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## **ASSESSMENT/SUPPLEMENT**

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### **PURPOSE**

The purpose of the comprehensive assessment is to learn about an individual's life situation, including the person's strengths and deficits, in order to develop a comprehensive care plan that considers the person's preferences, meets his/her identified needs, and helps the person achieve a desired quality of life.

### **CONTENT OF THE ASSESSMENT/SUPPLEMENT**

Prior to 2004, care managers were required to submit a separate Assessment form and Narrative as part of the COP-W/CIP II Waiver initial application packet. However, beginning in 2004, the Bureau of Long Term Support (BLTS) required care managers to use the COP-W/CIP II Assessment/Supplement to the Long Term Care Functional Screen – Version 6.0, as well as the Long Term Care Functional Screen (LTC FS). For initial COP-W/CIP II waiver applications, the Assessment/Supplement – Version 6.0 form (in this document referred to as the Supplement), together with the LTC FS, replaces the Assessment, the COP Functional Screen, and the Narrative. The Supplement also replaces the Health Form **IF** the Supplement is signed and dated by a registered nurse. If the Supplement is not signed and dated by a Registered Nurse, then a Health Form must also be completed.

The Supplement is a tool designed to enhance the care managers' conversations with waiver applicants. It covers the following key assessment areas:

- **General Health History, including diagnosis and medications**
- **Social History**
- **Abilities and Deficits in Activities of Daily Living (ADLs)**
- **Abilities and Deficits in Instrumental Activities of Daily Living (IADLs)**
- **Communication and Cognition**
- **Environmental Observations**
- **Community Participation**
- **Relationships, Informal Supports**
- **Mental Health and Behavior Issues**
- **Goals & Preferences**
- **Maintaining Maximum Independence**

The Supplement must be filled in completely by one of the following professionals;

- **A certified social worker;**
- **A qualified care manager, and/or**
- **A registered nurse**

If some questions on the Supplement do not apply to the applicant, care managers should indicate this on the form. If for some reason care managers deem it inappropriate to discuss an

element of the form, it is important that the care manager make a note about why it was not appropriate. Care managers should also consider utilizing interdisciplinary teams, including nurses, as they complete the Assessment/Supplement.

## **CONDUCTING THE ASSESSMENT AND SUPPLEMENT**

### Completing the Assessment

All individuals have the right to receive an assessment within 45 calendar days of application. The assessment may be delayed for an applicant who is eligible but will be placed on a waiting list for services provided that the applicant:

- Has been informed of his/her right to an assessment within the 45 days time limit, and
- Has been informed of the potential benefits the assessment may have even if service funds are currently unavailable, and
- Voluntarily agrees to delay the assessment based on an informed choice, and is placed on the waiting list for services.

### **Best practice tips for using the Assessment/Supplement**

- Become familiar with the tool so that conversations during the assessment are fluid and promote the development of a rapport between the care manager and the person.
- Don't rush to complete the assessment/supplement in the first visit, especially if the person becomes tired or aggravated.
- Remember: this is the time to begin discussions about the person's personal goals, preferences, and outcomes. See Section 1 in this manual for information on outcomes.
- The Assessment/Supplement must be completed by a care manager or social worker and/or a registered nurse. Other professionals may also participate who have expertise that would be helpful. It may be helpful to think of the assessment as a "process" because it takes time to fully understand and "know" a person. However, initially there is information that must be gathered in order to develop a service plan.
- It may be advisable to complete the initial assessment in two visits. For example, during the first visit, information about ADL's, IADL's, and financial information can be gathered. Often this information is enough to develop a preliminary plan. The second visit may cover the person's social history, physical environment, emotional functioning, cognitive functioning, and communication abilities. In addition, other areas surrounding the person's mental health, behavioral problems, or risks they choose to take, may be discussed. All information is essential to creating a comprehensive care plan.
- It is important to include the reason WHY the person needs assistance, or explain WHAT the person's functional or cognitive limitations are in section A in each of the ADLs and IADLs. A diagnosis per se does not give specific reasons why, or what, the person's

functional or cognitive limitations may be. While some generalizations can be assumed with certain diagnosis, it is important to remember that the care manager is assessing that person's individual capabilities or limitations. Each person's situation is unique and the assessment/supplement is the opportunity to learn about the specifics of the person.

- It is important to include what additional help or assistance the person requires and what are his or her preference in section B in each of the ADLs and IADLs. This information may be helpful to the care manager when it comes to assisting a person in achieving an outcome.

### **Collaboration Between the Social Worker/Care Manager and the Registered Nurse**

If more than one professional participates at different times in completing the assessment, it is important that the assessors share information learned during the assessment process as each brings his/her own expertise to the process.

### **Emphasis on Strengths and Need for Learning**

The assessment should reflect learning about the person's strengths as well as his/her deficits. Throughout the assessment process there should be questions asking if the person would like or would benefit from further training to become more independent in self-care. It is also helpful to learn if the person needs adaptive aids to promote independence.

### **Assessing Cognitive Function**

It is important to determine the person's functioning in this area although there may be other evaluations methods for doing so.

### **Preference and Choice**

Discovering the participant's choices and preference for service arrangements is an important part of the assessment process. These preferences should be honored as much as possible and should be clearly stated in the care plan.

### **VERY IMPORTANT**

- 1) It is important to complete the assessment/supplement in its entirety. Each section has value and is valuable in helping a care manager develop a care plan.
  - Note that the ADL and IADL sections have two-part questions. One part of a question deals with the current situation. It is where the care manager expands on **WHY** the assistance is needed, and **WHAT** the person's functional or cognitive limitations are. The second part of that question asks what additional support, assistance, or equipment the person needs. It also asks about the person's preference on what he/she would like. It is important that both parts are considered and asked. Again, this will guide the care manager to develop a plan that meets the needs of the person.

- 2) It is important that the information in the Assessment/Supplement and the Long Term Care Functional Screen coincide with each other. If there is a discrepancy in the information, a Quality Assurance Consultant will contact the care manager to discuss the information. If telephone conversations need to occur between the care manager and Quality Assurance Consultant, the length of time it takes to obtain approval for new plan applications is often extended.

In August 2007, the Assessment/Supplement to the Long Term Care Functional Screen became a word fillable document. This document can be accessed at:

<http://dhfs.wisconsin.gov/forms1/DDES/dde0980.doc>

## ASSESSMENT / SUPPLEMENT TO THE LONG TERM CARE FUNCTIONAL SCREEN

### 1. General Instructions

The Assessment/Supplement was developed as a means to collect sufficient information to meet the requirements for a complete assessment in the various Medicaid waivers. It was designed to be used in conjunction with the Wisconsin Adult Long Term Care Functional Screen in the initial application process. It is not required for program recertification. While the Assessment/Supplement may be used across several Medicaid waiver programs, the individual programs continue to have unique documentation requirements.

- a. **For CIP II/ COP-W**, the Assessment/Supplement, when used in conjunction with the automated Long Term Care Functional Screen, meets the requirements for the COP Assessment, the COP Functional Screen, the narrative and the Health Form in the **initial determination** of eligibility for the COP-W and CIP II Medicaid Waiver programs. A completed Assessment/Supplement must accompany the Long Term Care Functional Screen for all new applications submitted for approval. This form may be altered in appearance or formatted for electronic use but all data elements must be included in any locally developed version. **Note:** Locally generated versions of this form may not be used without prior approval.
- b. **For CIP 1A and CIP 1B** applicants, the Assessment/Supplement, when used in conjunction with the automated Long Term Care Functional Screen, meets the requirement for the CIP Assessment, the COP Functional screen and the LOC form (OQA-2256, Request for Title XIX Care Level Determination) in the **initial determination** of eligibility for CIP 1A and CIP 1B. A completed Assessment/Supplement or another approved assessment document must accompany the Long Term Care Functional Screen for all new applications submitted.

**For CIP 1A and CIP 1B**, the Assessment/Supplement **does not** replace the Service Plan Narrative. The narrative continues to be a required component of the service plan packet. The content of the narrative provides a detailed explanation of how the services included on the Individual Service Plan will be implemented to meet all of the applicant's needs that were identified in the assessment process. It is expected that the assessment will continue to be a person-centered process, focused on the applicant's preferences and conducted in a manner that encourages active applicant participation.

