LONG TERM LIVING TRAINING INSTITUTE OF PENNSYLVANIA

pennsylvania DEPARTMENT OF AGING

Level of Care Determination

Facilitator Guide

DERING CONSULTING GROUP

5/20/14

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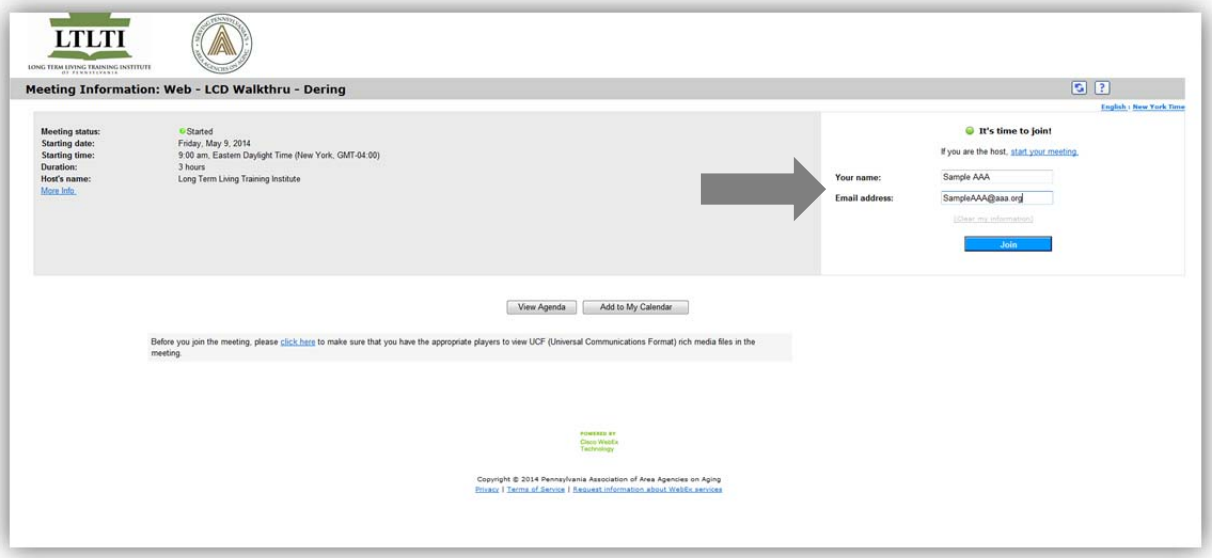
Level of Care Determination Facilitator Guide

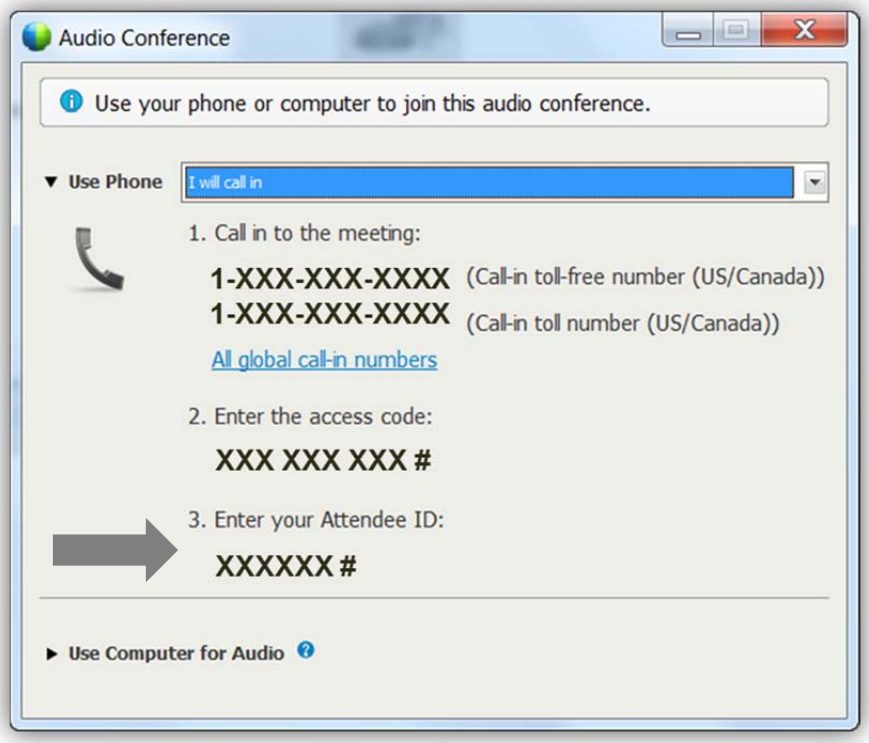
WebEx Information

- Use the **name of the AAA** when logging into the LCD Assessor Webinar.



- Select **"I will call in"** from the drop down menu.

❖ When calling in to the audio conference, enter the **Attendee ID**.



❖ Site reporter submits questions through chat. Include the AAA name when submitting questions.

LCD Assessor Webinar Agenda

Approx. Start Time	Topic
9:15	Department Welcome/Introductions
9:25	Assessor Certification
9:30	***Group Discussion – Assessor Certification***
9:40	Level of Care Definition
9:45	***Group Activity – Case Study Review***
10:30	**BREAK**
10:45	Assessor Roles and Responsibilities
11:05	***Group Discussion – LCD Time Frames***
11:25	Compliance and Quality Assurance
11:30	Summary of What Is New and Changed
11:45	Overview of the LCD Tool
12:00	**LUNCH**
1:00	Overview of the LCD Tool
1:30	***Group Activity – Overview of the LCD Tool***
2:15	**BREAK**
2:30	***Group Activity – Completed LCD Tool Review***
3:15	Questions/wrap-up
3:30	End of Webinar

Facilitator Guidelines

Facilitator Responsibilities

❖ **Before the Webinar**, the facilitator should:

- Coordinate training for all assessors in the agency or agency contractors.
- Register for webinars.
  - Receive an email with the dates and the registration form.
  - Choose webinars to attend.
  - Print and complete the registration form.
  - Fax the completed registration form to P4A at (717) 541-4217.
- Test technical requirements for the webinar.
  - Connect the computer to a projector or monitor that is visible to all participants.
  - Connect the computer to the Internet.
  - Launch the browser and connect to WebEx.
  - Set up a speakerphone that is audible to all participants.
- Complete the facilitator prework for the following activities:
  - Case Studies –
    Determine how the case studies will be divided among and completed by the group.
  - Level of Care Determination Time Frames –
    Review the Key Concepts, OLTL Bulletin 55-12-03, Exhibit C, Mosley vs. Alexander Settlement, and OBRA Target Assessments and plan for a group review and discussion.
  - Overview of the Level of Care Determination Tool –
    Review the LCD Tool prior to LCD Assessor Webinar.
- Print the attendance sheet.
- Print copies of the Assessor Workbook. The Assessor Workbook can be found on the PDA Website – LCD Training Materials May/June 2014.

❖ **The day of the Webinar**, the facilitator should:

- Set up the room for the webinar.
  - Establish an area for the attendance sheet and Assessor Workbooks.
  - Arrange tables so that participants can view the screen.
  - Plan areas for small groups to work together.
  - Create a "parking lot" for unanswered questions.
- Assign a reporter for your site.

❖ **During the Webinar**, the facilitator should:

- Call LTLTI at 717-541-4214 if there are any technology disruptions.
- Use the name of the AAA when logging into the LCD Assessor Webinar.
- Ensure all participants who fulfill the requirements of the training sign the attendance sheet.
- Inform participants of the ground rules and their responsibilities during training.
- Be present in the training/conference room throughout the entire session.
- Facilitate discussions among participants during group activity portions of the training.
- Be inclusive by encouraging the participation of all assessors in attendance.
- Answer participant questions as you are able. Keep a "parking lot" of unanswered questions.

❖ **After the Webinar**, the facilitator should:

- Scan and email the completed attendance sheet to RA-AIQUALITYACREDENT@pa.gov.
- Follow up on any unanswered questions and share the answers with the assessors.
- If your agency is hosting staff from other locations, communicate the results with the Assessment Supervisor of the visiting staff.

❖ Ensure participants:

- Arrive on time and respect the time allotted for breaks.
- Are present throughout the entire training.
- Power-off cell phones and mobile devices.
- Actively participate in group activities (your experience may help someone else).
- Sign in on the attendance sheet to receive credit for the course.
- Ask questions.

Attendance Sheet

Date: _____ **Location:** _____

Print Name:	Signature:

Scan and email the completed form to RA-AIQUALITYACREDENT@pa.gov. For questions, send an email to RA-AIQUALITYACREDENT@pa.gov.

Assessor Certification Checklist

Name:	Agency:

SAMS 3 Competency Demonstration	Proficient	Needs Improvement	Corrective Plan	Date	Supervisors Signature
1. Log into Harmony Portal & SAMS 3					
2. Navigate through SAMS 3 screens					
3. Open correct assessment					
4. Export an assessment to laptop					
5. Document the assessment correctly					
6. Import assessment from laptop to OMNIA PA					
7. Create a PDF version of the assessment in SAMS 3					
8. Export assessment to a folder on the computer so the assessment is accessible					
9. Enter a service delivery for the assessment					

Assessor Certification Checklist

Communication Competency Demonstration	Proficient	Needs Improvement	Corrective Plan	Date	Supervisors Signature
1. Schedule the assessment					
2. Engage the individual					
3. Explain the purpose of the visit & assessment					
4. Recognize individual needs (spiritual, cultural, educational, & life changing events)					
5. Utilize acceptable communication skills & dialogue during the assessment					
6. Provide opportunities for Q&A					
7. Summarize the visit & identify next steps & timeframes					
8. Provide contact information					
NFCE determinations meet the definition					
Des Moines University Medical Terminology Course completed					
Level of Care Determination Assessor Webinar attended					

Attestation for Assessor Certification

I hereby attest that I, (supervisor's name) as the supervisor of (assessor's name) have verified that (assessor's name) from the (area agency name) completed all the necessary prerequisite courses to become a certified assessor.

The aforementioned assessor has:

- Completed the Boston University Module requirements,
- Completed the Des Moines University Medical Terminology Course,
- Attended The Level of Care Determination Assessor Webinar,
- The skills and knowledge to complete level of care assessments and NFCE determinations accurately, and
- Knowledge and skills to manage assessments in the SAMS database.

This assessor is recommended for testing. I declare that the above statement is true and accurate to the best of my knowledge.

Assessors Signature_____ Date: _____

Supervisor Signature_____ Date: _____

Assessor Certification FAQs

1. **Why is the Department requiring credentialing of assessors now, when it was never required in the past?**

   Credentialing of assessors will help the Department build consistency in the level of care assessment and determination process throughout the network. It will also help agencies develop more credibility with those they serve by having "State Certified" assessors on staff. Certification indicates that all persons have the same knowledge base.

2. **Who is required to be certified?**

   All individuals who conduct level of care assessments must be certified prior to independently conducting assessments.

3. **How long do I have to complete all of the certification requirements?**

   Current staff must complete all certification requirements, including successfully passing the Assessor Exam, by December 31, 2014.

4. **What are the other METs required to complete level of care assessments?**

   In addition to the assessor certification requirements that must be completed by December 31, 2014; all staff who complete LCDs must meet the Civil Service METs for Aging Care Manager I, II, III, Assessor, Aging Supervisor or Community Health Nurse I or II. If a staff member was hired as a Service Coordinator, they may not have the required METs.

5. **How will newly hired assessors complete the certification process once the initial rollout is complete?**

   The training and webinars, culminating in readiness for the certification exam, will be made available via written materials and pre-recorded webinars to new assessors to successfully complete within a given time frame which is to be determined.

