladder program	<input type="checkbox"/>	<input type="checkbox"/>			
Catheter care	<input type="checkbox"/>	<input type="checkbox"/>			
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>			
Foot Care	<input type="checkbox"/>	<input type="checkbox"/>			
Injections	<input type="checkbox"/>	<input type="checkbox"/>			
IV Therapies	<input type="checkbox"/>	<input type="checkbox"/>			
Medication monitor	<input type="checkbox"/>	<input type="checkbox"/>			
Oxygen	<input type="checkbox"/>	<input type="checkbox"/>			
Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>			
Ostomy care	<input type="checkbox"/>	<input type="checkbox"/>			
Physical therapy regime	<input type="checkbox"/>	<input type="checkbox"/>			
Range of motion	<input type="checkbox"/>	<input type="checkbox"/>			
Respiratory treatment regime	<input type="checkbox"/>	<input type="checkbox"/>			
Speech therapy	<input type="checkbox"/>	<input type="checkbox"/>			
Suctioning	<input type="checkbox"/>	<input type="checkbox"/>			
Tube Feeding	<input type="checkbox"/>	<input type="checkbox"/>			
Ventilator Assistance	<input type="checkbox"/>	<input type="checkbox"/>			
Wound care/Dressing	<input type="checkbox"/>	<input type="checkbox"/>			
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			

**Comments:**

### Psycho/Social Health:

Support Systems:	Caregiver?	Phone:	Contacted?
<input type="checkbox"/> Spouse:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Friends:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Family:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Neighbor:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Faith Based Name:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Support Group:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Agency/ Organization:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Community Based:	<input type="checkbox"/>		<input type="checkbox"/>