### 2. Content and Completeness

All of the elements should be considered as **required information**. Specific questions that do not apply to the individual applicant may be noted as "Not Applicable." In all other elements the assessor should include enough information to present a clear, current picture of the applicant and his/her needs, current supports/services and preferences. As is the case with the other required documentation in the application packet, submission of an incomplete Assessment/Supplement may delay the eligibility determination.

### 3. Signature Requirements

- a. For CIP II/COP-W, the Assessment/Supplement must be signed by both the care manager **and** a registered nurse. If the RN signature cannot be obtained, a completed and signed DDE-810 (Medicaid Waiver Program Health Form) must accompany the application.
- b. For CIP 1A and CIP 1B, the Assessment/Supplement must be signed by the Support and Service Coordinator. The RN signature is **not required**.

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## NOTES

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## GENERAL APPLICANT INFORMATION

County/Waiver Agency		Date of Assessment	
Name – Applicant (Last, First, MI)		Date of Birth	Telephone Number
Address		City / State / Zip Code	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated			Social Security Number
Medicaid Number	Medicare Number	Other Insurance	

Others in Household

CONTACT INFORMATION	1 – Name – (Last, First)	Relationship	Telephone Number	
	Address			
	2 – Name – (Last, First)	Relationship	Telephone Number	
	Address			
	3 – Name – (Last, First)	Relationship	Telephone Number	
	Address			
	Other Contact(s) Guardian: <input type="checkbox"/> Person <input type="checkbox"/> Estate <input type="checkbox"/> Both <input type="checkbox"/> POA – HC—Activated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> POA <input type="checkbox"/> Rep Payee <input type="checkbox"/> Other role—specify:			
	Name – (Last, First)		Telephone Number	
	Name – (Last, First)		Telephone Number	

HSRS Target Group <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Physical Disability <input type="checkbox"/> Severe & Persistent Mental Illness <input type="checkbox"/> Adults and Elderly <input type="checkbox"/> Alcohol or Other Drug Abuse		Living Arrangement <input type="checkbox"/> Own Home/Apartment <input type="checkbox"/> Home of Relative/Other Person <input type="checkbox"/> Licensed/Certified AFH/CBRF/RCAC <input type="checkbox"/> Other—specify:	
Referral Source <input type="checkbox"/> Self <input type="checkbox"/> Relative/Family <input type="checkbox"/> Physician/Hospital/Clinic <input type="checkbox"/> Other—specify:		Prior Agency Contact <input type="checkbox"/> APS/EA Referral <input type="checkbox"/> County Waiting List <input type="checkbox"/> Other—specify:	

### SECTION 1: PERSONAL / SOCIAL

#### A - Social History

1. Personal/Family History (birthplace, parents, siblings, children, etc.)

2. Relevant Ethnic/Cultural Information (plan/service implications)

3. Education/Work/Employment History

4. Previous Living Arrangements

**B – Formal/Informal Supports**

Who are the persons or agencies providing support/assistance now? (family, friends, paid providers, etc.)

Identify formal/informal supports. Note stability/reliability of the support provided. Are they the person's **preferred providers**?

**Attach additional documentation if necessary**

	Name	Relationship	Support Provided (who, what, when, stable/reliable)	Preferred Provider (Why/why not?)
1				
2				
3				
4				
5				

Other Relevant Provider Information (others involved, concerns/gaps in services identified)

**SECTION 2: PERSONAL HEALTH AND SAFETY**

**A – Physical Health**

List diagnoses, prescribed medication(s), treatment, and prescribing physician/practitioner. Medications include prescribed over-the-counter remedies. The assessor should note where his/her observations or the reports of others that know the applicant well contradict any self-reported health information. **All health information reported (diagnoses, prescription medication, etc) must be verified.**

**Attach additional documentation if necessary**

Diagnosis	Medication/Treatment	Physician/Practitioner

List additional prescription and over-the-counter medications, if any. (If necessary, attach additional documentation.)

1. Generally, how would you describe your health?

2. How is your (indicate response, e.g., "fine," "so-so," "not so good," etc.; last exam date; need for follow-up):

- Vision \_\_\_\_\_  Has/needs glasses/contacts Last exam: \_\_\_\_\_  Needs exam
- Hearing \_\_\_\_\_  Has/needs hearing aid:  L  R  Both Last exam: \_\_\_\_\_  Needs exam
- Teeth \_\_\_\_\_  Has/needs dentures:  U  L  Both Last exam: \_\_\_\_\_  Needs exam
- Appetite \_\_\_\_\_ If other than "good, OK," etc., explain: \_\_\_\_\_
- Nutrition \_\_\_\_\_ Special diet?  Yes  No If yes, specify: \_\_\_\_\_

3. Do you currently have problems with (check and complete if response is yes; if no, go to the next item):

- Breathing?  Short of breath—specify when: \_\_\_\_\_  
 Uses oxygen—specify when: \_\_\_\_\_
- Dizziness/Balance/Falls? Last episode/fall occurred: \_\_\_\_\_  
How often in the last 12 months? \_\_\_\_\_
- Incontinence?  Yes  No  Bladder  Bowel  Both Frequency: \_\_\_\_\_  
Uses pads/briefs?  Yes  No \_\_\_\_\_

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4. When did you last see a doctor? \_\_\_\_\_

How often do you see your doctor: \_\_\_\_\_

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5. Who else do you see for health care and why? (dentist, specialist, therapist, chiropractor, etc.) \_\_\_\_\_

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6. Has your health changed recently?  Yes  No If yes, what changed and when? \_\_\_\_\_

What did the change require? (e.g., ER/clinic visit, hospital stay, new medication)

If hospitalized, date admitted: \_\_\_\_\_ Length of stay: \_\_\_\_\_

Nursing home admission? Date: \_\_\_\_\_ Length of stay: \_\_\_\_\_

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7. Other significant medical history (surgery/injury/accident/major illness, etc.) \_\_\_\_\_

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8. Additional notes/relevant information \_\_\_\_\_

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### B – Activities of Daily Living (ADLs)

**NOTE:** The numbered elements of **Sections B, C, D, and E** below correspond to the ADL, IADL, Communication/Cognition and Behavior/Mental Health sections of the LTC-FS. In each element, the assessor must first indicate the numerical screen code from the LTC-FS for the corresponding daily activity. (The automated version of this document will auto-fill the numerical codes.)

**In a)** of each element, the assessor must indicate the applicant rating on the LTC-FS and note the person's level of satisfaction with any assistance now in place.

**In b)** of each element, the assessor must document any additional services, equipment or supports the applicant requires or requests and the applicant's preference.

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**1. Bathing** **Screen Code:**  0  1  2

- a. Describe bathing assistance currently in place or note ability to bathe independently. Indicate type of assistance (adaptive equipment, hands-on/standby assist, etc.) and consumer satisfaction with current level of help.
- b. Is additional bathing assistance or adaptive equipment requested/indicated? Describe type and consumer preference(s).

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**2. Dressing** **Screen Code:**  0  1  2

- a. Describe assistance with dressing currently in place or note ability to dress independently. Indicate type of assistance (hands-on, cueing/prompting, adaptive equipment, etc.) and consumer satisfaction with current level of help.
- b. Is additional dressing assistance or adaptive equipment requested/indicated? Describe type and consumer preference(s).

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**3. Eating** **Screen Code:**  0  1  2

- a. Describe assistance with eating currently in place or note ability to eat independently. Indicate type of assistance (feeding, set-up, adaptive utensils, etc.) and consumer satisfaction with current level of help.
- b. Is additional assistance with eating or adaptive equipment requested/indicated? Describe type and consumer preference(s).

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**4. Mobility** **Screen Code:**  0  1  2

- a. Describe assistance with mobility currently in place or note independence in mobility. Indicate type (cane, walker, wheelchair, attendant, etc.) and consumer satisfaction with current level of help.
- b. Is additional assistance with mobility or adaptive equipment requested/indicated? Describe type and consumer preference(s).