6. **How will I take the exam?**

   The exam will be administered through the LTLTI Website. It will consist of multiple choice and true/false questions, by subject area. It will be a timed test; and the results will produce a grade of pass or fail.

7. **Can I retake the exam if I fail?**

   You can retake the exam one time. If you fail twice, you may be offered the opportunity to retest if you work with your supervisor on an Individual Development Plan to learn the necessary skills in the areas that you struggled with the test. Your supervisor will need to attest to your readiness before the test will be administered to you for a third time.

8. I am retiring in 18 months, is it necessary for me to take this test to prove my abilities?

All individuals who conduct level of care assessments must be certified prior to independently conducting assessments. This will be effective January 1, 2015.

9. Will the State be offering any kind of test preparation for those who have not taken a formal test in a long time?

Information will be forthcoming later in 2014 about several opportunities to participate in a classroom-based assessor certification exam-preparation course.

Case Studies

- During the LCD Assessor Webinars, there are eight case studies.
- Every site must complete a minimum of three case studies.
  - Case Study #1 – Jane
  - Case Study #2 – Jake
  - One additional case study
- The remaining case studies should be divided among the group.
- Each facilitator determines how the case studies will be divided among and completed by the group.
- Participants will have 15 minutes to complete the case studies.

Sample Case Study #7 — Mary

Mary is an 83-year-old female on dialysis 3 times a week for end stage renal disease. Dialysis leaves Mary very weak. She is retaining fluid in her legs and needs monitoring of her intake and output. She is beginning to show an onset of dementia. She requires hands-on assistance with bathing and dressing. Limited assistance is required with grooming and toileting. She is continent of bowel and bladder. Her mobility is limited due to weakness in her lower limbs. She has fallen 3 times in the past 6 months. One fall required a trip to the Emergency Room but no hospital admission. She is not bedbound but does need assistive devices for mobility. She does not walk outdoors due to her instability and weakness. She cannot perform any IADLs except money management and use of the telephone due to her weakened state. She requires set-up and verbal reminders for medications.

What is the Level of Care Determination?	
What is this determination based on?	

Case Study #7 Answer

Mary is NFCE because:

- ❖ Mary has a medical condition diagnosed by a physician, that includes:
  - End stage renal disease
  - Dementia
- ❖ Mary requires care above the level of room and board and requires care and services that are both skilled and inherently complex because she:
  - Requires monitoring of fluid retention, including intake and output.
  - Needs hands-on assistance with bathing and dressing.
  - Needs limited assist with toileting and grooming.
  - Requires hands-on assistance with ambulating.
  - Requires set-up and verbal reminders of medications, including monitoring of diuretics.

Level of Care Determination Time Frames

- Prior to the LCD Assessor Webinar, review the materials found on the following pages:
  - Key Concepts
  - OLTL Bulletin 55-12-03
  - Mosley vs. Alexander Settlement, Exhibit C
  - OBRA Target Assessments
- Using the Key Concepts as a reference, plan to facilitate a 15-minute group review and discussion of the materials during the LCD Assessor Webinars.

Key Concepts

Key Concepts

OLTL Bulletin 55-12-03

1. Ensures compliance with the 90-day federal requirement for Medicaid waiver eligibility determination.

2. The total number of days from date of request to issuance of Level of Care must not exceed 15 calendar days.

3. Provides parameters for contact with applicant, including:
   - Initial phone contact with applicant.
   - Guidance when applicant cannot be reached.
   - Sample letters for applicant contact.
   - Procedures for terminating an application.

Mosley vs. Alexander Settlement, Exhibit C

1. Establishes required time frames for level of care determination.
    - In-home intake visit occurs within seven calendar days.
    - Level of care determination occurs within 15 calendar days.
    - Documentation is forwarded to CAO within 40 calendar days.
2. Provides guidance for applicant contact, including:
    - Initial contact.
    - Intake visit.
    - Post-intake visit process for applicants.
    - Post-intake visit process for non-applicants.
3. Outlines all required documentation.
    - All paperwork is required at the time of intake visit.
    - Written correspondence is required of the IEB throughout the application process.
    - How to handle the level of care if the Physician Certification is not received by the IEB.

OBRA

1. Pre-Admission Screening Resident Review (PASRR) assessments to be completed for all individuals initially entering Nursing Facilities to determine if they have a Mental Illness (MI), Intellectual Disability (ID), or an Other Related Condition (ORC).

2. There are 2 levels of assessments:

   - PASRR Level 1 Identification Form (PASRR-ID) must be completed prior to or on day of admission for all individuals applying for nursing facility placement regardless of payment source.
   - PASRR Level 2 Evaluation (PASRR-EV) which must be completed prior to admission for all individuals identified through the Level 1 assessment as meeting the criteria of having an MI, ID, or ORC.

3. The AAA is responsible for:

   - Verifying that the MA-51 is completed appropriately by the physician.
   - Ensuring that the PASRR-ID is routinely completed by a nursing facility, hospital, primary care physician, or in some cases, a psychiatrist.
   - Reviewing the PASRR-ID to determine that it is appropriately completed. The AAA may have to complete the PASRR-ID when an individual is residing in the community. The assessor can refer to local resources, such as the mental health/mental retardation network or primary care physician, for assistance.
   - Completing the PASRR EV and the Transmittal Form.

4. AAA assessors must refer to the Program Office submission packet checklist for additional information that must be submitted to the Program Office for each target diagnosis.

OLTL Bulletin 55-12-03

Pennsylvania
DEPARTMENT OF PUBLIC WELFARE
DEPARTMENT OF AGING
www.dpw.state.pa.us

OFFICE OF LONG-TERM LIVING BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
December 31, 2012	December 31, 2012	55-12-03

SUBJECT:

Procedures and Timeframes Related to Performance of Level of Care Assessments and Independent Enrollment Broker Responsibilities

Bonnie L. Rose
Deputy Secretary, Office of Long-Term Living

PURPOSE

This bulletin establishes uniform procedures and timeframes for Area Agencies on Aging (AAAs) to follow to complete Level of Care Assessments (LOCAs), and sets forth the responsibilities of the Independent Enrollment Broker (IEB). This bulletin supercedes and replaces the Office of Long-Term Living (OLTL) bulletin issued on November 21, 2012 (#55-12-02).

SCOPE

This Bulletin applies to LOCAs performed by AAAs for the Office of Long-Term Living's waiver programs.

BACKGROUND/DISCUSSION

This bulletin will ensure compliance with the 90-day federal requirement for Medicaid waiver eligibility determination. See 42 CFR 435.911. It establishes the requirement that LOCAs be completed within a fifteen (15) calendar day period and provides for additional timeframes for the completion of tasks. This bulletin provides for corrections in the letters attached to the previous bulletin issued by OLTL on November 21, 2012. Changes are underlined.

PROCEDURE

When a AAA receives a request from the IEB for a LOCA to be performed, the AAA shall perform the LOCA within fifteen (15) calendar days, in accordance with the following procedure:

1. When a referral is received by a AAA from the IEB for a LOCA and the AAA makes contact with the applicant by phone or mail, the AAA must send a confirmation letter to the applicant (SEE ATTACHED SAMPLE LETTER #1) within three (3) business days confirming the date and time of the scheduled LOCA.

2. When a referral is received by a AAA from the IEB for a LOCA and the applicant has a valid telephone number but cannot be reached on the first call, the AAA shall:

- Initiate three phone contacts (including the initial call) with the applicant to schedule their LOCA. Calls must be made not less than two days apart and cannot extend more than five (5) business days. If contact has not been made via phone by the third call, a letter is to be sent by the AAA to the applicant informing them of a date by which the applicant must contact the AAA to schedule their LOCA. The date by which the applicant must respond should be no more than five (5) business days from the date on the letter. The letter may be sent on the day that the last call was placed to the applicant by the AAA and will inform the applicant that their application will be terminated if they do not call to schedule a LOCA by the required date. (SEE ATTACHED SAMPLE LETTER #2.)

  If the applicant does not respond, the AAA will inform the IEB no later than twenty (20) days after receiving the referral to terminate the application by faxing the LOCA request form back to the IEB, noting 'incomplete LOCA' on the form.

3. When a referral is received by a AAA from the IEB for a LOCA and the applicant does NOT have a valid telephone number, the AAA shall:

   - Send a letter to the applicant requesting that the applicant contact the AAA to schedule their LOCA no more than five (5) business days from the date on the letter. (SEE ATTACHED SAMPLE LETTER #3.)

     If the applicant does not respond, the AAA will inform the IEB no later than twenty (20) days after receiving the referral to terminate the application by faxing the LOCA request form back to the IEB, noting 'incomplete LOCA' on the form.

4. If, after a LOCA has been scheduled, the applicant calls to reschedule his or her appointment, the AAA must offer to reschedule the appointment and must inform the applicant that if they do not appear for the rescheduled appointment, their application will be terminated and they will have to reapply, thus delaying possible services.

   If the applicant does not respond, the AAA will inform the IEB no later than twenty (20) days after receiving the referral to terminate the application by faxing the LOCA request form back to the IEB, noting 'incomplete LOCA' on the form.

If a LOCA is not completed and submitted to the IEB within fifteen (15) calendar days from the date on which it was requested, the IEB will send a reminder to the AAA, with a copy to OLTL fifteen (15) calendar days after requesting the LOCA. The IEB shall provide a AAA with a second reminder within five (5) calendar days after the first reminder if the LOCA has not been received by the IEB.

The fifteen (15) calendar day requirement for completion of LOCAs also applies to the Aging Waiver.

Questions concerning this bulletin should be directed to the Bureau of Individual Support at 717-787-8091

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
Department of Aging/Office of Long-Term Living
Bureau of Individual Support
P.O. Box 2675
Harrisburg, PA 17105
(717) 787-8091

LETTER #1

Dear_____:

This letter is to confirm that you have scheduled an appointment on _____, 20_, at _____ for a Level of Care Assessment by the (insert agency name) to be conducted at (insert location LOCA to be done).

This assessment is a step in the eligibility determination process to determine whether or not you qualify for long-term living services provided under the medical assistance program. It is important, therefore, that you not miss this appointment.

If, however, an emergency arises and you must reschedule this appointment, please contact _____ at ( ) ___-_____ as soon as possible.

Sincerely,

LETTER #2

Dear _____:

The (insert agency name) recently received a referral for you to receive a Level of Care Assessment for long-term living services. This assessment is a step in the eligibility determination process to determine whether or not you qualify for long-term living services provided under the medical assistance (MA) program. It is important, therefore, that you schedule an appointment.

We have attempted, but been unable to reach you by phone. Please call us at ( ) ___-_____ by _____ (insert date which is 5 business days from the date you are sending this letter to the applicant) to schedule your appointment.

If you do not respond by the date above, your application for MA funded long-term living services will be terminated, which means that you will have to reapply for services.

Sincerely,

LETTER #3

Dear _____:

The (insert agency name) recently received a referral for you to receive a Level of Care Assessment for long-term living services. This assessment is a step in the eligibility determination process to determine whether or not you qualify for long-term living services provided under the medical assistance (MA) program. It is important, therefore, that you schedule an appointment.

We have attempted to reach you by phone but the number we were given is not correct. Please call us at ( ) ___-_____ by _____ (insert date which is 5 business days from the date you are sending this letter to the applicant) to schedule your appointment.

If you do not respond by the date above, your application for MA funded long-term living services will be terminated, which means that you will have to reapply for services.