Psycho/Social Problems:	
<input type="checkbox"/> Psychological illness present	<b>Significant Changes</b>
<input type="checkbox"/> Psychological illness history	<b>Losses</b>
<input type="checkbox"/> Depression	<input type="checkbox"/> Death of spouse
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Death of friend/family member
<input type="checkbox"/> Crying	<input type="checkbox"/> Death of pet
<input type="checkbox"/> Insomnia	<b>Changes</b>
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Change in residence <input type="checkbox"/> Divorce/separation <input type="checkbox"/> Retirement
<input type="checkbox"/> Loss of appetite <input type="checkbox"/> Concerns regarding potential psychosocial situation <input type="checkbox"/> Poor eye contact <input type="checkbox"/> Alcohol/Substance Abuse	<b>Threat/Victim</b> <input type="checkbox"/> Financial concern <input type="checkbox"/> Safety concerns <input type="checkbox"/> Victim of assault/theft <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	Intermittent Catheter	<input type="checkbox"/>	<input type="checkbox"/>
Adaptive Utinsels	<input type="checkbox"/>	<input type="checkbox"/>	IV Equipment	<input type="checkbox"/>	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>	<input type="checkbox"/>	Kitchen Access	<input type="checkbox"/>	<input type="checkbox"/>
Augmentative Communication Device	<input type="checkbox"/>	<input type="checkbox"/>	Lift chair Manual Lift	<input type="checkbox"/>	<input type="checkbox"/>
Bath Mat	<input type="checkbox"/>	<input type="checkbox"/>	Mechanical Lift	<input type="checkbox"/>	<input type="checkbox"/>
Bath/Shower Chair	<input type="checkbox"/>	<input type="checkbox"/>	Medication Box	<input type="checkbox"/>	<input type="checkbox"/>
Bathroom Access	<input type="checkbox"/>	<input type="checkbox"/>	Medication Dispenser	<input type="checkbox"/>	<input type="checkbox"/>
Braces	<input type="checkbox"/>	<input type="checkbox"/>	Monitors	<input type="checkbox"/>	<input type="checkbox"/>
Cane	<input type="checkbox"/>	<input type="checkbox"/>	Orthotics	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Stockings	<input type="checkbox"/>	<input type="checkbox"/>	Ostomy Supplies	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning Equipment	<input type="checkbox"/>	<input type="checkbox"/>	Pivot Board	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning Supplies	<input type="checkbox"/>	<input type="checkbox"/>	Plate Guard	<input type="checkbox"/>	<input type="checkbox"/>
Commode	<input type="checkbox"/>	<input type="checkbox"/>	Protheses	<input type="checkbox"/>	<input type="checkbox"/>
Crutches	<input type="checkbox"/>	<input type="checkbox"/>	Ramp	<input type="checkbox"/>	<input type="checkbox"/>
Electric Lift	<input type="checkbox"/>	<input type="checkbox"/>	Reacher	<input type="checkbox"/>	<input type="checkbox"/>
Electronic Monitor	<input type="checkbox"/>	<input type="checkbox"/>	Roll-In Shower	<input type="checkbox"/>	<input type="checkbox"/>
External Catheter	<input type="checkbox"/>	<input type="checkbox"/>	Scooter	<input type="checkbox"/>	<input type="checkbox"/>
Feeding Pump	<input type="checkbox"/>	<input type="checkbox"/>	Sliding Board	<input type="checkbox"/>	<input type="checkbox"/>
Feeding Tubes	<input type="checkbox"/>	<input type="checkbox"/>	Sock Aide	<input type="checkbox"/>	<input type="checkbox"/>
Foley Catheter	<input type="checkbox"/>	<input type="checkbox"/>	Standing Frame	<input type="checkbox"/>	<input type="checkbox"/>
Gait Belt	<input type="checkbox"/>	<input type="checkbox"/>	Transfer Bench	<input type="checkbox"/>	<input type="checkbox"/>
Grab Bars	<input type="checkbox"/>	<input type="checkbox"/>	Urinal	<input type="checkbox"/>	<input type="checkbox"/>
Hand Held Shower	<input type="checkbox"/>	<input type="checkbox"/>	Walker	<input type="checkbox"/>	<input type="checkbox"/>
Handrail	<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>
Hi Riser	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>				
LPN	<input type="checkbox"/>	<input type="checkbox"/>				
RN	<input type="checkbox"/>	<input type="checkbox"/>				
Psych RN	<input type="checkbox"/>	<input type="checkbox"/>				
Self	<input type="checkbox"/>	<input type="checkbox"/>				
Family	<input type="checkbox"/>	<input type="checkbox"/>				
Unpaid Provider	<input type="checkbox"/>	<input type="checkbox"/>				
Nursing Home	<input type="checkbox"/>	<input type="checkbox"/>				
PT	<input type="checkbox"/>	<input type="checkbox"/>				
OT	<input type="checkbox"/>	<input type="checkbox"/>				
RT	<input type="checkbox"/>	<input type="checkbox"/>				
ST	<input type="checkbox"/>	<input type="checkbox"/>				
Ambulance	<input type="checkbox"/>	<input type="checkbox"/>				

**Comments:**

### Unskilled Medicaid Services

Unskilled	N	R	Freq	D/W/M	Provider Name	Tasks to be completed
ACF/AFC	<input type="checkbox"/>	<input type="checkbox"/>				
ADC	<input type="checkbox"/>	<input type="checkbox"/>				
Counselor	<input type="checkbox"/>	<input type="checkbox"/>				
EM	<input type="checkbox"/>	<input type="checkbox"/>				
Family	<input type="checkbox"/>	<input type="checkbox"/>				
Home Care Provider	<input type="checkbox"/>	<input type="checkbox"/>				
Home Mod	<input type="checkbox"/>	<input type="checkbox"/>				
Homemaker	<input type="checkbox"/>	<input type="checkbox"/>				
ILST	<input type="checkbox"/>	<input type="checkbox"/>				
Med. Transport.	<input type="checkbox"/>	<input type="checkbox"/>				
Medication Dispense	<input type="checkbox"/>	<input type="checkbox"/>				
Non-Med. Transport.	<input type="checkbox"/>	<input type="checkbox"/>				
PCP	<input type="checkbox"/>	<input type="checkbox"/>				
Pest Control	<input type="checkbox"/>	<input type="checkbox"/>				
Self	<input type="checkbox"/>	<input type="checkbox"/>				
Unpaid	<input type="checkbox"/>	<input type="checkbox"/>				
Voc. Rehab	<input type="checkbox"/>	<input type="checkbox"/>				

**Comments:**