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**5. Toileting** **Screen Code:**  0  1  2

- a. Describe toileting assistance currently in place or note ability to toilet independently. Indicate type (commode, transfer assist, raised seat, incontinence pads/briefs, catheter, etc.) and consumer satisfaction with current level of help.
  - b. Is additional toileting assistance or adaptive equipment requested/indicated? Describe type and consumer preference(s).
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**6. Transferring**Screen Code:  0  1  2

- a. Describe transfer assistance currently in place or ability to transfer independently. Indicate type (with assist of one/two, transfer board, etc.) and consumer satisfaction with current level of help.
- b. Is additional transfer assistance or adaptive equipment requested/indicated? Describe type and consumer preference(s).

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**C – Instrumental Activities of Daily Living (ADLs)****1. Meal Preparation**Screen Code:  0  1  2  3

- a. Describe meal preparation assistance currently in place or note ability to prepare meals independently. Indicate type (shopping, home delivered, prepared by another person, etc.), frequency, and consumer satisfaction with current level of help.
- b. Is additional meal preparation assistance or adaptive equipment requested/indicated? Describe type and consumer preference(s).

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**2. Medication Management**Screen Code:  0  1  2a  2b

- a. Describe medication management assistance currently in place or note ability to manage medication independently. Indicate type (set up in med box, compu-med, or set up by another person, etc.), frequency, and consumer satisfaction with current level of help.
- b. Is additional medication management assistance or adaptive equipment requested/indicated? Describe type and consumer preference(s).

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**3. Money Management**Screen Code:  0  1  2

- a. Describe money management assistance currently in place or note ability to manage money independently. Indicate type of assistance (rep payee, POA, guardian, etc.), frequency, and consumer satisfaction with current type/level of assistance in place.
- b. Is additional money management assistance requested/indicated? Describe type and consumer preference(s).

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**4. Household Chores**Screen Code:  0  1  2

- a. Describe household chore assistance currently in place or note ability to manage household chores independently. Describe the type of help needed (laundry, cleaning, snow removal, etc.) **and** any tasks where consumer is independent. Describe frequency and consumer satisfaction with current type/level of assistance and provider(s).
- b. Is additional household chore or adaptive equipment requested/indicated? Describe type and consumer preference(s).

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**5. Telephone**Ability - Screen Code:  1a  1b Access - Screen Code:  2a  2b

- a. Describe telephone/communication systems currently in place. Describe type (basic, wireless, cellular, PERS, etc.) and consumer satisfaction with the systems now installed.
- b. Are additional communication aids or adaptive telephone systems or equipment requested/indicated? Describe type and consumer preference(s).

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**6. Transportation**Screen Code:  1a  1b  1c  1d  2  3

- a. Describe transportation assistance currently in place or ability to transport self independently. Describe transport assistance type (bus, taxi, specialized vehicle, volunteer, etc.) and consumer satisfaction with current transportation services.
- b. Are additional transportation services or vehicle adaptations requested/indicated? Describe type and consumer preference(s).

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**D – Communication and Cognition****1. Communication**Screen Code:  0  1  2

- a. Describe communication assistance/aids currently in place. Describe type (interpreter, assistive listening devices, low vision aids, telecommunications aids, etc.) and consumer satisfaction with communication aids now in place.
- b. Are additional communication aids or adaptive communication equipment requested/indicated? Describe type and consumer preference(s).

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**2. Memory / Orientation**Screen Code:  0  1  2  3

- a. Memory/orientation concerns expressed at time of referral? Describe concerns and any health/safety risk reported.

Reported by: (consumer, family, friend, physician, other source)

b. Memory/orientation impairment evident at assessment? Describe concerns and any health/safety risk noted.

Further assessment/follow-up indicated? (Specify)

**3. Cognition / Judgment**

Screen Code:  0  1  2  3

a. Decision-making concerns expressed at referral? Describe concerns and any health/safety risk reported.

Reported by: (consumer, family, friend, physician, other source)

b. Decision-making abilities or impairments evident at assessment? Describe abilities and any health/safety risk noted.

Further assessment/follow-up indicated? (Specify)

**E – Behaviors and Mental Health**

**NOTE:** For CIP 1A/1B applicants—if screen codes 1, 2 or 3 are checked in items 2 or 3 below, attach the behavior intervention plan to the assessment/supplement.

**1. Wandering**

Screen Code:  0  1  2  3

a. Describe the frequency of wandering and level of risk as reported at referral.

Describe the person’s awareness, if any, of the risk that wandering poses to his/her health and safety.

Is the wandering behavior purposeful?

b. Describe any safety measures or intervention plans in place to address wandering behavior (increased supervision, alarm, etc.)

c. Are additional safety measures/intervention plans indicated? Specify:

**2. Self-Injurious Behaviors**

Screen Code:  0  1  2  3

a. Describe self-injurious behaviors observed or documented.

b. If a behavior intervention plan is in place, who is responsible for implementing the plan? (If no plan, why?)

**3. Offensive or Violent Behaviors to Others**

Screen Code:  0  1  2  3

a. Describe the offensive, violent or dangerous behavior observed or documented.

b. If a behavior intervention plan is in place, who is responsible for implementing the plan? (If no plan, why?)

**4. Mental Health Needs**

Screen Code:  0  1  2  3

a. Describe mental health needs observed or documented.

b. If mental health treatment or services are in place, who is responsible for providing the treatment or services? (If no treatment/services are in place, why?)

**5. Substance Abuse**

Screen Code:  0  1  2

a. Describe substance abuse problems observed or documented.

b. If substance abuse treatment or services are in place, who is responsible for providing the treatment or services?

**SECTION 3: HOME AND COMMUNITY ENVIRONMENT**

**A – Home Environment—Safety and Accessibility** (*Home safety/access issues may be those identified by the consumer or the assessor.*)

1. Identify any needed repairs or modifications **inside** of the home that will improve safety or accessibility (e.g., doors, steps, railings, tub/shower, heating/plumbing/electrical, etc.) List:

2. Identify any needed repairs or modifications **outside** of the home that will improve safety or accessibility (e.g., ramp, steps/stairs, lighting, locks/security, etc.) List:

- 
3. Identify any **structural barriers** to emergency evacuation from the home. Participant cannot access exit(s) (blocked/locked doors, cannot use stairs, steps, etc.).

Other structural concerns? Specify:

- 
4. Identify any concerns about the **person's ability to evacuate** in an emergency:  
 Independent     With cues or direction     With assistance     Evacuation plan in place?     Yes     No  
If unable to evacuate independently, who will assist?

- 
5. Other concerns about the home:     Expensive rent/utilities     Lack of privacy     Lack of space     Needs major repairs—List:

Other concerns

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### **B – Community Environment—Safety and Access to Community Resources**

1. Do you feel safe/secure in your home?     Yes     No    In your neighborhood?     Yes     No  
If no, list safety concerns (high crime, too crowded, too isolated, etc.)

- 
2. Does your home's location limit access to social and community resources (e.g., see family, attend activities, access medical care, banking, shopping, etc.)?     Yes     No    If yes, describe:

- 
3. Preferences—Setting:     Urban     Rural     Live alone     With others     Stay in current setting  
Move to:     Another neighborhood/community     Another living arrangement (home, apartment, CBRF, etc.)  
List preference(s) (living arrangement, setting, etc.)

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## **SECTION 4: MAXIMIZING INDEPENDENCE**

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### **A – Personal Independence**

1. Do you make your own choices about your daily routine (waking/bed time, social activities, etc.)? Describe
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2. Did you have the opportunity to **choose and direct** the help you receive (service provider, type of service, schedule, etc.)?  
 Yes     No—If no, do you have a preferred service provider(s), service schedule, etc.? Describe:
- 
3. Do you generally make your own decisions about your medical care and treatment (choosing a doctor/health care provider, making appointments, etc.)?     Yes     No—If no, who helps with those decisions or makes the decisions for you?
- 
4. What do you **like** to do in your free time? (hobbies, crafts, interests, etc.)
- 
5. What do you **want** to do in the future? (**Includes** BIG plans or not so big plans: see the world, change the world—**or**—see a movie, change my address, etc.)

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### **B – Community Participation—Social**

1. What kind of outside activities (classes, clubs, community/sporting events, church, etc.) do you enjoy?
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2. What stops you from pursuing the activities you enjoy? (Identify barriers to participation—e.g., health, lack of information, transportation, attendant care, cost, etc.)
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3. Do you see your friends (other than caregivers) as often as you'd like? Describe:  
  
If no, what stops you from seeing them (health, distance, transportation, etc.)?

