LCD 6-11-14

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

1. PSA number conducting assessment

- ☐ 01
- ☐ 02
- ☐ 03
- ☐ 04
- ☐ 05
- ☐ 06
- ☐ 07
- ☐ 08
- ☐ 09
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- ☐ 37
- ☐ 38
- ☐ 39

1. PSA number conducting assessment

- [ ] 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
- [ ] AL-Assisted Living
- [ ] Chart Review
- [ ] DC-Domiciliary Care
- [ ] Deceased Individual
- [ ] 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 (POA)
- [ ] 5 - Friend
- [ ] 6 - Other-Document Name and Relationship in Notes

7. Identify who referred the individual

- [ ] AAA-Conducting Assessment
- [ ] AAA-Other
- [ ] Family
- [ ] 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 AL, DC 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

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

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- Complete assessment based on individual's condition prior to dying.
- ☐ 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:

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
- ☐ 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 (1)
- ☐ 2 - Incorrect (0)

2. What is the YEAR?

- ☐ 1 - Correct (1)
- ☐ 2 - Incorrect (0)

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

- ☐ 1 - Correct (1)
- ☐ 2 - Incorrect (0)

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 ($23) (1)
- ☐ 2 - Incorrect (0)
- ☐ 3 - Unanswered (0)

5b. How much do you have left?

- ☐ 1 - Correct ($77) (2)
- ☐ 2 - Incorrect (0)
- ☐ 3 - Unanswered (0)

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

- ☐ 0-4 (0)
- ☐ 5-9 (1)
- ☐ 10-14 (2)
- ☐ 15+ (3)
- ☐ Unanswered (0)

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

- ☐ Apple (1);
- ☐ Pen (1);
- ☐ Tie (1);
- ☐ House (1);
- ☐ Car (1);
- ☐ Unanswered/ None Correct (0)

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 (78) (0);
- ☐ 6-4-9 (946) (1);
- ☐ 8-5-3-7 (7358) (1);
- ☐ Unanswered/ None correct (0)

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 (2);
- ☐ Time correct (2)
- ☐ Unanswered/ None Correct (0)

10a. Place an X in the triangle

- ☐ 1 - Correct (Triangle) (1)
- ☐ 2 - Incorrect (0)

10b. Which of the figures is the largest?

- ☐ 1 - Correct (Square) (1)
- ☐ 2 - Incorrect (0)

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 name? (Jill) (2);
- ☐ What state did she live in? (Illinois) (2);
- ☐ What work did she do? (Stockbroker) (2);
- ☐ When did she go back to work? (Kids were teenagers) (2);
- ☐ Unanswered/ None Correct (0)

3.C. SLUMS RESULTS

1. SLUMS Consumers Total Score

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's Degree
- [ ] Other-Document Details in Notes

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

- [ ] Normal (HS 27+, Non HS 25+)
- [ ] MNCD-Mild Neurocognitive Disorder (HS 21-26, Non HS 20-24)
- [ ] Mild Dementia (HS 16-20, Non HS 15-19)
- [ ] Moderate Dementia (HS 11-15, Non HS 11-14)
- [ ] Severe Dementia (Any 10 or Less)

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 diagnoses 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 /CIRCULATORY SYSTEMS

1. Select all HEART/ 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/ Artery Disease)
- [ ] Other-Document Details in Notes

2. Current treatments for HEART/ 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/ CIRCULATORY diagnoses 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/ 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 diagnoses 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
- [ ] Paraplegia
- [ ] Osteoporosis
- [ ] Poor Balance
- [ ] Quadriplegia
- [ ] 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
- [ ] Elevate Legs
- [ ] Medications-List in 9.D
- [ ] Physical/ Occupational Therapy
- [ ] Prosthesis(es)
- [ ] Splint
- [ ] Traction
- [ ] Other-Document Details in Notes

3. Does the MUSCULOSKELETAL diagnoses 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 diagnoses 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 SYSTEMS

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 diagnoses:

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

3. Does the ENDOCRINE/ METABOLIC diagnoses 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
- [ ] Benign Prostatic Hypertrophy (BPH)
- [ ] Ascites
- [ ] 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 diagnoses 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
- [ ] Transfusion(s)
- [ ] Wound Therapy
- [ ] Other-Document Details in Notes

4. Does the INFECTIONS/ IMMUNE SYSTEM diagnoses 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 any current CANCER diagnoses?

- [ ] 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:

- [ ] 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 diagnoses 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 any NEUROLOGICAL diagnoses, 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 diagnoses:

- [ ] 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 diagnoses 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 any diagnoses 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 diagnoses affect the individual's ability to function?

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

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

7.A. PSYCHIATRIC

1. If there is any 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 diagnoses 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 diagnoses 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. FRAILTY 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

6. Indovidual shows symptoms of being frail?

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

6. Individual shows symptoms of being depressed?

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 mounth (PO)	7 = topical
2 = sub lingual (SL)	8 = inhalation
3 = intramuscular (IM)	9 = enteral tube
4 = intravenous (IV)	10 = other
5 = subcutaneous (SQ)	11 = eye drop
6 = rectal (R)	12 = transdermal

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

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

a. Name and Dose	b. Form	c. # Taken	d. Freq	e. Comments
-				

4. Does the individual take all medications as prescribed?

- ☐ No-Document Details in Notes
- ☐ Yes

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 mounth (PO)	7 = topical
2 = sub lingual (SL)	8 = inhalation
3 = intramuscular (IM)	9 = enteral tube
4 = intravenous (IV)	10 = other
5 = subcutaneous (SQ)	11 = eye drop
6 = rectal (R)	12 = transdermal

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

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

a. Name and Dose	b. Form	c. # Taken	d. Freq	e. Comments
-				

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. INDIVIDUAL'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. Individual is recommended NFCE:

False

6. Recommended Tier for NFCE Consumers. If 0, consumer is recommended NFI.

0

7. Are the assessor and the model clinical eligibility results the same? If False, document reasons in NOTES.

False

8. Document the reason(s) why assessor disagrees with indicator:

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