Sincerely,

Mosley vs. Alexander Settlement, Exhibit C

EXHIBIT C

All signed applications and other documentation, if any, gathered by the IEB under the process specified below must be submitted to the CAO no later than 40 calendar days from the Application Date. When a deadline under this process falls on a Saturday, on a Sunday or on a Pennsylvania legal holiday, then the deadline shall be the next business day.

A. SCOPE

(1) For purposes of the Ongoing Process, "Applicant" means:

- An individual who signs or, on whose behalf the individual's representative signs a PA 600L/WP; or
- An MA recipient who expresses or whose representative expresses an intention to the IEB that the MA recipient be considered for participation in an OLTL Waiver

B. INITIAL CONTACT

(1) When a potential consumer or consumer's representative calls the IEB, the IEB will determine whether the caller is making an "inquiry" or a "request to apply" for services. If the call is a "request to apply," the IEB proceeds to the step in subsection (2) below.

(a) A contact is an inquiry if the individual is only requesting general information regarding OLTL Waivers or Waiver services or in-home services generally, but is not expressing any intention to be considered for participation in a Waiver. If any question exists as to whether a contact is an inquiry or a "request to apply," the contact should be treated as a request to apply.

(b) The IEB must keep a record of the name, address and telephone number of each person making an inquiry and the date of the inquiry.

1

(2) If the call is a request to apply, the IEB will follow a "Script," which is attached as Appendix A.

(3) If, during the Initial Contact, the potential consumer decides not to proceed with the application process, the IEB will note that in its records and the case will be closed.

(4) If the potential consumer says he/she wants to continue with the application process, the IEB will schedule an in-home Intake Visit, which **must** be conducted within seven (7) calendar days of the Initial Contact unless the potential consumer requests that the visit take place at a later date or there are other circumstances beyond the control of the IEB.

(a) If the Intake Visit does not occur within seven (7) calendar days of the Initial Contact, the IEB will note the reason for the delay in its records.

(5) The IEB will check CIS prior to the Intake Visit to determine whether the potential consumer is an MA recipient.

C. INTAKE VISIT

(1) The IEB will bring the following forms to all Intake Visits:

(a) Care Management Instrument (CMI)

(b) Freedom of Choice Form

(c) Service Provider Choice Form

(d) Authorization of Release of Information (PA4)

(e) Information about the Estate Recovery Program

(f) Citizenship Form

(g) Notice of Privacy Practices, includes Acknowledgement Form

(h) Waiver Participant's Rights and Responsibilities

(i) A flow chart entitled "PA Enrollment Broker (IEB) Application Process for Home and Community Based Service

(j) Notice of Right to Timely Eligibility Determination

(2) If a potential consumer is not an MA recipient, in addition to the forms specified in subsection (1) above, the IEB will bring the following forms to the intake visit:

(a) 0192 Waiver Application (for the AIDS Waiver)

(b) PA 600L or PA 600WP (12 Community Choice counties)

(3) The IEB will complete the CMI.

(a) If the CMI indicates that the consumer may not be programmatically or clinically eligible, the IEB will explain that a person must meet certain eligibility requirements to get waiver services, but the consumer has the right to file an application and continue with the application process.

(b) If the consumer or his/her representative wants to continue the application process:

(i) If consumer is an MA recipient, the IEB will proceed to the step in Section D. below.

(ii) **If consumer is an MA recipient, the date of the Intake Visit is the Application date.**

(c) If the consumer is not an MA recipient, the IEB will explain to the consumer or his/her representative that in order to begin the application process, the consumer or his/her representative must sign a PA 600L/WP and that the consumer or representative will have to complete the form and submit supporting documentation.

(i) If the consumer signs the PA 600L/WP at the Intake Visit, the consumer is an "Applicant."

(ii) If for some reason the consumer does not want to sign the PA 600L/WP form at the Intake Visit, the IEB will leave the form and explain to the consumer that the application process will not start until the form is signed and returned to the IEB.

(iii) **The date the consumer returns a signed PA 600L/WP to the IEB is the Application Date. In most cases, the Application Date will be the date of the Intake Visit.**

(4) The IEB will review the application process, including the need for a Physician Certification and a LOCA, and assist the consumer or his/her representative as necessary to complete the forms identified in (1) and (2) above.

D. POST-INTAKE VISIT PROCESS FOR APPLICANTS:

(1) **An Applicant must receive an eligibility determination within 90 days of the Application Date.**

(a) If consumer is an MA recipient, the Application Date is the date of the Intake Visit.

(b) If the consumer is not an MA recipient, the Application Date is the date on which the consumer returns a signed PA 600L/WP to the IEB. In most cases, the Application Date will be the date of the Intake Visit.

(2) For each Applicant, the IEB will:

(a) Within seven (7) calendar days of the Application Date, send a Physician Certification form (see OLTL Bulletin # 05-10-04, 51-10-04, 55-10-04, 59-10-04 (July 6, 2010)) to the Applicant's physician to be completed, unless the Applicant decides to get the form completed him/herself. The IEB will request the physician complete and send the form so that it is received by the IEB no later than ten (10) calendar days after the date the IEB sent the form to the physician.

(b) Within fifteen (15) calendar days of the Application Date, request the AAA to conduct and submit a LOCA to the IEB within fifteen (15) calendar days of the date of the request.

(i) The IEB will notify the AAA of the deadline which the IEB gave for submission of the Physician Certification.

(ii) If the Physician Certification is received before the AAA submits the LOCA to the IEB, the IEB will forward the Physician Certification to the AAA.

(iii) If the Physician Certification is not received before the AAA conducts the assessment and completes the LOCA, then the AAA will complete the LOCA, but will note on the LOCA that the Physician Certification was not submitted and that the consumer is, therefore, NFI.

(3) If LOCA is not completed and submitted to the IEB within fifteen (15) calendar days from the date on which the IEB requests the LOCA:

(a) Starting on the fifteenth (15^{th}) day, the IEB will send two reminders to the AAA with a copy to OLTL, with the second reminder sent five (5) calendar days after the first reminder.

(b) If the LOCA is not received by the IEB within five (5) calendar days of the second reminder, the IEB will refer the case to OLTL for follow-up.

(4) For each Applicant that the IEB refers to OLTL because it has not received a LOCA, within ten (10) calendar days of the IEB referral, OLTL will contact the AAA to determine why the LOCA has not been completed.

(a) If the AAA has been unable to complete the LOCA because the Applicant has refused to cooperate, or is no longer interested, OLTL will instruct the IEB to complete and submit a PA 1768 Form or an updated PA 1768 Form to the CAO verifying that the individual does not qualify for waiver services. In the comment section, the IEB will note whether the Applicant did not cooperate and, if so, the nature of the lack of cooperation or whether the Applicant is no longer interested in receiving OLTL waiver services.

(b) For all other Applicants, OLTL will set a deadline for completion of the LOCA, which will be no later than ten (10) calendar days after the contact with the AAA.

(i) If the LOCA is not completed by the deadline, then OLTL will arrange for an assessment to be conducted and the LOCA completed by staff or designee of OLTL within five (5) calendar days. Subsection (6) will apply.

(5) If the Physician Certification is not received by the deadline for completion of the LOCA, the assessor will conduct the assessment and complete the LOCA, but will note on the LOCA that the Physician Certification was not received and that the Applicant is therefore NFI.

(6) If the IEB does not receive the physician cert within ten (10) calendar days from the date on which the IEB sent the Physician Certification form to the physician:

(a) Starting on the tenth (10^{th}) day, the IEB will make a total of two (2) reminder calls to the physician, with the second call made five (5) calendar days after the first call, and at least one (1) call to the Applicant during that period, explaining that the application will be denied if the Physician Certification form is not received.

(b) If the IEB does not receive the Physician Certification form within seven (7) calendar days of the last reminder call, the IEB will send a written notice to the Applicant advising that, unless a Physician Certification is received within ten (10) calendar days of the notice, the Applicant may be determined ineligible for OLTL Waiver services.

(7) For each Applicant for whom a LOCA has been completed by the AAA:

(a) If the Applicant is NFCE, within seven (7) calendar days of the date the LOCA is completed, the IEB will refer the Applicant to OLTL to determine whether the Applicant is Program Eligible for the OLTL Waiver identified by the IEB or another OLTL Waiver.

(i) Within seven (7) calendar days of receiving the referral, OLTL will notify the IEB whether the Applicant is Program Eligible for an OLTL Waiver.

(ii) Within seven (7) calendar days of the date that OLTL determines whether the Applicant meets the Program eligibility criteria for an OLTL Waiver, the IEB will complete and submit a PA 1768 form to the CAO.

(b) If the Applicant is NFI because the LOCA was completed without a Physician Certification, within seven (7) calendar days of the date of the LOCA determination, the IEB will complete and submit a PA 1768 to the CAO, along with the signed PA 600L/WP and whatever supporting documentation has been provided to the IEB. The IEB will note in the comment section of the PA 1768 that the Applicant is NFI because the physician did not submit a Physician Certification. The IEB will also note whether the assessor's recommended level of care for the consumer is NFCE.

(i) If a Physician Certification is received by the IEB before the CAO issues a Notice of Eligibility/Ineligibility, and the physician recommends or orders nursing facility level of care, the IEB will complete and submit an updated PA 1768 Form noting that the Applicant is NFCE **provided that,** on the LOCA, the assessor's recommended level of care for the Applicant is NFCE.

(c) If the Applicant is NFI based upon the LOCA, within seven (7) calendar days of the date of the LOCA determination, the IEB will complete and submit a PA 1768 to the CAO, along with the signed PA 600L/WP and whatever supporting documentation has been provided to the IEB.

(8) Whether or not the LOCA has been received, no later than forty (40) calendar days after the Application Date, the IEB must forward to the CAO the PA1768, the PA600WP/L, and all supporting documentation received by that date.

(a) If the LOCA has not been received as of the date the IEB forwards the application package to the CAO, the IEB will leave the ELIGIBILITY/PROGRAM ASSESSMENT INFORMATION section of the PA 1768 blank and note in the comment section that the LOCA is pending.

(b) Once the LOCA is received, the IEB will send an updated PA 1768 Form to the CAO in accordance with section D.6.(c).

(9) For each Applicant for whom the CAO receives an application package from the IEB, the CAO will:

(a) If the application includes all needed supporting documentation upon receipt, make a financial eligibility determination and Issue a Notice of Eligibility/Ineligibility no later than forty-five (45) calendar days from the date the CAO receives the application package; or

(b) If the application is missing needed supporting documentation, request that the Applicant provide additional supporting information within ten (10) calendar days and issue a Notice of Eligibility/Ineligibility no later than forty-five (45) calendar days from the date the CAO receives the application package.

(c) If the individual was marked NFI because the physician did not submit a Physician Certification, but the assessor's recommended level of care for the consumer is otherwise NFCE (see subsection D.(7)(b), above), the CAO will not issue the Notice of Ineligibility/Eligibility prior to receipt of the Physician Certification or prior to forty-five (45) days of receipt of the application package, whichever occurs first.

E. POST INTAKE PROCESS FOR NON APPLICANTS:

(1) If the individual, who is not an MA recipient, does not sign the PA 600L/WP at the Intake Visit, the individual is not considered an "Applicant."

(2) For each such individual, the IEB will:

(a) Within thirty (30) calendar days of the Intake Visit, contact the individual by written correspondence that includes a PA 600L/WP asking if he/she is still seeking OLTL Waiver services and offering to assist the individual to complete the form;

(b) If the individual requests assistance, the IEB will schedule an Intake Visit, which must occur with seven (7) calendar days of the individual's request.

(c) If the Applicant submits a signed PA 600L/WP in response to the IEB's inquiry, the steps in Section D. (1) through (9) will apply.