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### **C – Community Participation—Employment / Education**

1. Are you interested in pursuing employment (volunteer/paid, full-time/part-time)? Specify:
- 
2. Are you interested in pursuing educational opportunities (take class, complete degree program, etc.)? Specify:
- 
3. **If applicable**, what stops you from pursuing your employment or education interests? (Identify barriers to pursuit of education/employment interests—e.g., lack of information, transportation gaps, cost, etc.).
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**SECTION 5: PARTICIPANT RIGHTS / INFORMED CHOICE**

*Completion of section 5 is **REQUIRED** FOR CIP 1A/1B and BIW. Section 5 is **optional** for CIP II/COP-W.*

<b>A – Respecting Rights and Choices</b>	Yes	No
1. Has the person/guardian participated in the assessment and plan process?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have the participant rights been reviewed with the person and his/her guardian?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the participant understand their rights?	<input type="checkbox"/>	<input type="checkbox"/>
If “no,” is the guardian informed and able to act on the participant’s behalf?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person/guardian been given a choice of service provider?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the person/guardian participated in interviewing potential providers?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has person/guardian contacted provider references?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the person/guardian been given a choice of living arrangement?	<input type="checkbox"/>	<input type="checkbox"/>

<b>B – Legal Issues</b>	Yes	No
1. Chapter 51/Chapter 55 petition/hearing pending?	<input type="checkbox"/>	<input type="checkbox"/>
2. Court-ordered medication/treatment/services?	<input type="checkbox"/>	<input type="checkbox"/>
3. Restraining orders in place/pending?	<input type="checkbox"/>	<input type="checkbox"/>
4. Civil/criminal charges pending?	<input type="checkbox"/>	<input type="checkbox"/>
5. Other court history (traffic, bankruptcy, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>

Explain any “yes” above

<b>SIGNATURE</b> – Assessor (Qualified Care Manager/Support and Service Coordinator, RN)	Date Signed
<b>SIGNATURE</b> – Registered Nurse	Date Signed

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## NOTES

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## LONG TERM CARE FUNCTIONAL SCREEN

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### INTRODUCTION

The Long-Term Care Functional Screen (LTC FS) was developed to provide an automated and objective way to determine the long-term care needs of elders, people with physical disabilities, and people with developmental disabilities. Using input from stakeholders, and clinical practitioners, the LTC FS was developed to serve multiple purposes including establishing nursing home level of care for eligibility, providing helpful information to people making decisions about long-term care, and supporting research.

The Department of Health and Family Services (DHFS) received approval from the federal Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) to use the new LTC FS to determine eligibility for home and community-based waivers for adults in Family Care pilot counties and in other sites. This implementation began in Family Care pilot counties and Partnership sites on October 22, 2001. Use of the LTC FS was expanded to other LTC programs statewide in 2004.

As an automated screening tool, the LTC FS is designed to replace other tools currently in use to determine COP and Waiver level of care, and reduces the complexity of waiver management. The screen relays information with regard to functional eligibility and level of care upon entry of all correct and applicable information. The results are reliable and objective because they are based on criteria that are applied in a consistent manner to the data entered into the system. In addition, the data collected in doing the LTC FS provides a source of important management information for long-term support programs.



### LTC FUNCTIONAL SCREEN AND COP WAIVERS

In December 2003, DHFS issued DDES Memo Series 2003-14 stating that *all* counties currently operating COP and Home and Community-Based Waiver programs were required to implement the Long Term Care Functional Screen (LTC FS) to determine eligibility and level of care for elders, and adults with physical or developmental disabilities in those programs by calendar year 2005. DHFS developed a LTC FS training curriculum to support counties as they transition from the COP Functional Screen to the LTC FS. Effective January 1, 2005, all counties in Wisconsin use the LTC FS. Each agency is to have a “screen lead” responsible for coordinating use of the LTC FS in his/her agency.

## PURPOSE

The LTC FS is an "inventory of needs" or list of activities that people do each day, either by themselves or with the help of others who support them. The screen gathers information about whether a person needs help and how much he/she needs in performing these activities.

The LTC FS also looks at both "Activities of Daily Living" (ADL's), which include bathing, dressing, toileting, transferring, mobility, and eating, and "Instrumental Activities of Daily Living" (IADL's), which include meal preparation, managing medications, money management, laundry and chores, using the telephone, and transportation. In addition, the screen has questions about cognition, behavior, diagnoses, medically oriented tasks, employment, and includes indicators for mental health problems, substance abuse problems, and other conditions that put a person at-risk of institutionalization. Upon completion of the screen, the clinical professional who administered the screen can instantly see the applicant's level of care and eligibility for Family Care and other home and community-based waiver programs in Wisconsin.

Another purpose of the LTC FS is to determine a nursing home level of care or a Developmental Disability level of care. An individual who receives a waiver eligible nursing home level of care, AND, is of the appropriate target group for the CIP II/COP-W program may qualify for Medicaid waiver program funding. This eligibility documentation is required by 46.27(2)(g) of the Wisconsin Statutes.

## INSTRUCTIONS FOR COMPLETING THE SCREEN

The Long Term Care Functional Screen must be completed by a certified screener. All persons administering the Long Term Care Functional Screen must meet the following four conditions:

- BA or BS degree, preferably in a health or human service related field, and at least one year of experience working with at least one of the target populations; or prior approval from DHFS based on a combination of post-secondary education and experience or on a written plan for formal and on-the-job training to develop the required expertise prepared by the agency. Important note: in waiver counties, people screening DD individuals must be qualified as a Qualified Mental Retardation Professional (QMRP).
- Have experience working with long term care consumers.
- Meet all training requirements as specified by DHFS. Currently, completion of the web-based clinical certification course meets the training requirements.
- Pass all eight (8) of the Screener Certification exams after receiving the training. All 8 tests must be successfully completed (a score of 80% or better) to become a certified LTC FS screener.

The LTC FS must be completed for all new applicants applying for participation in the COP-W/CIP II program. In addition, the LTC FS must be completed for all current waiver participants at annual recertification.

Once the LTC FS is completed, the screener selects the “calculate eligibility” button. The eligibility logic built into the screen is then able to determine the person’s Nursing Home Level of Care (NH LOC), and/or Developmental Disability Level of Care (DD LOC) – if applicable based on the information entered.

**IMPORTANT:** An applicant/participant **must** receive a Nursing Home level of care to be eligible for COP-W and CIP II. The reason for this is because these two programs can only serve nursing home eligible people.

## TIPS FOR COMPLETING THE LONG TERM CARE FUNCTIONAL SCREEN IN GENERAL

- The LTC FS Clinical Instructions are essential in understanding and selecting the correct response to best reflect the applicant/participant needs. The LTC FS Clinical Instructions are updated on a regular basis. Screeners should reference the most current version of the instructions in order to ensure that the LTC FS is completed correctly. Each county screen lead is informed when the clinical instructions have been updated. The fact that the clinical instructions have been updated should be shared with all screeners.

The LTC FS Clinical Instructions can be accessed at the following website:

[dhfs.wisconsin.gov/LTCare/FunctionalScreen/](http://dhfs.wisconsin.gov/LTCare/FunctionalScreen/)

or

through the Help functions in the LTC FS system.

- Obtain information from the applicant/participant directly. Information should be obtained on a face-to-face basis.
- Gather information in a way that is appropriate for the participant's target group, and use other persons as necessary to obtain correct information.
- Ask open - ended questions instead of "yes/no" questions. It is not uncommon for applicant's/participant's to sometimes underrate or minimize their need for help from others. He/she may exaggerate their abilities.
- Ask the applicant/participant to describe the procedure he/she uses to complete a task. This may give the screener a more accurate "picture" of the applicant's/ participant's abilities.
- When obtaining information from others, it is not uncommon for guardians, spouses, family members, and health care and institutional providers to overrate the applicant's/ participant's dependency on others.
- If a screener receives conflicting information from different people, the best source of information (besides the person themselves) is someone who does a lot of direct care for the person and who also likes the person. For example, a screener may get more accurate information from a personal care worker who actually observes and assists the person on a regular basis, than a family member who "thinks" about the type of help/assistance the person needs. (Remember to get the necessary release of information.)
- If an applicant/participant gives what appears to be inaccurate information, the screener should do the following three things:
  - a. Seek more details. Ask more questions. Ask the applicant/participant for a demonstration. Ask to look at the bathroom to check for accessibility and/or adaptive equipment.
  - b. Talk to other persons who know the applicant/participant for more information, insight regarding the applicant's/participant's abilities (Reminder: get a release of information)
  - c. Use your professional judgment to select the best answer.

