

I. Application Type

LOC Type: Chronic and Convalescent Nursing Home Rest Home with Nursing Supervision
 Screen Type: Applicant Resident applying for LTC Medicaid
 Resident/Medical improvement Resident/Prior ST Decision
 Expected length of stay: Long Term Short Term Estimated at (# of days) : <30 30-60 60-90 90-120

II. Demographics

A. Individual

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

Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____ Marital Status: M S W D

Gender: Male Female

Payment Method: Medicaid Active Medicaid Eligible Medicaid Pending Medicare/Medicaid Eligible

Medicare Medicare and Medicaid Self Pay/Insurance

Medicare# _____ Medicaid # _____

B. Conservator/Legal Guardian

Name: _____

Address: Check here if same as II.A (if not, specify below)

Street: _____ City: _____ State: _____ Zip: _____

C. Typical Living Situation: NF Hospital Homeless Home with family Home alone

Group Home Other (Specify: _____)

D. Current Location

Medical Facility Psychiatric Facility NF Hospital ED Community Other _____

Facility Name _____ Admit Date: _____

Location Address: Check here if same as II.A (if not, specify below)

Street _____ City _____ State _____ Zip: _____

E. Admitting Information

Admitting Facility: _____ Admission Date: _____

Street _____ City _____ State _____ Zip: _____

III. Functional Capabilities Needs Assessment

1. ACTIVITIES OF DAILY LIVING (ADL)

Choose the single best answer for each ADL.

0 – Independent or supervision < daily	Requires no assistance or supervision. If assistive devices are used, needs no monitoring, assistance, or supervision to use those devices.
1 – Supervision daily	Capable of completing most parts of the activity independently but needs some supervision or assistance (e.g., cues/prompts, etc).
2 – Hands on	Capable of completing some parts of the activity but needs continual supervision or assistance (e.g., assistance with weight bearing tasks, extensive physical assistance).
3 – Total Dependence	Requires total assistance with the activity.
Bathing	Abilities to get into and out of the bathing area, adjust the water temperature, and cleanse the body and hair.
Dressing	Abilities to select weather appropriate clothing and put on and adjust clothing.
Eating/feeding	Abilities to use utensils, set up food tray, eat appropriate amount, and eat at appropriate pace; feeding by nasogastric, gastrostomy, jejunostomy, or parenteral route. Does not include supervision of obesity or weight reduction.
Toileting	Abilities to transfer to/from the toilet, adjust clothing, and attend to hygiene, and/or

Client First/Middle Name: _____ Last Name: _____

		ostomy or catheter care.
	Mobility	Ambulation and use of wheelchair, cane, walker, crutch, or other mobility aid.
	Transfer	Movement from surface to surface (e.g., chair to wheelchair or bed to chair).
	Continence	Includes supports needed to either: assist the individual to control one's body to empty the bladder and/or bowel appropriately, or, to appropriately change incontinence pads/briefs, cleanse the changing pads, and dispose of soiled articles.

For each ADL rated 1, 2, or 3, describe assistance needed, including frequency and reason for support needs (including physical and cognitive). If applicable, include details about tube feedings, IV fluids, fluid monitoring, catheter or ostomy care, mobility aids, transfer aids, and incontinence care: _____

2. MEAL PREPARATION (Choose the single best answer.)

- Requires no assistance or supervision.
- Capable of preparing meals with minimal assistance (e.g., set-up of ingredients, oversight, or cueing).
- Requires continual supervision or physical assistance with multiple components of meal preparation.
- Requires total physical assistance with meal preparation.

3. MEDICATION SUPPORTS (Choose all that apply.)

Supports Needed	Medication Supports Needed to be physically capable of adhering to physician ordered medication regimen. Rate compliance issues separately under item #9 of this section (<i>Behaviors</i>).
<input type="checkbox"/>	None and/or does not apply
<input type="checkbox"/>	Set ups
<input type="checkbox"/>	Verbal or gestural assistance (reminding, instructing, coaching, pointing)
<input type="checkbox"/>	Physical assistance with some or all of the physical steps of taking medications, and adherence cannot be ensured with verbal and gestural support alone.
<input type="checkbox"/>	Injections
<input type="checkbox"/>	Other (Specify):

If support needs were selected, describe the reason for the needed support and either complete Section IV.1 or fax a copy of the medication list (e.g., MAR or MD orders)

4. ORIENTATION

Choose the single best answer for each type of orientation.	_____ Self (awareness of own name)
0 – Fully oriented and needs no prompting or cueing.	_____ Place (awareness of current location)
1 – Occasionally disoriented & needs prompting or cueing.	_____ Time (awareness of current date & time)
2 – Disoriented all or most of the time.	_____ Situation (awareness of current situation)

5. MEMORY (CHOOSE ONE)

- Able to remember past and present events with no cueing or prompting.
- Needs cueing or prompting to remember past and/or present events.
- Unable to remember past and present events such that daily supervision is needed to prevent harm

6. JUDGMENT (CHOOSE ONE)

- Solves problems and makes decisions with no assistance.
- Solves problems & makes decisions with minimal assistance (e.g., prompts or cues may be required).
- Unable to solve problems well and make appropriate decisions such that daily supervision is needed to prevent harm

7. COMMUNICATION (CHOOSE ONE)

- Communicates information in intelligibly & understands information conveyed without assistance.
- Needs assistance to communicate information and/or understand information conveyed.