(d) If the IEB does not receive a signed PA 600L/WP form within thirty (30) days, the IEB will notify the individual that no further action can be taken because the form has not been signed and that his/her case is closed but can be reopened when the signed form is received.

OBRA Target Assessments

Federal laws governing nursing facilities were revised, effective January 1989, by Public Law 100-203, the Omnibus Budget Reconciliation Act (OBRA) of 1987 (Nursing Home Reform Act), and 42 Code of Federal Regulations (CFR) Sections 483.100 - 483.116. These laws require Pre-Admission Screening Resident Review (PASRR) assessments to be completed for all individuals initially entering nursing facilities to determine if they have a Mental Illness (MI), Intellectual Disability (ID), or Other Related Condition (ORC). If an individual has a diagnosis of MI, ID, or ORC, the screening will help determine whether nursing facility care is appropriate and whether the individual needs specialized services.

There are two levels of assessments in the OBRA process. The process applies to all individuals seeking admission to a Medicaid certified nursing facility.

- PASRR Level I Identification Form (PASRR-ID) which must be completed prior to or no later than the day of admission for all individuals applying for nursing facility placement regardless of payment source.

- PASRR Level II Evaluation (PASRR-EV) which must be completed prior to admission for all individuals identified through the Level I assessment as meeting the criteria of having an MI, ID, or ORC. A Level II assessment may need to be completed for individuals already in the nursing facility if they have a change in condition that would make them meet the criteria of having an MI, ID, or ORC condition.

The Department designates the AAAs as the agencies responsible for conducting the PASRR-EV assessment. The AAA must complete a Level of Care Determination (LCD) and a PASRR-EV for all individuals who have been identified through the Level I assessment as needing further evaluation.

The following forms completed in the OBRA process are:

1. Medical Evaluation Form (MA-51) – This form is completed by the physician as part of the level of care determination.
    - Level I Assessment (PASRR-ID) – This form evaluates whether an individual meets the criteria of having a MI, ID, or ORC condition who is seeking admission to a nursing facility. All referrals for a Level II assessment must include a completed PASRR-ID.
    - Level II Assessment (PASRR-EV) – This form is used to determine if the individual meets the criteria of a MI, ID, or ORC condition and could benefit from specialized services provided through the appropriate Program Office.
2. Level of Care Determination (LCD) Tool – This standardized instrument is used as an assessment tool to determine if an individual meets the criteria of being nursing facility clinically eligible (NFCE) which allows them to seek various services including waivers and nursing facility placement.

3. Transmittal Form – This form provides the AAA's recommendation regarding the individual's Level of Care and recommendation for the need for specialized services. There are two Transmittal Forms currently utilized:
    - The Transmittal Form Evaluation Agency to Program Office is completed and sent with assessment packets going to OMHSAS and OLTL.
    - The Transmittal – Preliminary Evaluation Report Recommendation for the ID Target Population Form is completed and sent with the assessment packets to the Regional Developmental Disabilities Program Office.

4. Program Office Letter of Determination – This form is generated by the Program Office to notify the individual, the AAA, the hospital, the nursing facility, and other relevant entities of the final determination. The letter identifies whether the individual requires a nursing facility level of care, meets criteria for having a MI, ID, or ORC, and requires specialized services.

5. Right to Appeal and to a Fair Hearing – Along with the Program Office Letter of Determination, the Right to Appeal and to a Fair Hearing is sent to an individual by the Program Office as notification to their hearings and appeals rights under the OBRA process.

Once the AAA has completed the entire assessment process, the following information must be submitted to the appropriate Program Office. Please refer to the link for specifics by Program Office (Program Office submission packet checklist).

- LCD
- Level I Assessment (PASRR-ID) and if applicable the Out of State ID
- MA-51 (unsigned) (Script is not permitted)
- Level II Assessment (PASRR-EV)
- Any information and consultations obtained to document the need for specialized services on the PASRR-EV
- Transmittal Form with recommendation
- Any other relevant information

The OBRA process is complete when the AAA receives the Letter of Determination from the Program Office.

Note: The AAA should review each case individually and contact the appropriate Program Office with any questions about what information should be included in the transmittal.

OBRA Special Circumstances

1. Exceptional Admission

   An individual who meets criteria of having a MI, ID, or ORC can be admitted to a nursing facility under the exceptional admission process as defined on the PASRR-ID form.

   There are four exception types as defined on the PASRR-ID:

   - Exempted hospital discharge for convalescent care (not more than 30 days),
   - Respite care (not more than 14 days),
   - Persons requiring emergency placement as certified by the AAA Protective Services Unit (not more than 30 days), and
   - Persons in a coma or functioning at a brain stem level

2. Dual and Multiple Target Diagnoses

   The assessment may identify individuals who can be appropriately served by more than one Program Office. After an individual is identified and could be served by more than one Program Office, all applicable Program Offices are to review the assessment packet. The AAA is responsible to send out only one packet.

   - If the individual is a dual target for OMHSAS and ODP, the order of the Program Office review is:
     1) OMHSAS
     2) ODP
   - If the individual is a dual target for ORC and OMHSAS, the order of Program Office review is:
     1) OMHSAS
     2) ORC
   - If the individual is a target for all three, the order for review is:
     1) OMHSAS
     2) ODP
     3) ORC

3. Out of State Admissions

   The Program Offices cannot accept an ID from another state. The AAA can make a determination on an individual using the Out of State ID if the AAA determines they have sufficient supporting documentation and have completed the PASRR-EV. It is the responsibility of the in-state nursing facility to complete and send to the AAA office a PASRR-ID prior to or on the day of admission to the facility. The AAA sends the entire packet including the Out of State ID, PASRR-ID, and the PASRR-EV to the appropriate Program Office.

4. Current Nursing Facility Residents

   If the assessment is being completed to determine Medicaid eligibility, the AAA completes the LCD and the PASRR-EV if required. The AAA should coordinate with the appropriate Field Operations Office to determine who will complete the PASRR-EV assessment and submission to the Program Office for individuals meeting the criteria for MI, ID, or ORC.

Overview of the Level of Care Determination Tool

- Review the LCD Tool prior to LCD Assessor Webinar.
- During the LCD Assessor Webinar, facilitate a 15-minute group review and discussion of the LCD Tool.
  - Review each section of the LCD Tool.
  - Use the Instructions for Completing the LCD Tool and Frequently Asked Questions found in the Resources section as a reference.
  - Submit questions for each tool section. Indicate the section and question number when submitting your question.

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1. INTRODUCTION

1.A. INDIVIDUAL'S IDENTIFICATION

1. **Date when AAA received the referral for the Level of Care Assessment**

_____/_____/_____

2. **Individual's Last Name**

_____

3. **Individual's First Name**

_____

4. **Individual's Middle Initial**

_____

5. **Individual's Name Suffix (If applicable)**

_____

6. **Individual's Nickname / Alias**

_____

_____

_____

_____

7. **Individual's Date of Birth (DOB)**

_____/_____/_____

8. **Individual's Gender**

- ☐ Male
- ☐ Female

9. **Individual's Ethnicity (Check only one)**

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

10. **Individual's Race**

- ☐ American Indian/Native Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Non-Minority (White, non-Hispanic)
- ☐ White-Hispanic
- ☐ Unknown/Unavailable
- ☐ Other-Document Details in Notes

11. **Individual's Social Security Number (SSN)**

_____-_____-_____

12a. **Does the individual have a Medicaid number?**

- ☐ No
- ☐ Yes
- ☐ Pending

12b. **Indicate Medicaid recipient number**

_____

13a. **Does the individual have Medicare?**

- ☐ No
- ☐ Yes

13b. **Indicate Medicare recipient number**

_____

14a. **Does the individual have any other insurance?**

- ☐ No
- ☐ Yes
- ☐ Don't know

14b. **Indicate other insurance information**

_____

1.B. ASSESSMENT INFORMATION

4/29/2014

1. PSA number conducting assessment

- ☐ 01
- ☐ 02
- ☐ 03
- ☐ 04
- ☐ 05
- ☐ 06
- ☐ 07
- ☐ 08
- ☐ 09
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17
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- ☐ 38
- ☐ 39
- ☐ 40
- ☐ 41
- ☐ 42
- ☐ 43
- ☐ 44
- ☐ 45
- ☐ 46
- ☐ 47
- ☐ 48
- ☐ 49
- ☐ 50
- ☐ 51
- ☐ 52

2. Indicate type of assessment

- ☐ Aging Waiver Annual
- ☐ Change in Condition
- ☐ DC-Domiciliary Care Annual
- ☐ Initial
- ☐ OBRA
- ☐ PCH-Personal Care Home Annual
- ☐ Other-Document Details in Notes

3. Where was the individual interviewed?

- ☐ AAA-Area Agency on Aging
- ☐ Chart Review
- ☐ AL-Assisted Living
- ☐ Deceased Individual
- ☐ DC-Domiciliary Care
- ☐ Home
- ☐ Home of Relative /Caregiver
- ☐ Hospital
- ☐ Mental Health Facility
- ☐ Nursing Home
- ☐ PCH-Personal Care Home
- ☐ Specialized /Rehab Facility
- ☐ Other-Document Details in Notes

4. Date of the visit/chart review

_____/_____/_____

5. Did the individual participate in the assessment?

- ☐ No-Document Details in Notes
- ☐ Yes

6. If anyone else participated during the time of the determination, please document the Relationship. (Document Name in Notes)

- ☐ 1 - Spouse /Domestic Partner
- ☐ 2 - Family-Other than Spouse
- ☐ 3 - Legal Guardian
- ☐ 4 - Durable Power of Attorney
- ☐ 5 - Friend
- ☐ 6 - Other-Document Name and Relationship in Notes

7. Identify who referred the individual

- ☐ AAA-Conducting Assessment
- ☐ Family
- ☐ AAA-Other
- ☐ Hospital
- ☐ IEB-Independent Enrollment Broker
- ☐ Nursing or Rehab Facility
- ☐ PCH-Personal Care Home
- ☐ Physician
- ☐ Self
- ☐ Social Services Agency
- ☐ Supports Coordination Agency
- ☐ Unavailable
- ☐ Other-Document Details in Notes

1.C. INDIVIDUAL'S DEMOGRAPHICS

1. Type of PERMANENT residence in which the individual resides

- ☐ AL-Assisted Living
- ☐ Apartment
- ☐ DC-Domiciliary Care
- ☐ Group Home
- ☐ Homeless
- ☐ Nursing Home
- ☐ Own Home
- ☐ PCH-Personal Care Home
- ☐ Relative's Home
- ☐ Specialized Rehab /Rehab Facility
- ☐ State Institution
- ☐ Unknown
- ☐ Other-Document Details in Notes

2. What is the individual's PERMANENT living arrangement? (Include in the "Lives Alone" category individuals who live in an Assisted Living, Dom Care, or PCH, pay rent and have NO ROOMMATE.)

- ☐ Lives Alone
- ☐ Lives with Spouse Only
- ☐ Lives with Child(ren) but not Spouse
- ☐ Lives with other Family Member(s)
- ☐ Unknown
- ☐ Other-Document Details in Notes

3. Individual's marital status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Legally Separated
- ☐ Widowed
- ☐ Other-Document Details in Notes

4a. Is the individual a Veteran?

- ☐ No
- ☐ Yes-Skip to 1.C.5a
- ☐ Unable to Determine

4b. Is the individual the spouse or child of a Veteran?

- ☐ No
- ☐ Yes
- ☐ Unable to Determine

5a. Does the individual require communication assistance?