- Do not “inflate” an applicant’s/participant’s answers. Instead, select the answer that most accurately describes the person’s abilities.
- Be as objective as possible. Ask yourself “would another screener choose the same answer that I did?” That is why your professional judgment must be based on as much objective information as possible. Asking questions, asking for demonstrations, and carefully observing can obtain objective information.
- Use the “Note” sections throughout the LTC FS to expand, clarify or explain why a type of assistance is needed or not needed. Having this information may reduce the need for a screener to justify why a section of the screen was completed in a certain way. The “Note” sections give the screener an opportunity to add any additional information that the screener feels may be useful in getting an accurate picture of who the person is and the type of assistance is needed and why.

## **GENERAL TIPS/SUGGESTIONS FOR COMPLETING SPECIFIC SECTIONS OF THE LONG TERM CARE FUNCTIONAL SCREEN**

- **Selecting the appropriate target group**
  - a) Reminder: in order to be eligible for the COP-W/CIP II program, the applicant/participant must have a condition that is expected to last for more than one year.
  - b) For participation in the COP-W/CIP II program an applicant/participant must meet the definition of Frail Elder, Physical Disability, Alzheimer’s disease or other irreversible dementia, or a terminal condition with death expected with one year from the date of the screening.
  - c) An applicant/participant may also have a Developmental Disability per FEDERAL definition. However, the applicant/participant must also meet the definition of Frail Elder or Physical Disability and receive a nursing home level of care to be found eligible for the COP-W/CIP II program. **Very important:** If an applicant/participant has a diagnosis of mental retardation and is **under** the age of 65, he/she is **not** eligible to participate in the COP-W/CIP II program even if a nursing home level of care is obtained. The COP-W/CIP II program cannot serve persons under the age of 65 who have a diagnosis of mental retardation. Persons who fall into this category may be able to be served on either CIP 1 or COP depending upon available funding.
  - d) A screener should check as many of the target groups that are applicable to the person.
  - e) **IMPORTANT TIP:** if an applicant/participant has a diagnosis of mental illness or substance abuse that is impacting the applicant’s/participant’s abilities, the screener should refer to the appropriate decision tree to assist the screener in determining if the applicant/participant also has a diagnosis of Frail Elder, Physical Disability, Alzheimer’s, etc. The decision trees can be accessed through the LTC FS web site at:

Or

- **Tips for completing the Activities of Daily Living and Instrumental Activities of Daily Living section of the LTC FS**

- a) **Screening a person who is currently in an institution**

When completing the LTC FS on someone who is preparing to be discharged from a nursing home or hospital, complete the screen based on how the person would function at their home or the type of assistance they will require once he/she is discharged home. Do not complete the screen based on the assistance the person is receiving while in the nursing home or hospital. Envision the person at home. Talk to facility staff, family members, etc. to get the most accurate picture of the person's needs at home once he/she is discharged.

- b) **Abilities fluctuate**

It isn't uncommon for a person's abilities or needs to fluctuate depending upon his/her diagnosis. Listen to how people answer questions pertaining to how much help they need, or how often something occurs. Listen to key phrases like: "now and then", or "every few weeks," or "a few times, not mostly". However, if a person or family member were to say phrases like: "He always does this", or "Most of the time", or "I can't do that", this might indicate that the person's need for assistance is fairly consistent.

Use the following guidelines when selecting a frequency for fluctuating abilities:

- If the person's functional abilities vary over months or years, select the answer that seems closest to the average frequency of help needed.
- If the person's functional abilities vary day-to-day select the answer that most accurately describes their needs on a "bad" day.
- If the person's functional abilities vary week-to-week, try to select answers that reflect how you would staff them if you had to.

Things to remember/consider:

- "Long term care needs" implies the need for help from another person
- The person's deficits/impairments as a result of their physical disability and/or medical diagnosis should re-occur at least twice within a 90 day timeframe

*Example: an applicant has Multiple Sclerosis. About one week out of the month the illness exacerbates itself to the point that she is unable to complete her ADL's and IADL's and requires a great deal of assistance from her spouse. But when the MS is "under control" she is more independent in completing her ADL's and IADL's. Given that the person's abilities fluctuate routinely (ie within the same month's time), and when her illness is exacerbated she requires assistance from another person, the screener should indicate that the applicant needs help with her ADL's or IADL's.*

**c) Observation**

If need be, ask the person to complete a task, or show you how they complete a task. This may give the screener a more accurate picture of the person's needs, particularly when conflicting information is presented.

**d) Just because a person has it or gets it doesn't automatically mean they need it**

If an apartment building routinely installs grab bars in the bathroom of all the apartments, or a CBRF routinely assists a person with dressing or medication because that is what the staff is "supposed to do", does not necessarily mean the person "needs" or requires that assistance. The screener should score the LTC FS based on whether or not the person actually uses/needs the equipment or assistance that is provided. Remember, the LTC FS should be completed based on the person's functioning, not the service they receive or the adaptive equipment that might be made available to them.

**e) Just because you don't like or agree with the decisions that people make doesn't mean the person needs assistance**

*Example: If a competent person with full decisional capacity makes an informed choice to mishandle or gamble his/her funds, or eat foods that are a direct contradiction to a medical condition he/she has, the person should be screened as "independent" with those types of IADL's. A screener should not indicate that a person needs help from another person unless the person is functionally or cognitively unable to complete or manage those tasks.*

**f) Just because a person never had to do a task or never learned how to do a task, does not mean the person can't do the task**

Determining a person's ability to complete an ADL or IADL should be based on a person's loss of functioning. In other words, the screener should ask him/herself "is there a physical or cognitive reason why the person cannot complete the task independently". Just because a person never learned how to cook, or perhaps their culture dictates that he/she does not complete a task, does not necessarily mean the person could not do the task. The screener should rely on the person's diagnosis, observations, etc. to determine if there is a functional reason why the person does not complete a particular task.

**g) Indicate if the person uses adaptive equipment**

Become familiar with the pieces of equipment that is listed on the LTC FS. If a person has the equipment AND NEEDS the equipment, check that on the LTC FS. The logic in the screen takes this into account when calculating the level of care.

• **Tips for completing the Diagnoses section of the LTC FS**

**a) All diagnoses must be verified.**

This can be done in one of three ways: 1) a medical doctor, a registered nurse, or other health care professional can state it to the screener, or 2) a screener can copy this information directly from recent health care records, or 3) it is very clearly stated – in exact words – by the person, family member or advocate, etc. what the diagnoses are.\*

\* The exception to accepting the exact words from a person or a family member or advocate regarding a person's diagnosis, is when a diagnosis involves a psychiatric

diagnosis, behavior diagnoses, or dementia. A screener must confirm those diagnoses with a health care provider or by the person's medical records.

**b) Do not interpret the person's complaints or symptoms and then check a specific diagnosis based on that.**

For example if a person indicates that their vision is poor, it would not be appropriate to automatically check "Cataract/Glaucoma/Diabetic Retinopathy" based on that alone. Again, all diagnosis must be verified.

**c) Do not interpret the person's medication that he/she is taking as verification as to what diagnosis he/she may have.**

There are many medications that are prescribed for more than one medical concern or diagnosis. A screener must verify a person's diagnosis.

• **Tips for completing the Health Related Services (HRS)Table in the LTC FS**

**a) This is a very important component of the LTC FS.**

It is important that it be filled out correctly and accurately. Screeners should refer to the LTC FS Clinical Instructions for guidance and information.

**b) Consult others**

Most screeners are not medical experts. It is permissible and in fact encouraged to consult with a health care provider in order to accurately complete the Health Related Services screen. Ask the person's health care provider what health related services does the person need and at what frequency. Another resource may be the registered nurse within the county agency (if applicable).