Client First/Middle Name: _____ Last Name: _____

Inability to communicate information in an intelligible manner and/or understand information conveyed

(choose all that apply)

Communication Method: Verbal Sign language Writing Gestures Other:

8. VISION: (CHOOSE ALL THAT APPLY)

- No problems indicated
- Cataracts Glaucoma Blind
- Orientation/mobility problems due to vision
- Other (specify): _____

9. BEHAVIORS (CHOOSE ALL THAT APPLY)

- No problems indicated Verbally aggressive toward others Wanders/runs away
- Self-injurious Physically aggressive toward others
- Unsafe or unhealthy habits such as throwing or smearing food or excrement, disrobing in inappropriate situations, screaming, making inappropriate sexual advances.
- Threats to Health/Safety: Inability to follow a medication or dietary regimen without supervision; creating a fire hazard; exhibiting poor judgment which is potentially harmful to self or others.

Describe frequency and severity of behaviors: _____

Describe needs related to behaviors, including type of required intervention: _____

IV. Medical Needs

1. Provide the following information for each physician ordered medication (**This section is optional & should be provided if medication information is a factor in supporting or clarifying the individual's need for NF level of care and, if so, a medication list (such as a MAR or MD orders) may be faxed in lieu of completing this table).**

Check here if you are faxing the MAR or Medication list

Medication	Diagnosis	Dosage	Route/Frequency

2. A. No Yes The physician has ordered at least one (or a combination) of the **rehabilitative services** listed below (complete the table below) If yes, to 2.A, No Yes The individual presents with restorative potential

	Start Date	Frequency (# of days/week)	Duration
<input type="checkbox"/> Speech Therapy			
<input type="checkbox"/> Physical Therapy			
<input type="checkbox"/> Occupational Therapy			

Client First/Middle Name: _____ Last Name: _____

<input type="checkbox"/> Respiratory Therapy			
--	--	--	--

3. a. No Yes (Chronic and convalescent Nursing Home/CCNH) The individual has uncontrolled, unstable, and/or chronic conditions requiring continuous skilled nursing services and/or nursing supervision on a daily basis or has chronic conditions requiring substantial assistance with personal care on a daily basis.

b. No Yes (Rest Home with Nursing Supervision/RHNH) The individual has controlled and/or stable chronic conditions requiring skilled nursing services, nursing supervision, or assistance with personal care on a daily basis.

If yes to either #3.a or 3.b, complete the following:

c. Describe medical diagnoses/history which qualify the individual under either 3.a or 3.b and note whether the condition is chronic or acute, stable/unstable, and/or current/status post.

d. Describe required nursing services related to the medical condition(s). Include frequency, intensity and any associated fluctuations in medical presentation (e.g., changes in lab values, vitals, or levels, increase in frequency of MD visits, etc.) that necessitate skilled nursing services.

V. Additional Comments

Additional Notes/Comments (Use this area for any important information you think was not adequately addressed in the above sections.) _____

VI. Attestation

Certification that the client meets the nursing facility level of care criteria described in Section 19-13- D(8)(t)(d)(1) of the Public Health Code must be provided by a physician, APRN, or physician assistant. This certification must be signed and dated by the practitioner; telephone and voice orders are not acceptable.

Signature: _____ Credentials: _____ Date: _____

VII. Referral Source Information

By entering my name and credentials, I attest that I am the person who completed this form. I understand that CT DSS considers knowingly submitting inaccurate, incomplete, or misleading LOC information to be Medicaid fraud, and I have completed this form to the best of my knowledge.

Person completing form: _____ Facility: _____

Facility Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

VIII. Special Instructions

*This form may be completed at www.pasrr.com or faxed to Ascend at **877.431.9568**. The physician's attestation must be faxed once the screen is complete to 1-877-431-9568. **Mailed forms may be sent to: Ascend Management Innovations • Attn: Connecticut Division • 227 French Landing Drive, Suite 250 • Nashville, TN 37228 • Phone: 877-431-1388 • Fax: 877-431-9568 • For assistance with completing this form or accessing WEBSTARS™, call Ascend toll free at 1.877.431.1388 and ask to speak with a CT LTC nurse reviewer.***