- ☐ No-Skip to 1.C.6a
- ☐ Yes-Complete 1.C.5b
- ☐ Unable to Determine

5b. What type of communication assistance is required? Document Details in Notes

- ☐ Assistive Technology
- ☐ Interpreter
- ☐ Large Print
- ☐ Picture Book
- ☐ Unable to Communicate
- ☐ Unknown
- ☐ Other-Document Details in Notes

6a. Does the individual use sign language as their PRIMARY language?

- ☐ No-Skip to 1.C.7
- ☐ Yes-Complete 1.C.6b

6b. What type of sign language is used?

- ☐ American Sign Language
- ☐ International Sign Language
- ☐ Makaton
- ☐ Manually Coded Language-English
- ☐ Manually Coded Language-Non-English
- ☐ Tactile Signing
- ☐ Other-Document Details in Notes

7. What is the individual's PRIMARY language?

- ☐ English
- ☐ Russian
- ☐ Spanish
- ☐ Other-Document Details in Notes

1.D. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED

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1. Is the individual's postal/mailing address exactly the same as the residential address?

- ☐ No-Complete Section 1.E (Postal/Mailing address)
- ☐ Yes

2a. Residential County

- ☐ Adams
- ☐ Allegheny
- ☐ Armstrong
- ☐ Beaver
- ☐ Bedford
- ☐ Berks
- ☐ Blair
- ☐ Bradford
- ☐ Bucks
- ☐ Butler
- ☐ Cambria
- ☐ Cameron
- ☐ Carbon
- ☐ Centre
- ☐ Chester
- ☐ Clarion
- ☐ Clearfield
- ☐ Clinton
- ☐ Columbia
- ☐ Crawford
- ☐ Cumberland
- ☐ Dauphin
- ☐ Delaware
- ☐ Elk
- ☐ Erie
- ☐ Fayette
- ☐ Forest
- ☐ Franklin
- ☐ Fulton
- ☐ Greene
- ☐ Huntingdon
- ☐ Indiana
- ☐ Jefferson
- ☐ Juniata
- ☐ Lackawanna
- ☐ Lancaster
- ☐ Lawrence
- ☐ Lebanon
- ☐ Lehigh
- ☐ Luzerne
- ☐ Lycoming
- ☐ McKean
- ☐ Mercer
- ☐ Mifflin
- ☐ Monroe
- ☐ Montgomery
- ☐ Montour
- ☐ Northampton
- ☐ Northumberland
- ☐ Perry
- ☐ Philadelphia
- ☐ Pike
- ☐ Potter
- ☐ Schuylkill
- ☐ Snyder
- ☐ Somerset
- ☐ Sullivan
- ☐ Susquehanna
- ☐ Tioga
- ☐ Union
- ☐ Venango
- ☐ Warren
- ☐ Washington
- ☐ Wayne
- ☐ Westmoreland
- ☐ Wyoming
- ☐ York
- ☐ Out of State

2b. Residential Street Address

_____

2c. Residential Address Second Line (Apt or Room #, Building or Complex Name, etc.)

_____

2d. Residential Municipality - REQUIRED (usually a Township or Boro where individual votes, pays taxes)

2e. Residential City/Town

2f. Residential State

_____

2g. Residential Zip Code

_____

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3. Directions to the individual's home

4. Does individual reside in a rural area?

- ☐ No
- ☐ Yes

5a. Primary Phone Number

5b. Mobile Phone Number

5c. Other Phone Number (Enter number where individual can be reached.)

5d. E-mail Address

6. What was the outcome when the individual was offered a voter registration form? REQUIRED

- ☐ AAA will submit completed voter registration
- ☐ Individual declined application
- ☐ Individual declined-already registered
- ☐ Individual will submit completed voter registration
- ☐ Does not meet voter requirements (i.e. citizenship, etc.)
- ☐ No Response

1.E. INDIVIDUAL'S POSTAL/MAILING ADDRESS INFORMATION

1a. Postal Street Address

1b. Postal Address Line 2 (optional)

1c. Postal City/Town

1d. Postal State

1e. Postal Zip Code

1.F. EMERGENCY CONTACT

1. Name of Emergency Contact

2. Relationship of Emergency Contact

3. Telephone Number of Emergency Contact

4. Work Telephone Number of Emergency Contact

2. USE OF MEDICAL SERVICES

2.A. HOSPITAL, NURSING FACILITY, ER, INPATIENT PSYCHIATRIC VISITS/STAYS

1. What is the individual's current level of consciousness?

- ☐ Comatose-Skip to 13.A
- ☐ Conscious-Complete Assessment
- ☐ Deceased-Skip to 13.A
- ☐ Persistent Vegetative State-Skip to 13.A

2. Has the individual stayed in the HOSPITAL in the LAST 12 MONTHS?

- ☐ No-Skip to 2.A.4
- ☐ Yes-Complete 2.A.3
- ☐ Unable to determine-Document Details in Notes

3. The approximate number of times the individual has stayed overnight in the HOSPITAL in the LAST 12 MONTHS. Document Details in Notes.

4. The approximate number of times the individual has visited the ER in the LAST 12 MONTHS and was NOT admitted.

5. The approximate number of times the individual was admitted to a NURSING FACILITY in the LAST 12 MONTHS. Document Details in Notes.

6. The approximate number of times the individual was an Inpatient in a PSYCHIATRIC Facility in the LAST 24 MONTHS. Document Details in Notes.

2.B. PRIMARY PHYSICIAN INFORMATION

1. Does the individual have a PRIMARY Care Physician?

- ☐ No
- ☐ Yes

2. PRIMARY Physician's Name

3. PRIMARY Physician's Street Address

4. PRIMARY Physician's City or Town

5. PRIMARY Physician's State

6. PRIMARY Physician's Zip Code

7. PRIMARY Physician's Business Phone Number (Requires 10 digits to transfer to SAMS, optional 1-5 digit extension.)

8. PRIMARY Physician's FAX Number

9. PRIMARY Physician's E-MAIL ADDRESS

10. Additional Physicians

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3. SAINT LOUIS UNIVERSITY MENTAL STATUS (SLUMS)

3.A. SLUMS PREPARATION

1. Determine if the individual is alert. Alert indicates that the individual is fully awake and able to focus.

- ☐ Alert
- ☐ Confused
- ☐ Distractible
- ☐ Drowsy
- ☐ Inattentive
- ☐ Preoccupied

2. Do you have trouble with your memory?

- ☐ No-Skip to 4.A.1
- ☐ Yes

3. May I ask you some questions about your memory?

- ☐ No
- ☐ Yes
- ☐ Other-Document Details in Notes

4. Is the individual able to complete the SLUMS Exam?

- ☐ No-Document Details in Notes
- ☐ Yes

3.B. SLUMS QUESTIONNAIRE

1. What DAY of the week is it?

- ☐ 1 - Correct answer
- ☐ 2 - Incorrect or not answered

2. What is the YEAR?

- ☐ 1 - Correct answer
- ☐ 2 - Incorrect answer

3. What is the name of the STATE we are in?

- ☐ 1 - Correct answer
- ☐ 2 - Incorrect answer

4. Please remember these five objects. I will ask you what they are later. Apple, Pen, Tie, House, Car

_____

5a. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20. How much did you spend?

- ☐ 1 - Correct
- ☐ 2 - Incorrect
- ☐ 3 - Unanswered

5b. How much do you have left?

- ☐ 1 - Correct
- ☐ 2 - Incorrect
- ☐ 3 - Unanswered

6. Please name as many animals as you can in one minute.

- ☐ 0-4
- ☐ 5-9
- ☐ 10-14
- ☐ 15+
- ☐ Unanswered

7. What were the five objects I asked you to remember? One point for each correct response.

- ☐ Apple
- ☐ Pen
- ☐ Tie
- ☐ House
- ☐ Car
- ☐ Unanswered /None Correct

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say four-two, you would say two-four.

- ☐ 8-7
- ☐ 6-4-9
- ☐ 8-5-3-7
- ☐ Unanswered /None correct

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.

- ☐ Hour markers correct
- ☐ Time correct
- ☐ Unanswered /None Correct

10a. Place an X in the triangle

- ☐ 1 - Correct
- ☐ 2 - Incorrect

10b. Which of the figures is the largest?

- ☐ 1 - Correct
- ☐ 2 - Incorrect

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

- ☐ What was the female's name? (Jill)
- ☐ What state did she live in? (Illinois)
- ☐ What work did she do? (Stockbroker)
- ☐ When did she go back to work? (Kids were teenagers)
- ☐ Unanswered /None Correct

3.C. SLUMS RESULTS

1. SLUMS Total Score - This will be an INDICATOR

2. Record the highest grade (1-12) the individual completed in school.

3. Identify the highest educational degree that the individual obtained.

- ☐ High School Graduate /or GED
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Graduate's Degree
- ☐ Doctoral Degree
- ☐ Other-Document Details in Notes

4. Assessor's conclusion after completion of the Individual's SLUMS Exam:

- ☐ Normal
- ☐ MNCD-Mild Neurocognitive Disorder
- ☐ Mild Dementia
- ☐ Moderate Dementia
- ☐ Severe Dementia

4. DIAGNOSES

4.A. RESPIRATORY

1. Select all RESPIRATORY diagnoses

- [ ] None-Skip to 4.B.1
- [ ] Asthma
- [ ] COPD-Chronic Obstructive Pulmonary Disease
- [ ] Emphysema
- [ ] Pulmonary Edema
- [ ] Respiratory Failure
- [ ] Other-Document Details in Notes

2. Current treatments for RESPIRATORY diagnoses

- [ ] None
- [ ] Medications-List in 9.D
- [ ] Oxygen
- [ ] Respiratory Treatments (Nebulizers, inhalants, etc.)
- [ ] Suctioning
- [ ] Tracheostomy/Trach Care
- [ ] Ventilator/Vent Care
- [ ] Other-Document Details in Notes

3. Does the RESPIRATORY diagnosis affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

4. Is the individual able to self-manage care of the RESPIRATORY condition(s)?

- [ ] No-Document Details in Notes
- [ ] Yes
- [ ] Unable to Determine-Document Details in Notes

4.B. HEART/CIRCULATION

1. Select all HEART and/or CIRCULATORY system diagnoses

- [ ] None-Skip to 4.C.1
- [ ] A-Fib and other Dysrhythmia, Bradycardia, Tachycardia
- [ ] Anemia
- [ ] Ascites
- [ ] CAD-Coronary Artery Disease: including Angina, Myocardial Infarction, ASHD
- [ ] DVT-Deep Vein Thrombosis
- [ ] Heart Failure: including CHF, Pulmonary Edema
- [ ] Hypertension
- [ ] PE-Pulmonary Embolus
- [ ] PVD/PAD (Peripheral Vascular or Artery Disease)
- [ ] Other-Document Details in Notes

2. Current treatments for HEART and/or CIRCULATORY System diagnoses

- [ ] None
- [ ] Cardiac Rehabilitation
- [ ] Compression Device, TED Hose, Ace Bandage Wrap(s)
- [ ] Medications-List in 9.D
- [ ] Pacemaker
- [ ] Special Diet
- [ ] Other-Document Details in Notes

3. Does the HEART and/or CIRCULATORY diagnosis affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

4. Is the individual able to self-manage care of the HEART and/or CIRCULATORY system condition(s)?

- [ ] No-Document Details in Notes
- [ ] Yes
- [ ] Unable to Determine-Document Details in Notes

4.C. GASTROINTESTINAL

1. Select all GASTROINTESTINAL diagnoses

- [ ] None-Skip to 4.D.1
- [ ] Barrett's Esophagus
- [ ] Crohn's Disease
- [ ] Diverticulitis
- [ ] GERD
- [ ] Hernia
- [ ] IBS-Irritable Bowel Syndrome
- [ ] Laryngeal Reflux Disease
- [ ] Other-Document Details in Notes