**c) Based on needs – not just on what the person is getting**

Example: If a person refuses a needed health related service and isn't receiving it, a screener should still capture the need on the HRS table.

**d) Doesn't matter who is performing the skilled task\***

Remember family members are often taught how to complete very technical skilled nursing tasks. \*The only exception to this is "Nursing Assessment and Intervention". With regard to that task, a registered nurse is required to perform assessments/intervention, although another person may perform data gathering tasks for the registered nurse.

**e) The tasks need to be completed in the person's home\*.**

A screener should not select the skilled task if the task is performed in a clinic or acute/primary medical institution. \*The only exception to this is if the skilled task involved is dialysis, transfusions, ulcer and wound care (under certain situations) and skilled therapies.

**f) Selecting "Independent" on the HRS Table**

If a person performs a task listed on the HRS chart independently, it is important to indicate that as it may affect eligibility. Tip: if a family member, or perhaps a staff member at a substitute care facility performs the task for the person but the person tells you or demonstrates for you that he/she is perfectly capable of completely the task by themselves, the screener should select the person is independent. Reason: the HRS

chart is designed to capture what assistance, if any, does the person NEED in completing the task. The screener should select the appropriate response based on the person's functional/cognitive need.

- **Tips for completing the Communication & Cognition section of the LTC FS**

- a) As always, the information gathered in order to complete the LTC FS should be done during a face-to-face contact with the person. However, it may be necessary to review medical records (including mental status exams if they are current) and talk with other persons familiar with the person in completing this section of the screen.
- b) If a person speaks a different language than the screener, or uses sign language, that does not mean the person is unable to communicate. The key to completing this section of the screen is to ask yourself "is the person able to communicate efficiently, accurately and with relative ease."
- c) When it comes to completing the section about "Memory Loss" a screener should rely on his/her own observation and evidence to support what the screener has selected. This is one area where a screener can be somewhat more subjective and use their professional judgment.
- d) Regarding "Resistive to Care" – just because a competent person refuses assistance or services does not mean the person is "resistive to care". This section is primarily for persons who are resistive to care due to a cognitive impairment. There does not have to be a legal declaration of incompetence, but there should be either a medical diagnosis or indications in other parts of the screen to indicate the person has a cognitive impairment.

- **Tips for completing the Behavior/Mental Health section of the LTC FS**

- a) Information gathered for this section should be obtained during an interview, but it is also likely that information will be gathered from collateral contacts and other professionals.
- b) The behavior of wandering is associated with a person who has a cognitive impairment who unsafely leaves his/her home without telling anyone.
- c) With regard to self-injurious behavior it is important to think of this as physical self-abuse, and not the absence of self-care. In other words, a screener should not include unhealthy lifestyle choices (smoking, excessive alcohol use, not following a diabetic diet, sexual promiscuity) as displaying self-injurious behavior.
- d) With regard to mental health, be sure to verify diagnosis. Just because a person is prescribed an anti-depressant does not necessarily mean that they have a diagnosis of depression.

The Department conducted a webcast on this section of the LTC FS on July 1, 2008. This webcast can be viewed by accessing the Webcast Library at:  
<http://media1.wi.gov/DHFS/Catalog/Front.aspx?cid=b9f62403-7b9c-434c-aef1-9f2c8fba6780>

- **Tips for completing the Risk section of the LTC FS**

- a) This is a very important component of the LTC FS. It is important that it be filled out correctly.
- b) The screener is determining whether in his/her professional judgment, the person is at some type of risk. It does not matter if the person is choosing a level of risk in their life. The key issue is: “Does the screener feel there is a level of risk for this person whether the person chooses to put themselves at risk or not”.
- c) The screener may select more than one response in this section.

A screener should ask themselves: “Is the person at risk of going into a nursing home within 6 to 8 weeks”.

Nursing Home Skilled Nursing Facility - Level I and Nursing Home Intermediate Care Facility - Level II are eligible levels of care for CIP II and COP-W. Level III is *not* a waiver eligible level of care; it indicates COP eligibility.

If the applicant is placed on a waiting list, the Long Term Care Functional Screen may need to be redone. The LTC FS must be dated within 90 days prior to the waiver start date. (Note: For new plans, the effective date cannot be earlier than the Long Term Care Functional Screen screen completion date.) If too much time has elapsed or if the individual's functional status has changed by the time his/her name comes up for services, then the Long Term Care Functional Screen must be updated using the current screen completion date.

## NO ACTIVE TREATMENT RATINGS

COP-W and CIP II can typically serve persons with *developmental disabilities* that are primarily physical in nature, such as cerebral palsy, when there is *no mental retardation*. A person with a developmental disability must receive a No Active Treatment (NAT) rating to be eligible for CIP II or COP-W. In addition, the person must also receive a Nursing Home Level of Care on the LTC FS.

Individuals who have a diagnosis of *mental retardation* must be age 65 or older and must receive an NAT rating to be eligible for CIP II and COP-W, in addition to meeting the target group of either Frail Elder or Physical Disability. Individuals with a diagnosis of mental retardation who are under age 65 are not eligible for CIP II or COP-W, but may be appropriate candidates for CIP 1A, CIP 1B, or COP.

An NAT rating means the individual is not currently engaged in active treatment and would not benefit from active treatment. Active treatment means an ongoing, organized effort to help the person with mental retardation to attain his or her developmental capacity through regular participation, in accordance with an individualized plan, in a program designed to enable the person to attain the optimal physical, intellectual, social, and vocational levels of functioning of which he or she is capable. The NAT module of the LTC FS is not used to determine NAT for CIP II or COP-W.

The NAT determination will be made at the time the waiver application or recertification is approved. The care manager should request an NAT rating in writing. A note in the cover letter or on top of the LTC FS would fulfill this requirement. The care manager must also include information about the following topics so the reviewer can make the determination: perceptual skills, sensory motor skills, self-help skills, communication skills, social skills, self-direction, emotional stability, and effective use of time (including leisure time). This information can be incorporated in Part C of the Health Form if desired, or in the Assessment/Supplement for initial waiver applications, or within the “Notes” section of the LTC FS.

**Important note:** If a person is currently being served by the CIP 1A or CIP 1B program and the plan is to transition that person into the COP-W/CIP II program, additional documentation is necessary. Specifically, the care manager must submit a copy of the most recent ISP from the person’s participation in the CIP 1A or 1B program with the application. In addition, the care manager must document five additional criteria. Those five criteria are:

1. How has the person’s needs changed that now warrants a No Active Treatment?
2. Does the transition from CIP to COP-W/CIP II involve an informed choice of the person or guardian that supports a No Active Treatment?
3. What will happen to the person if the NAT is denied?
4. A comparison between the service plan the person was receiving when he/she was on CIP and what the services the person will be receiving if a NAT is given, and lastly,
5. All other eligibility criteria for participating in the COP-W/CIP II have been met.

Each application that involves a transfer from CIP 1A or CIP 1B to the COP-W/CIP II program is also reviewed jointly by both the COP section and the Developmental Disability Service section within the Bureau of Long Term Support. This Bureau makes the decision to approve or deny each transfer application.

### **Why are NATs Required?**

- As a result of the deinstitutionalization movement for individuals with developmental disabilities, the federal government set up guidelines for the use of Medicaid reimbursement to reduce the occurrence of inappropriate placements in facilities funded by Medicaid.
- Medicaid reimbursement is restricted for individuals with developmental disabilities that reside in institutional settings unless active treatment is received (i.e. if they are in an institution, they must be receiving active treatment for Medicaid to fund the care). Medicaid will fund the placement of a person with a developmental disability who requires active treatment in an intermediate care facility for the mentally retarded (ICF-MR). Some nursing homes have distinct units that are licensed as ICF-MRs.
- Nursing homes, by definition, are nursing care facilities and do not provide active treatment. For a person with a developmental disability to be placed in a nursing home, it must first be demonstrated the individual does not require or would not benefit from active treatment.
- Since individuals must meet the standards for nursing home admission to be eligible for the CIP II and COP-W programs, it must be demonstrated the individuals do not require active treatment. It is also necessary for CIP II/COP-W eligibility to establish there is no mental retardation when the individual is under age 65.

The following is a link to the Department's form – Determination of No Active Treatment (NAT) Rating:

<http://dhfs.wisconsin.gov/forms1/ddes/DDE0922.pdf>

**DETERMINATION OF NO ACTIVE TREATMENT (NAT) RATING**

Name – Applicant/Participant	Date of Birth	County of Residence
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To be eligible for CIP II/COP-W, persons with developmental disabilities must receive a No Active Treatment (NAT) rating. The NAT rating must be determined at application and then re-determined annually by a person who is a Qualified Mental Retardation Professional (QMRP). To qualify for an initial NAT rating or for continuation of the NAT rating, either items 1, 2 (and at least one sub-item), or 3 must be checked.

- 1. He/she has a developmental disability such as epilepsy, brain injury prior to age 22, autism, or cerebral palsy with NO mental retardation AND he/she is able to function with little supervision. [CFR 483.440(a)(ii)(2)].
- 2. He/she is 65 years of age or older, has a developmental disability AND also mental retardation, BUT whose needs are similar to elderly residents of a nursing home. The individual has reached his/her maximum potential as evidenced by checking at least one of the following items:
  - A. Degenerative health status requiring skilled nursing intervention.
  - B. All treatment programs have been discontinued due to the determination that the maximum benefit has been reached.
  - C. Adaptive behavioral assessments by community service boards and other professionals indicate that he/she has reached his/her maximum potential and the major portion of care is maintenance of present skills and no further growth is expected.
- 3. He/she has a developmental disability, is 65 years of age or older, and has a life expectancy of less than 12 months.
- 4. The individual is NOT eligible for a NAT rating because:
  - A. He/she is under the age of 65 and has mental retardation
  - B. Other: \_\_\_\_\_

<b>SIGNATURE</b> – QMRP Making Determination	Date Signed
<b>SIGNATURE</b> – BLTS Staff Completing Review (initial application only)	Date of Review

**NAT RE-DETERMINATION**

Date	SIGNATURE of QMRP

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## NOTES

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## NON-ELIGIBILITY AND APPEALS

If the person does not receive a nursing home level of care at recertification, consider the following:

- The care manager can review the LTC FS and Health Form (and compare to previous forms if possible) to ascertain that all pertinent information has been included.
- If it appears the person still does not meet nursing home level of care, the care manager may wish to call a COP-Waiver Quality Assurance Consultant to discuss the situation. It will be helpful to have as much information as possible, including the ineligible LTC FS, the Health Form, a previous LTC FS, the Assessment, a narrative summary (if applicable), and any collateral information (Occupational or Physical Therapy notes, hospital/nursing home discharge summaries, home care agency assessments, case notes, or medical records).
- If, after further review, the level of care remains insufficient, the person is ineligible for waiver services. If an insufficient level of care is determined at recertification, the participant should be sent a ten-day notice that services will be terminated in ten days for Group A participants. For Group B and Group C participants, if an insufficient level of care is determined at recertification, the participant should be sent a ten-day notice that services will be terminated at a date that coincides with the Medicaid termination date as determined by the Income Maintenance worker. The participant has the right to pursue an appeal under Chapter 227 of the Administrative Code. The appeal process for CIP II and COP-W is found within the Medicaid Waivers Manual. When an individual files an appeal with the Office of Administrative Hearings, the county *must* send copies of the Long Term Care Functional Screen and signed Health Form to BLTS. BLTS will request a rating from the Division of Quality Assurance for the administrative hearing on the appeal. If the participant files an appeal prior to the termination date stated in the written termination notice, all services must continue until the appeal is heard.

Care managers should notify the income maintenance worker if a person does not pass the Long Term Care Functional Screen. A denial or termination of waiver eligibility may also result in a denial or termination of Medicaid (i.e., for Group B and Group C). If an individual is denied or terminated from the Waiver Program, he/she can then apply through the county IM worker for Medicaid via other eligibility criteria.

Please note, when an individual no longer meets a nursing home level of care on the LTC FS for the CIP II or COP-W programs at recertification time, he/she may qualify for program funding from the Community Options Program (COP). This funding may be available for the person when referred to COP as an Interdivisional Agreement 1.67 in accordance with s.46.27 (6r)(b)(3). Each county develops their own policy regarding Interdivisional Agreement 1.67.



## **CONFIDENTIALITY**

Any information collected for the screen or during the screening process is confidential. The LTC FS is voluntary, but is required for participation in COP and/or waiver programs. Information collected on the screen should be treated as HIPAA (Health Insurance Portability and Accountability Act) covered data.



## **TRAINING INFORMATION**

The current version of the screen is a web-based application that must be entered on-line. An in-depth review of, and instructions for, the web-based functional screen can be seen via the certification course described below.

Only experienced professionals who have taken a training course and have passed a certification exam can administer the screen. At this time, the training course must be taken on-line. Agency workers seeking to become certified screeners must work with their agency "screen leads" to register for the course.

Additional information on the LTC Functional Screen is available at the following site:  
<http://www.dhfs.state.wi.us/LTCare/FunctionalScreen/INDEX.HTM>.

## COMMON QUESTIONS AND ANSWERS

- **Can level of care be determined from a form other than the LTC FS? What if the applicant is currently in a nursing home and has an eligible level of care?**

No other form may be used for this purpose. The LTC FS is required for all COP-W/CIP II waiver applications. The LTC FS is used to determine non-financial eligibility for the waiver programs.

- **Can a person with a complex, yet stable, medical condition be found eligible for the waivers?**

It depends. The computer logic within the LTC FS determines what nursing home level of care a person receives based on information entered from a certified screener. All information regarding an applicant's ability to complete their ADL's and IADL's, what kind of skilled nursing tasks does he/she require, what behavioral or cognitive abilities do they have, is the person at risk of institutionalization, etc. all impact the level of care determination a person receives on the LTC FS.

- **If a person with mental retardation is on CIP IA or IB, can s/he be moved to CIP II or COP-W at age 65?**

It depends. In order for a person with mental retardation who is over the age of 65 to be on the COP-W/CIP program, the person must meet the definition of either Frail Elder or Physical Disability, must receive an appropriate nursing home level of care, reside in a waiver allowable setting, and receive a NAT rating. In addition, the care plan will be reviewed to determine if there has been a change in the person's care plan to reflect a service plan that is more conducive to maintaining the person in the community, as opposed to just a shift in funding of services just because the person is over age 65. See Chapter II of the Medicaid Waivers Manual for more information about this process.

- **Under what circumstances can a person with mental illness be eligible?**

Cases in which participants have mental health problems are complex because these problems often impact how people take care of themselves. It is not uncommon for people with mental health issues to neglect proper nutrition, hygiene, or basic health care. In order to be served by the waiver, a person with a primary diagnosis of mental health issues must have: a disability determination (even if it is based on a CMI diagnosis), a long term physical condition or illness (i.e. meet the definition of either Frail Elder or Physical Disability), and, pass the Long Term Care Functional Screen at a nursing home Level I or Level II. Care managers should review the decision tree for persons who have both a mental illness and are elderly, and review the decision tree for persons who have both a mental illness and a physical disability. These decisions trees will assist the care manager in determining if the person is eligible for participation in the COP-W/CIP II program.

The decision trees can be accessed through the LTC FS web site at:

[dhfs.wisconsin.gov/LTCare/FunctionalScreen/ComorbiditiesElders.pdf](https://dhfs.wisconsin.gov/LTCare/FunctionalScreen/ComorbiditiesElders.pdf)

Or

[dhfs.wisconsin.gov/LTCare/FunctionalScreen/ComorbiditiesPD.pdf](https://dhfs.wisconsin.gov/LTCare/FunctionalScreen/ComorbiditiesPD.pdf)

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## HEALTH FORM

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### PURPOSE

The purpose of the Health Form is to document the individual's medical condition at a given time and to demonstrate to the Centers for Medicare & Medicaid Services (CMS) that the individual has seen a doctor, registered nurse, or physician's assistant at least once a year. The Health Form also provides the care manager with an annual medical update and helps to verify whether or not the person has unstable health and is maintaining an eligible nursing home level of care.

### COMPLETING THE HEALTH FORM

The care manager is responsible for obtaining a completed Health Form signed by the individual's physician (M.D.), registered nurse, or physician's assistant for initial certification (if the Assessment/Supplement, version 6.0, is not signed by a registered nurse), and, for all annual recertifications. For initial certification, the Health Form should be completed (if necessary) within 90 days (before or after) of the waiver start date. For recertifications, the Health Form needs to be completed within 90 days before or after the recertification month.