2. Current treatments for GASTROINTESTINAL diagnoses

- [ ] None
- [ ] Aspiration Precautions
- [ ] Feeding Tube (Any)
- [ ] Medications-List in 9.D
- [ ] Ostomy (Any)
- [ ] Speech Therapy
- [ ] TPN-Total Parenteral Nutrition
- [ ] Other-Document Details in Notes

3. Does the GASTROINTESTINAL diagnosis affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

4. Is the individual able to self-manage care of GASTROINTESTINAL condition(s)?

- ☐ No-Document Details in Notes
- ☐ Yes
- ☐ Unable to Determine-Document Details in Notes

4.D. MUSCULOSKELETAL

1. Musculoskeletal diagnoses and/or signs and symptoms of Musculoskeletal diagnoses:

- ☐ None-Skip to 4.E.1
- ☐ Ambulatory Dysfunction
- ☐ Arthritis-Document Type of Arthritis in Notes
- ☐ Contracture(s)
- ☐ Frequent Fractures
- ☐ Joint Deformity
- ☐ Limited Range of Motion
- ☐ Paralysis-Document Details in Notes
- ☐ Osteoporosis
- ☐ Poor Balance
- ☐ Spasms
- ☐ Spinal Stenosis
- ☐ Weakness
- ☐ Other-Document Details in Notes

2. Current treatments for MUSCULOSKELETAL diagnoses

- ☐ None
- ☐ Assistive Devices-Document Details in Notes
- ☐ Brace(s)
- ☐ Cast
- ☐ Medications-List in 9.D
- ☐ Elevate Legs
- ☐ Physical /Occupational Therapy
- ☐ Prosthesis(es)
- ☐ Splint
- ☐ Traction
- ☐ Other-Document Details in Notes

3. Does the MUSCULOSKELETAL diagnosis affect the individual's ability to function?

- ☐ No
- ☐ Yes-Document Details in Notes

4. Is the individual able to self-manage care of the MUSCULOSKELETAL condition(s)?

- ☐ No-Document Details in Notes
- ☐ Yes
- ☐ Unable to Determine-Document Details in Notes

4.E. SKIN

1. Select all SKIN diagnoses:

- ☐ None-Skip to 4.F.1
- ☐ Dry Skin
- ☐ Incision (surgical)
- ☐ Psoriasis
- ☐ Rash
- ☐ Ulcer
- ☐ Wound
- ☐ Other-Document Details in Notes

2. Check ALL affected SKIN location(s):

- ☐ Abdomen
- ☐ Ankle(s)
- ☐ Arm(s)
- ☐ Back of Knee(s)
- ☐ Buttock(s)
- ☐ Chest
- ☐ Face
- ☐ Foot/Feet
- ☐ Hip(s)
- ☐ Leg(s)
- ☐ Lower Back
- ☐ Shoulder Blade(s)
- ☐ Spine
- ☐ Tailbone
- ☐ Other-Document Details in Notes

3. Identify the highest known ULCER STAGE.

- ☐ 0 - Unstageable
- ☐ 1 - Stage 1 - Redness
- ☐ 2 - Stage 2 - Partial Skin Loss
- ☐ 3 - Stage 3 - Full Thickness
- ☐ 4 - Stage 4 - Muscle and/or Bone Exposed
- ☐ 5 - Unknown

4. Current treatments for SKIN diagnoses

- ☐ None
- ☐ Debridement
- ☐ Medications-List in 9.D
- ☐ Pressure Relieving Devices
- ☐ Surgery
- ☐ Unna Boot(s)
- ☐ Wound Dressing
- ☐ Wound Therapy
- ☐ Wound VAC
- ☐ Other-Document Details in Notes

5. Does the SKIN diagnosis affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

6. Is the individual able to self-manage care of the SKIN condition(s)?

- [ ] No-Document Details in Notes
- [ ] Yes
- [ ] Unable to Determine-Document Detail in Notes

4.F. ENDOCRINE/METABOLIC

1. Select all ENDOCRINE/METABOLIC diagnoses

- [ ] None-Skip to 4.G.1
- [ ] Ascites
- [ ] Cirrhosis
- [ ] Diabetes Mellitus (DM)-Insulin Dependent
- [ ] Diabetes Mellitus (DM)-Non-insulin Dependent
- [ ] Diabetic Neuropathy
- [ ] Hypoglycemia
- [ ] Thyroid Disorder
- [ ] Other-Document Details in Notes

2. Select all the current treatments for ENDOCRINE/METABOLIC diagnosis

- [ ] None
- [ ] Blood Transfusions
- [ ] Blood Sugar Monitoring
- [ ] Medications-List in 9.D
- [ ] Special Diet
- [ ] Other-Document Details in Notes

3. Does the ENDOCRINE/METABOLIC diagnosis affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

4. Is the individual able to self-manage care of the ENDOCRINE/METABOLIC condition(s)?

- [ ] No-Document Details in Notes
- [ ] Yes
- [ ] Unable to Determine-Document Details in Notes

4.G. GENITOURINARY

1. Select all GENITOURINARY diagnoses

- [ ] None-Skip to 4.H.1
- [ ] Ascites
- [ ] Benign Prostatic Hypertrophy (BPH)
- [ ] Bladder Disorders, including neurogenic or overactive bladder, urinary retention
- [ ] Frequent Urinary Tract Infections (UTI)
- [ ] Renal Insufficiency/Failure (ESRD)
- [ ] Other-Document Details in Notes

2. Current treatments for GENITOURINARY diagnoses

- [ ] None
- [ ] Catheter
- [ ] Dialysis
- [ ] Fluid Restrictions
- [ ] Medications-List in 9.D
- [ ] Ostomy
- [ ] Other-Document Details in Notes

3. Does the GENITOURINARY diagnosis affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

4. Is the individual able to self-manage care of the GENITOURINARY condition(s)?

- [ ] No-Document Details in Notes
- [ ] Yes
- [ ] Unable to Determine-Document Details in Notes

4.H. INFECTIONS/IMMUNE SYSTEM

1. Select all INFECTION/IMMUNE System diagnoses

- [ ] None-Skip to 4.I.1
- [ ] AIDS Asymptomatic
- [ ] AIDS Symptomatic
- [ ] Hepatitis
- [ ] HIV
- [ ] MRSA/VRE/C-Dif
- [ ] TB-Tuberculosis
- [ ] Other-Document Details in Notes

2. If HIV or AIDS is indicated in 4.H.1, has the individual ever had lab results of CD4 count under 400?

- [ ] No
- [ ] Yes
- [ ] Unknown

3. Current Treatments for INFECTION/IMMUNE System Diagnoses

- [ ] None
- [ ] Intravenous Therapy
- [ ] Isolation
- [ ] Laboratory Result Monitoring
- [ ] Medications-List in 9.D
- [ ] Wound Therapy
- [ ] Other-Document Details in Notes
- [ ] Transfusion(s)

4. Does the INFECTIONS/IMMUNE SYSTEM diagnosis affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

5. Is the individual able to self-manage care of the INFECTION/IMMUNE System conditions?

- [ ] No-Document Details in Notes
- [ ] Yes
- [ ] Unable to Determine-Document Details in Notes

4.I. CANCER

1. Does the individual have a current CANCER diagnosis?

- [ ] No-Skip to 5.A.1
- [ ] Yes

2. If Yes, identify the Cancer Stage:

- [ ] 0 - Unstageable
- [ ] 1 - Stage 1
- [ ] 2 - Stage 2
- [ ] 3 - Stage 3
- [ ] 4 - Stage 4
- [ ] 5 - Unknown

3. Select all current CANCER Diagnoses:

- [ ] Ascites
- [ ] Basal Cell
- [ ] Bile Duct
- [ ] Bladder
- [ ] Bone
- [ ] Brain
- [ ] Breast
- [ ] Cervical
- [ ] Colon
- [ ] Colorectal
- [ ] Endometrial
- [ ] Esophageal
- [ ] Gallbladder
- [ ] Gastric
- [ ] Hodgkin's Disease
- [ ] Kidney
- [ ] Leukemia
- [ ] Liver
- [ ] Lung
- [ ] Lymphatic
- [ ] Multiple Myeloma
- [ ] Non-Hodgkin's Lymphoma
- [ ] Oral
- [ ] Ovarian
- [ ] Pancreatic
- [ ] Prostate
- [ ] Sarcoma
- [ ] Skin
- [ ] Testicular
- [ ] Throat
- [ ] Thyroid
- [ ] Uterine
- [ ] Vaginal
- [ ] Other-Document Details in Notes

4. Current treatments for CANCER diagnoses:

- [ ] None
- [ ] Aspiration Precautions
- [ ] Bone Marrow Transplant
- [ ] Chemo /Radiation Combination
- [ ] Chemotherapy
- [ ] Hospice Care
- [ ] Indwelling Catheter /Services
- [ ] Maintenance /Preventative Skin Care
- [ ] Medications-List in 9.D
- [ ] Occupational Therapy
- [ ] Ostomy /Related Services
- [ ] Oxygen
- [ ] Palliative Care
- [ ] Physical Therapy
- [ ] Radiation
- [ ] Respiratory Therapy
- [ ] Restorative Care
- [ ] Speech Therapy
- [ ] Suctioning
- [ ] Surgery
- [ ] Transfusion(s)
- [ ] Tube Feedings /TPN
- [ ] Other-Document Details in Notes

5. Does the CANCER diagnosis affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

6. Is the individual able to self-manage the CANCER conditions?

- [ ] No-Document Details in Notes
- [ ] Yes
- [ ] Unable to Determine

5. NEUROLOGICAL (MANDATORY completion of Section 8 if Neurological diagnosis)

5.A. NEUROLOGICAL

1. If there is a NEUROLOGICAL diagnosis, select all types & completion of Section 8 Behaviors is MANDATORY.

- [ ] None-Skip to 6.A.1
- [ ] ALS
- [ ] Alzheimer's Disease
- [ ] Autism
- [ ] Cerebral Palsy
- [ ] CVA/TIA/Stroke
- [ ] Dementia (Include all Non-Alzheimer's Dementia)
- [ ] Multiple Sclerosis
- [ ] Muscular Dystrophy
- [ ] Neuropathy
- [ ] Parkinson's Disease
- [ ] Seizure Disorder
- [ ] TBI-Traumatic Brain Injury
- [ ] Other-Document Details in Notes

2. Current treatments for NEUROLOGICAL diagnosis

- [ ] None
- [ ] Braces
- [ ] Cervical Collar
- [ ] Cognitive /Behavioral Therapy
- [ ] Electrical Stimulation Device
- [ ] Medications-List in 9.D
- [ ] Seizure Precautions
- [ ] Therapy-Document Details in Notes
- [ ] Traction
- [ ] Other-Document Details in Notes

3. Is the individual ABLE to communicate?

- [ ] No-Document Details in Notes
- [ ] Yes

4. What characteristics describe the individual's cognitive state?

- [ ] Appears to be cognitively intact
- [ ] Executive functioning impaired-Document Details in Notes
- [ ] Inability to adapt to changes in routine or location
- [ ] Inability to follow commands
- [ ] Non-communicative
- [ ] Poor long term memory
- [ ] Poor short term memory
- [ ] Slow response to questions
- [ ] Other-Document Details in Notes

5. Does the NEUROLOGICAL diagnosis affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

6. Is the individual able to self-manage care of the NEUROLOGICAL condition(s)?

- [ ] No-Document Details in Notes
- [ ] Yes
- [ ] Unable to Determine-Document Details in Notes

6. INTELLECTUAL DEVELOPMENTAL DISABILITY (IDD) (MANDATORY completion of Section 8 if IDD diagnosis)

6.A. INTELLECTUAL DEVELOPMENTAL DISABILITY (IDD)

1. Does the individual have a diagnosis of Intellectual Developmental Disability (IDD) from birth to 22nd birthday or known to the ID system?