The care manager should confirm that the information on the Health Form supports the information on the LTC FS.

### **Part A**

Part A is to be completed by the care manager. Write the name of the county agency. Write the applicant's name, his/her date of birth, the name of the applicant's physician, and the physician's clinic and phone number.

### **Part B**

Part B is to be completed by a physician (M.D.), registered nurse, or physician's assistant.

1. **Participant's Diagnosis, Disabilities, and Impairments** – Ask the doctor, nurse, or physician’s assistant to list *ALL* the participant's diagnoses, disabilities, and impairments (medical, physical, developmental, and psychological, including nutritional impairments and terminal care). Include the prognoses and rehabilitation potential. If pertinent, address issues surrounding depression or isolation and what impact this is having on the individual. Indicate if the person's condition is stable or unstable.
2. **Medications** - Ask the doctor, nurse, or physician’s assistant to indicate the name, dosage, and frequency of over-the-counter and prescription medications. Include ointments and eye drops. Indicate whether or not medications need to be supervised. All medications ordered by the physician should be listed.
3. **Need for Therapy, Home Health, Personal Care, or Treatments** - Check all items that apply.
4. **Diagnostic Tests** - Describe both the frequency and the type of tests. Diagnostic tests must be ordered by the physician. It does not matter who conducts the test (e.g. diabetics check their own blood sugar levels).
5. **Diet/Nutrition** - Describe the nutritional content, amount, and form of the person's diet. Indicate if nutrient supplements (e.g. Ensure) are required. If the individual is at risk of developing or exacerbating health problems related to nutrition and needs special nutritional monitoring, indicate the following: therapeutic diet needs, hydration needs, weigh-in frequency, reinforcement needed to maintain a diet, nutritional teaching, or nutritional supplements required.
6. **Signature and Date** - For CIP II and COP-W, the Health Form must be signed and dated by either a registered nurse (R.N.), physician (M.D), or a Physician’s Assistant (P.A.).

▪ **Part C**

Part C of the Health Form is now **OPTIONAL**. Information that once was gathered in that section of the Health Form should be written in the Assessment/Supplement and in the “Notes” section of the Long Term Care Functional Screen. In the event section C will be completed, it can be completed by a care manager, registered nurse, or other professional familiar with the individual.

1. **Mobility/Activity Limitations** - To what degree is the individual's mobility/activity limited? What adaptive aids are used? Are normal activities to be restricted? If so, describe what, how, and for what duration. Indicate the distance the individual is able to walk, whether independently or with assistance. "Independent" means without the help of any individual or adaptive aid.

2. **Other Information** - Provide information on cognitive abilities, communication, social abilities (disruptive or abusive behavior), or special health needs. Include any information that might enhance understanding of the individual's current care situation.

The care manager could use Part C to clarify why certain items were checked on the LTC FS or left off the Health Form by the doctor, nurse or physician's assistant. Information in Part C can explain any discrepancies between the information on the LTC FS and the Health Form.

**IMPORTANT NOTE:** Counties using the LTC FS and Assessment/Supplement – version 6.0, do not need to complete a Health Form for initial plans **IF** a registered nurse (RN) signs and dates the Assessment/Supplement. If a RN does not sign/date the Assessment/Supplement, then a Health Form must be completed.

However, for all annual recertifications, a Health Form must be completed. See Section 6 – Ongoing Care Management for more information.

## **ELIGIBILITY DETERMINATION**

The Health Form is reviewed to see if the medical information is consistent with the LTC FS. BLTS may ask the Division Quality Assurance to review the LTC FS and Health Form during the eligibility process, during monitoring, or as part of an appeal. A signed Health Form is required as part of the appeal process.

Information on the Health Form must be current (within 90 days before or after the waiver start date).

A copy of the Department's form – Medicaid Waiver Program – Health Report is available at: <http://dhfs.wisconsin.gov/forms1/ddes/DDE0810.doc>

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## NOTES

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## MEDICAID WAIVER PROGRAM HEALTH REPORT

**Use of form:** Personally identifiable information collected on this form is confidential and will be used for identification purposes and to document the individual's health information necessary in determining eligibility for services. Completion of this form is necessary to meet the requirements of Wis. Stats. 46.27(11) and 46.277(4).

**Instructions:** Complete within 90 days (before or after) the Waiver Start Date and annually within 90 days (before or after) the Waiver recertification month for each CIP II or COP-W participant.

### A. TO BE COMPLETED BY CARE MANAGER

Name – Participant (Last, First, MI)	Date of Birth (mm/dd/yyyy)
Name – County Agency / Care Manager	
Name – Physician / Clinic / Office	Physician's Telephone Number

### B. TO BE COMPLETED BY PHYSICIAN OR REGISTERED NURSE

1. Describe participant's diagnosis (i.e., disabilities / impairments / rehabilitation potential / prognosis). List primary diagnosis first. If necessary, attach additional documentation.)

1a. Condition is considered:  Stable  Unstable (Check one.)

2. List name of medications, dosage and frequency. Include injections, prescription and over-the-counter medications ordered. If necessary, attach additional documentation.

2a.  Yes  No Medications should be supervised. (Check one.)

3. Physician's Orders

a. Therapies / home health (Check all that apply.)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Home nursing care    | <input type="checkbox"/> Home health aide                      | <input type="checkbox"/> Personal care |
| <input type="checkbox"/> Occupational therapy | <input type="checkbox"/> Speech therapy                        | <input type="checkbox"/> Other         |
| <input type="checkbox"/> Physical therapy     | <input type="checkbox"/> Assistance with housekeeping / chores |  |

b. Treatments

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Oxygen        | <input type="checkbox"/> Ostomy care            | <input type="checkbox"/> Feeding tube    | <input type="checkbox"/> Range of motion     |
| <input type="checkbox"/> Dialysis      | <input type="checkbox"/> Suctioning             | <input type="checkbox"/> Parenteral / IV | <input type="checkbox"/> Other – List below. |
| <input type="checkbox"/> IV meds       | <input type="checkbox"/> Transfusions           | <input type="checkbox"/> Severe pain     | _____  |
| <input type="checkbox"/> Decubiti care | <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Radiation       | _____  |
| <input type="checkbox"/> Ventilator    | <input type="checkbox"/> Catheter – Type: _____ |  | _____  |

4. Ongoing diagnostic tests required – type and frequency

5. Diet / nutrition – List special instructions

SIGNATURE – Physician, Physician Assistant or Registered Nurse

Date Signed

CARE MANAGER – See page 2

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**C. COMPLETION OF ITEMS 1 AND 2 BELOW ARE OPTIONAL.**

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If part C is completed, the information should be provided by the care manager, nurse or another professional familiar with this applicant / participant. Enter information not found on the Long Term Care Functional Screen or the Assessment / Supplement, or that is missing from page one of this form.

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1. Describe mobility / activity limitations. List DME or adaptive aids needed.

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2. Other relevant information: Mental status, orientation, communication, social abilities, special health needs or other applicant / participant-specific information that substantiates the level of care determination.

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Name – Person filling out part C

Title

## COMMON QUESTIONS AND ANSWERS

- **Is it necessary for the participant to see a doctor during the recertification month if he/she sees a doctor regularly?**

No. Remember the Health Form can be signed and dated 90 days before or after the recertification month. However, if the doctor (M.D.), registered nurse (R.N.), or physician's assistant (P.A.) is slow to complete the Health Form, it may help to schedule an appointment around the time the recertification is due. Then, the participant can give the Health Form directly to the doctor (M.D.), registered nurse or P.A. to complete while the participant is in their office to ensure that the form is filled out in a timely manner.

- **What should be done if the Health Form comes back from the doctor and it is illegible?**

The care manager can attach current medical information that supplements the Health Form. The medical information should be current and include the individual's diagnoses and medications.

- **Does the actual Health Form need to be signed and dated if the attached documentation that gives information pertaining to diagnosis, medications, etc. is signed and dated by an appropriate health care professional (i.e., MD, RN or PA)?**

No, as long as the additional documentation is signed, dated and attached to the Health Form.