- ☐ No-Skip to 7.A.1
- ☐ Yes-Section 8-Behaviors is MANDATORY

2. Is the individual able to self-manage care of the IDD condition?

- ☐ No-Document Details in Notes
- ☐ Yes
- ☐ Unable to Determine

3. Does the IDD diagnosis affect the individual's ability to function?

- ☐ No-Document Details in Notes
- ☐ Yes
- ☐ Unable to Determine

7. MENTAL HEALTH (MANDATORY completion of Section 8 if Psychiatric diagnosis)

7.A. PSYCHIATRIC

1. If there is a PSYCHIATRIC diagnosis, select all types & completion of Section 8 Behaviors is mandatory.

- [ ] None-Skip to 8.A.1
- [ ] Anxiety Disorders
- [ ] Bipolar Disorders
- [ ] Depressive Disorders
- [ ] Disruptive Impulse Control /Conduct Disorders
- [ ] Eating Disorders
- [ ] Obsessive Compulsive Disorders
- [ ] Personality Disorders
- [ ] Schizophrenia /Other Psychotic Disorders
- [ ] Sleep /Wake Disorders
- [ ] Somatic Symptom /Related Disorders
- [ ] Trauma, Stress /Related Disorders
- [ ] Other-Document Details in Notes

2. Current treatments for PSYCHIATRIC diagnoses

- [ ] None
- [ ] ECT-Electroconvulsive Therapy
- [ ] Medications-List in 9.D
- [ ] Outpatient Psychiatric Care
- [ ] Other-Document Details in Notes

3. Does the PSYCHIATRIC diagnosis affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

4. Is the individual able to self-manage care of the PSYCHIATRIC conditions?

- [ ] No-Document Details in Notes
- [ ] Yes
- [ ] Unable to Determine-Document Details in Notes

8. BEHAVIORS - MANDATORY if Neurological, IDD or Psychiatric Diagnosis

8.A. BEHAVIORS

1. Does the individual present with any BEHAVIORAL signs/symptoms? This Section is REQUIRED if a Neurological, IDD or Psychiatric Diagnosis was noted in Section 5, 6 or 7.

- ☐ No-Skip to 9.A.1
- ☐ Yes-Complete ALL of Section 8
- ☐ Unable to Determine-Complete ALL of Section 8

2a. Does the individual exhibit PHYSICAL behavioral symptoms toward OTHERS?

- ☐ No-Skip to 3a
- ☐ Yes-Complete 2b-c

2b. Specify ALL types of aggressive PHYSICAL behavior toward OTHERS (If not listed, Document in Notes.)

- ☐ Biting
- ☐ Hair pulling
- ☐ Hitting
- ☐ Kicking
- ☐ Picking
- ☐ Scratching
- ☐ Sexual acting out /behavior
- ☐ Spitting
- ☐ Other-Document Details in Notes

2c. Does the aggressive PHYSICAL behavior toward OTHERS interfere with the individual's ability to function daily?

- ☐ No-Document Details in Notes (Why the behavior does NOT interfere.)
- ☐ Yes-Document Details in Notes (How the behavior interferes.)

3a. Does the individual exhibit aggressive PHYSICAL behavioral symptoms towards SELF?

- ☐ No-Skip to 4a
- ☐ Yes-Complete 3b-c

3b. Specify ALL types of aggressive PHYSICAL behavior towards SELF (If not listed, Document in Notes.)

- ☐ Biting
- ☐ Hair pulling
- ☐ Hitting
- ☐ Kicking
- ☐ Picking
- ☐ Scratching
- ☐ Spitting
- ☐ Other-Document Details in Notes

3c. Does the aggressive PHYSICAL behavior toward SELF interfere with the individual's ability to function daily?

- ☐ No-Document Details in Notes (Why the behavior does NOT interfere.)
- ☐ Yes-Document Details in Notes (How the behavior interferes.)

4a. Does the individual exhibit aggressive VERBAL behavior symptoms toward OTHERS?

- ☐ No-Skip to 5a
- ☐ Yes-Complete 4b-c

4b. Specify ALL types of aggressive VERBAL behavior towards OTHERS (If not listed, document in Notes.)

- ☐ Cursing
- ☐ Screaming
- ☐ Threatening
- ☐ Other-Document Details in Notes

4c. Does the aggressive VERBAL behavior toward OTHERS interfere with the individual's ability to function daily?

- ☐ No-Document Details in Notes (Why the behavior does NOT interfere.)
- ☐ Yes-Document Details in Notes (How the behavior interferes.)

5a. Does the individual exhibit any GENERAL aggressive VERBAL behavior symptoms not specifically directed toward self or others?

- ☐ No-Skip to 6a
- ☐ Yes-Complete 5b-c

5b. Select ALL GENERAL aggressive VERBAL behaviors (If not listed, Document in Notes.)

- ☐ Disruptive sounds
- ☐ Yelling out
- ☐ Other-Document Details in Notes

5c. Does the GENERAL aggressive VERBAL behavior interfere with the individual's ability to function daily?

- ☐ No-Document Details in Notes (Why the behavior does NOT interfere.)
- ☐ Yes-Document Details in Notes (How the behavior interferes.)

6a. Does the individual exhibit any OTHER behavioral symptoms?

- ☐ Yes-Complete 6b-c
- ☐ No-Skip to Section 9

6b. Specify ALL OTHER types of behaviors reported (If not listed, Document in Notes.)

- ☐ Fecal Smearing
- ☐ Hoarding
- ☐ Pacing
- ☐ Public Disrobing
- ☐ Rummaging
- ☐ Sundowner's Syndrome
- ☐ Other-Document Details in Notes

6c. Do the OTHER types of behaviors interfere with the individual's ability to function daily?

- ☐ No-Document Details in Notes (Why the behavior does NOT interfere.)
- ☐ Yes-Document Details in Notes (How the behavior interferes.)

9. OTHER MEDICAL INFORMATION

9.A. INFORMATION

1. Has the individual exhibited ELOPEMENT behavior in the past 6 months? If so, indicate the FREQUENCY.

- ☐ Never
- ☐ Daily
- ☐ Less than once a month
- ☐ Several times a week
- ☐ Several times a month
- ☐ Once a month
- ☐ Other-Document Details in Notes

2. Does the individual require supervision?

- ☐ No-Skip to 9.A.4
- ☐ Yes-Complete 9.A.2a

2a. How long can the individual be routinely left alone?

- ☐ Indefinitely
- ☐ Entire day and overnight
- ☐ Eight (8) hours or more - day or night
- ☐ Eight (8) hours or more - daytime only
- ☐ Four (4) hours or more - day or night
- ☐ Four (4) hours or more - daytime only
- ☐ Less than four (4) hours
- ☐ Cannot be left alone

3. Why does the individual require supervision?

- ☐ Cognitive Diagnosis
- ☐ General physical condition
- ☐ Environmental issue
- ☐ Other-Document Details in Notes

4. Can the individual evacuate their home in the event of a fire?

- ☐ No-Document Details in Notes
- ☐ Yes

9.B. FRAILITY SCORE

1. Are you tired?

- ☐ No
- ☐ Yes

2. Can you walk up a flight of stairs?

- ☐ No
- ☐ Yes

3. Can you walk a city block (250-350 feet)?

- ☐ No
- ☐ Yes

4. Do you have more than 5 illnesses?

- ☐ No
- ☐ Yes

5. Have you lost more than 5% of your weight in the last year?

- ☐ No
- ☐ Yes

9.C. DEPRESSION / LIFE SATISFACTION

1. Are you basically satisfied with your life?

- ☐ No
- ☐ Yes

2. Do you often get bored?

- ☐ No
- ☐ Yes

3. Do you often feel hopeless?

- ☐ No
- ☐ Yes

4. Do you prefer to stay at home, rather than going out and doing new things?

- ☐ No
- ☐ Yes

5. Do you ever have feelings of worthlessness?

- ☐ No
- ☐ Yes

9.D. MEDICATION MANAGEMENT

1. Does the individual take any PRESCRIBED Medications?

- ☐ No-Skip to 9.D.5
- ☐ Yes

2. Does the individual have a central venous line?

- ☐ No
- ☐ Yes-Document Type & Details in Notes

3. List all PRESCRIBED Medications taken by the individual

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 lingua (SL)
3 = intramuscular (IM)
4 = intravenous (IV)
5 = subcutaneous (SQ)
6 = rectal (R)
7 = topica
8 = inhalation
9 = enteral tube
10 = other
11 = eye drop
12 = transdermal

d. Frequency: Code the number of times per period the med is administered using the following list:

PR = (PRN) as necessary
1H = (QH) every hour
2H = (Q2H) every 2 hours
3H = (Q3H) every 3 hours
4H = (Q4H) every 4 hours
6H = (Q6H) every 6 hours
8H = (Q8H) every eight hours
1D = (QD or HS) once daily
2D = (BID) two times daily
(notates every 12 hours)
3D = (TID) 3 times daily
4D = (QID) four times daily
OD = every other day
1W = (Q week) once each week
2W = 2 times every week
3W = 3 times every week
4W = 4 times each week
5W = 5 times each week
6W = 6 times each week
1M = (Q month) once/mo.
2M = twice every month
C = Continuous
O = Other

a. Name and Dose	b. Form	c. No. Taken	d. Freqe. Comments

5. List all OVER THE COUNTER (OTC) Medications taken by the individual

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
11 = eye drop
12 = transdermal

d. Frequency: Code the number of times per period the med is administered using the following list:

PR = (PRN) as necessary
1H = (QH) every hour
2H = (Q2H) every 2 hours
3H = (Q3H) every 3 hours
4H = (Q4H) every 4 hours
6H = (Q6H) every 6 hours
8H = (Q8H) every eight hours
1D = (QD or HS) once daily
2D = (BID) two times daily
(notates every 12 hours)
3D = (TID) 3 times daily
4D = (QID) four times daily
OD = every other day
1W = (Q week) once each week
2W = 2 times every week
3W = 3 times every week
4W = 4 times each week
5W = 5 times each week
6W = 6 times each week
1M = (Q month) once/mo.
2M = twice every month
C = Continuous
O = Other

a. Name and Dose	b. Form	c. No. Taken	d. Freqe. Comments

4. Does the individual take all medications as prescribed?

- ☐ No-Document Details in Notes
- ☐ Yes

6. Does the individual have any allergies or adverse reactions to any medication?

- ☐ No
- ☐ Yes-Document Details in Notes

7. What is the individual's ability level to manage medication?

- ☐ 1 - Independent-Skip to 9.E
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

8. If limited assistance, indicate all types needed for medication management:

- ☐ Assistance with Self-Injections /Independent with Oral Medications
- ☐ Coaxing
- ☐ Medication Dispenser
- ☐ Set-up /Prepackaged
- ☐ Verbal Reminders
- ☐ Other-Document Details in Notes

9. Who assists the individual with medication administration?

- ☐ Formal Support-Document Details in Notes
- ☐ Informal Support-Document Details in Notes
- ☐ Other-Document Details in Notes

9.E. HEIGHT/WEIGHT

1. What is the individual's height?

_____

2. What is the individual's weight?

_____

3. What is the individual's weight type?

- ☐ Normal-height/weight appropriate
- ☐ Morbidly Obese
- ☐ Obese
- ☐ Overweight
- ☐ Underweight

9.F. PAIN

1. Does the individual report PAIN?

- ☐ No-Skip to 10.A.1
- ☐ Yes
- ☐ Unable to Determine-Skip to 10.A.1

2. Location(s) of PAIN site(s)

- ☐ Back
- ☐ Bone
- ☐ Chest
- ☐ Head
- ☐ Hip
- ☐ Incision site
- ☐ Knee
- ☐ Soft tissue (muscle)
- ☐ Stomach
- ☐ Other Joint-Document Details in Notes
- ☐ Other-Document Details in Notes

3. Indicate the level of PAIN the individual reports using a scale from 0-10 (0=no pain, 10=severe pain)

- ☐ 0=No pain
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10=Severe pain

4. Indicate the frequency the individual reports the PAIN.

- ☐ Less than Daily
- ☐ Daily-One Episode
- ☐ Daily-Multiple Episodes
- ☐ Continuous
- ☐ Other-Document Details in Notes

5. Select all the current treatments for PAIN diagnoses:

- ☐ None
- ☐ Acupuncture
- ☐ Chiropractic Care /Services
- ☐ Exercises
- ☐ Heat /Cold Applications
- ☐ Massage
- ☐ Medications-List in 9.D
- ☐ Pain Management Center
- ☐ Physical Therapy
- ☐ Other-Document Details in Notes

6. Does PAIN affect the individual's ability to function?

- ☐ No
- ☐ Yes-Document Details in Notes

10. ACTIVITIES OF DAILY LIVING (ADLs)

10.A. ADLs

1a. BATHING Ability to prepare a bath and wash oneself, includes turning on the water, regulating temperature, etc.

- [ ] 1 - Independent
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

1b. If Limited Assistance, indicate ALL types needed for BATHING

- [ ] Assistance with the use of equipment or assistive devices
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

2a. DRESSING Ability to remove clothes from a closet/drawer; application of clothing, including shoes/socks (regular/TEDS); orthotics; prostheses; removal/storage of items; managing fasteners; and to use any needed assistive devices.

- [ ] 1 - Independent
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

2b. If Limited Assistance, indicate ALL types needed for DRESSING

- [ ] Assistance with the use of equipment or assistive device
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

3a. GROOMING/PERSONAL HYGIENE Ability to comb/brush hair; brush teeth; care for/inset dentures; shave; apply make-up (if worn); apply deodorant, etc.

- [ ] 1 - Independent
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

3b. If Limited Assistance, indicate ALL types needed for GROOMING/PERSONAL HYGIENE

- [ ] Assistance with the use of equipment or assistive devices
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

4a. EATING Ability to eat/drink; cut, chew, swallow food; and to use any needed assistive devices

- [ ] 1 - Independent
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance
- [ ] 4 - Does not eat-Skip to 10.A.4c

4b. If Limited Assistance, indicate ALL types needed for EATING

- [ ] Assistance with the use of equipment or assistive devices
- [ ] Encouragement, cueing or coaxing
- [ ] Guided maneuvering of limbs
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

4c. If response to 9.A.4a is "4-Does not eat", indicate type of nutritional intake. Check ALL that apply:

- [ ] IV Fluids
- [ ] NPO (nothing by mouth)
- [ ] Parenteral Nutrition
- [ ] Tube Feeding
- [ ] Other-Document Details in Notes

5a. TRANSFER Ability to move between surfaces, including to/from bed, chair, wheelchair, or to a standing position; onto or off a commode; and to manage/use any needed assistive devices.

- [ ] 1 - Independent
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

5b. If Limited Assistance, indicate ALL types needed for TRANSFER

- [ ] Assistance with the use of equipment or assistive devices
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

6a. TOILETING Ability to manage bowel and bladder elimination

- [ ] 1 - Independent
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance
- [ ] 4 - Self management of indwelling catheter or ostomy

6b. If Limited Assistance, indicate ALL types needed for TOILETING

- [ ] Assistance with incontinence products
- [ ] Assistance with the use of equipment or assistive devices
- [ ] Clothing maneuvers/adjustment
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs
- [ ] Personal hygiene post toileting
- [ ] Setup
- [ ] Supervision
- [ ] Other-Document Details in Notes

6c. BLADDER CONTINENCE Indicate the description that best describes the individual's BLADDER function

- [ ] 1 - Continent - Complete control, no type of catheter or urinary collection device
- [ ] 2 - Usually Continent - Incontinence episodes once a week or less
- [ ] 3 - Incontinent - Inadequate control, multiple daily episodes
- [ ] 4 - Continent - with indwelling catheter

6d. BOWEL CONTINENCE Indicate the description that best describes the individual's BOWEL function

- [ ] 1 - Continent - Complete control, no ostomy device
- [ ] 2 - Usually Continent - Incontinence episodes once a week or less
- [ ] 3 - Incontinent - Inadequate control, multiple daily episodes
- [ ] 4 - Continent - with Ostomy

7a. WALKING Ability to safely walk to/from one area to another; manage/use any needed ambulation devices

- [ ] 1 - Independent
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

7b. If Limited Assistance, indicate ALL types needed for WALKING

- [ ] Assistance with the use of equipment or assistive devices
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

11. MOBILITY

11.A. CONSUMER'S MOBILITY

1. BEDBOUND Is the individual bedbound? Indicate in notes any comments or relevant information

- ☐ No
- ☐ Yes-Skip to 12.A
- ☐ Unable to Determine

2a. INDOOR MOBILITY Ability of movement within INTERIOR environment

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

2b. If Limited Assistance, indicate ALL types needed for INDOOR MOBILITY

- ☐ Assistance with the use of equipment or assistive devices
- ☐ Encouragement, cueing, or coaxing
- ☐ Guided maneuvering of limbs
- ☐ Set-up
- ☐ Supervision
- ☐ Other-Document Details in Notes

3a. OUTDOOR MOBILITY Ability of movement OUTSIDE living arrangement

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Extensive/Total Assistance

3b. If Limited Assistance, indicate ALL types needed for OUTDOOR MOBILITY

- ☐ Assistance with the use of equipment or assistive devices
- ☐ Encouragement, cueing, or coaxing
- ☐ Guided maneuvering of limbs
- ☐ Set-up
- ☐ Supervision
- ☐ Other-Document Details in Notes

4a. STAIR MOBILITY Movement safely up and down STEPS

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Extensive/Total Assistance

4b. If Limited Assistance, indicate ALL types needed for STAIR MOBILITY

- ☐ Assistance with the use of equipment or assistive devices
- ☐ Encouragement, cueing, or coaxing
- ☐ Guided maneuvering of limbs
- ☐ Set-up
- ☐ Supervision
- ☐ Other-Document Details in Notes

5. What is the individual's weight bearing status?

- ☐ Full weight bearing
- ☐ Non-weight bearing
- ☐ Partial weight bearing
- ☐ Toe touch weight bearing
- ☐ Unable to Determine

6. Select all that affect the individual's mobility.

- ☐ None
- ☐ Ambulation Dysfunction
- ☐ Aphasia
- ☐ Fatigues Easily
- ☐ Muscle Stiffness
- ☐ Pain
- ☐ Poor Balance
- ☐ Rigidity
- ☐ Shuffling Gait
- ☐ Spasms
- ☐ Tremors /Twitches
- ☐ Other-Document Details in Notes

11.B. FALLS

1. Is the individual at risk of falling?

- ☐ No
- ☐ Yes
- ☐ Unable to Determine

2. Select the number of times the individual has fallen in the last 6 months.

- ☐ None
- ☐ 1
- ☐ 2
- ☐ 3 or More

3. Reasons for falls-Document Details in Notes

- ☐ Accidental
- ☐ Environmental
- ☐ Medical
- ☐ Other-Document Details in Notes

12. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

12.A. IADLs

1. MEAL PREPARATION Ability to plan/prepare meals, use of kitchen appliances, heat meals. List any needed adaptive equipment/assistive devices in Notes.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

2. HOUSEWORK Ability to maintain living space, includes tasks such as dishwashing, making the bed, dusting, running the vacuum or sweeping an area. List any needed adaptive equipment/assistive devices in Notes.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Extensive/Total Assistance

3. LAUNDRY Ability to gather clothes, place clothes in washing machine, turn on appliance, remove clothes and place in dryer, or hand wash items and hang to dry. List any needed adaptive equipment/assistive devices in Notes.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

4. SHOPPING Ability to go to the store and purchase needed items, includes groceries and other items. List any needed adaptive equipment/assistive devices in Notes.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

5. TRANSPORTATION Ability to travel on public transportation or drive a car. List any needed adaptive equipment/assistive devices in Notes.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

6. MONEY MANAGEMENT Ability to manage financial matters, writing checks, paying bills, going to the bank. List any needed adaptive equipment/assistive devices in Notes.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

7. TELEPHONE Ability to obtain phone numbers, dial the telephone and communicate with person on the other end. List any needed adaptive equipment/assistive devices in Notes.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

8. HOME MANAGEMENT Ability to perform heavier household tasks such as taking out the trash, completing minor repairs around the living space, yard work and/or snow removal. List any needed adaptive equipment/assistive devices in Notes.

- ☐ 1 - Independent
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

13. LEVEL OF CARE DETERMINATION (LCD) ASSESSMENT DATA

13.A. ASSESSMENT OUTCOME

1. What Level of Care did the physician recommend?

- ☐ NFCE-Nursing Facility Clinically Eligible
- ☐ NFI-Nursing Facility Ineligible
- ☐ Evaluation not required

2. What is the date the AAA received the individual's MA-51 or Rx Script, signed by a physician?

_____/_____/_____

3. What is the Level of Care determination for this individual?

- ☐ NFCE-Nursing Facility Clinically Eligible
- ☐ NFI-Nursing Facility Ineligible

4. Summarize how the functional limitations of the individual's medical conditions support the level of care determination. Document a summary of diagnoses & treatments and how the limitations impede the individual's ability to manage own care needs.

_____

_____

_____

_____

5. Document the reason(s) why assessor disagrees with indictor:

_____

_____

_____

_____

13.B. INDIVIDUAL'S PLACE OF SERVICE PREFERENCE

1. Does the individual want to be served in the community?

- ☐ No
- ☐ Yes

2. Having been determined NFI, what is the individual's PREFERRED RESIDENTIAL setting?

- ☐ Home
- ☐ DC-NFI (Domiciliary Care)
- ☐ PCH-NFI (Personal Care Home)
- ☐ Other-Document Details in Notes

3. Having been determined NFI, what is the individual's PREFERRED COMMUNITY Service Program?

- ☐ ACT 150
- ☐ CSP-NFI (Caregiver Support Program)
- ☐ OPTIONS-NFI
- ☐ Other-Document Details in Notes

13.C. LEVEL OF CARE AUTHENTICATION

1. Name of the assessor completing this assessment

_____

2. Date of assessor's signature

_____/_____/_____

3. Name of Registered Nurse reviewing the assessment for Clinical Eligibility

_____

4. Date of Registered Nurse review

_____/_____/_____

5. Name of assessment Supervisor who reviewed and approved the Level of Care

_____

6. Date assessment Supervisor approved the assessment

_____/_____/_____

7. Date the Level of Care is being issued

_____/_____/_____

Completed Level of Care Determination Tool Review

- Two completed LCD Tools will be provided.
- The group can be divided to review the two completed LCD Tools with each group reviewing 1 completed LCD Tool.
- During the LCD Assessor Webinar, facilitate a 30-minute group review and discussion of the completed LCD Tools.
  - Determine the level of care.
  - Develop documentation to support the level of care determination.