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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00366 (10/2024) |  | **STATE OF WISCONSIN** |
| WISCONSIN ADULT LONG TERM CARE FUNCTIONAL SCREEN (LTCFS) |
| **BASIC INFORMATION** |
| **Basic Screen Information** |
| Name – Screening Agency      |
| Referral Date      | Screen Type (Check only one box)[ ]  01 Initial Screen[ ]  02 Rescreen  |
| Name – Screener      | Screener ID      |
| **Applicant Information** |
| Title | Name – Applicant (First) | (Middle) | (Last) |
|       |       |       |       |
| Gender[ ]  Male[ ]  Female | Date of Birth (mm/dd/yyyy)      | Social Security Number (###-##-####)      |
| Address      |
| City      | State      | ZIP Code      |
| Home Phone(     )       -       | Work Phone(     )       -       | Cell Phone(     )       -       |
| County of Residence      | County/Tribe of Responsibility      |
| Directions:       |
|  |
| **Notes**:       |
| **SCREEN INFORMATION** |
| **Source of Information****Referral Source**  |
| [ ]  Self[ ]  Family/Significant Other[ ]  Friend/Neighbor/Advocate[ ]  Physician/Clinic[ ]  Hospital Discharge Staff[ ]  Nursing Home[ ]  CBRF (Group Home)[ ]  AFH (Adult Family Home) | [ ]  RCAC (Residential Care Apartment Complex)[ ]  FDD/ICF-IID[ ]  State Center[ ]  Home Health Agency[ ]  Community Agency[ ]  Other—Specify:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Guardian or other legal representative |
|  |
| **Primary Source for Screen Information**  |
| [ ]  Self[ ]  Guardian or other legal representative[ ]  Family Member[ ]  Spouse/Significant Other[ ]  Parent | [ ]  Child[ ]  Advocate[ ]  Case Manager[ ]  Hospital Staff[ ]  Nursing Home Staff | [ ]  ICF-IID/Center Staff[ ]  Residential Care Staff[ ]  Home Health, Personal Care, or Supportive Home Care Staff |
| [ ]  Other—Specify:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Indicate name(s):      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **Location Where Screen Interview was Conducted** |
| [ ]  Person’s Current Residence [ ]  Temporary Residence (non-institutional)[ ]  Nursing Home | [ ]  Hospital[ ]  Agency Office/Resource Center |
| [ ]  Other—Specify:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **ICA Read Only** |
| [ ]  Advocates4U [ ]  Connections[ ]  First Person Care Consultants[ ]  Midstate Independent Living Choices (MILC)[ ]  Progressive Community Services (PCS)[ ]  TMG |
| **Notes**:       |

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| **DEMOGRAPHICS** |
| **Medical Insurance** (Check all boxes that apply) |
| [ ]  Medicare | Policy Number: |      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | [ ]  Part A |  |
|  | [ ]  Part B |  |
|  | [ ]  Medicare Managed Care |
| [ ]  Medicaid |
| [ ]  Private Insurance [includes employer-sponsored (job benefit) insurance] |
| [ ]  Private Long-Term Care Insurance |
| [ ]  VA Benefits–Policy #:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Railroad Retirement–Policy #:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Other insurance |
| [ ]  No medical insurance at this time |
|  |
| **Ethnicity**—**Is Applicant Hispanic or Latino?** |
| [ ]  Yes [ ]  No |
|  |  |
| **Race** (Check all boxes that apply) |
| [ ]  American Indian or Alaska Native |  |
| [ ]  Asian |  |
| [ ]  Black or African American |  |
| [ ]  Native Hawaiian or Other Pacific Islander |  |
| [ ]  White |  |
| [ ]  Other |  |
|  |
| **If an interpreter is required, select language below**  |
| [ ]  American Sign Language | [ ]  Hmong | [ ]  Other—Specify: |
| [ ]  Spanish | [ ]  Russian |  |       |
| [ ]  Vietnamese | [ ]  A Native American Language |  |
|  |  |
| **Contact Information 1** |
| [ ]  Adult Child | [ ]  Parent/Step-Parent | [ ]  Spouse |
| [ ]  Ex-Spouse | [ ]  Power of Attorney | [ ]  Other Informal Caregiver/Support: |
| [ ]  Guardian of Person | [ ]  Sibling |  |      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Name (First) | (Middle Initial) | (Last) |
|       |       |       |
| Address      |
| City      | State      | ZIP Code      |
| Home Phone(     )       -       | Work Phone(     )       -       | Cell Phone(     )       -       |
| Best time to contact and/or comments:       |

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| **Contact Information 2** |
| [ ]  Adult Child | [ ]  Parent/Step-Parent | [ ]  Spouse |
| [ ]  Ex-Spouse | [ ]  Power of Attorney | [ ]  Other Informal Caregiver/Support:  |
| [ ]  Guardian of Person | [ ]  Sibling |  |      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Name (First) | (Middle Initial) | (Last) |
|       |       |       |
| Address      |
| City      | State      | ZIP Code      |
| Home Phone(     )       -       | Work Phone(     )       -       | Cell Phone(     )       -       |
| Best time to contact and/or comments:       |
| **Contact Information 3** |
| [ ]  Adult Child | [ ]  Parent/Step-Parent | [ ]  Spouse |
| [ ]  Ex-Spouse | [ ]  Power of Attorney | [ ]  Other Informal Caregiver/Support:  |
| [ ]  Guardian of Person | [ ]  Sibling |  |      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Name (First) | (Middle Initial) | (Last) |
|       |       |       |
| Address      |
| City      | State      | ZIP Code      |
| Home Phone(     )       -       | Work Phone(     )       -       | Cell Phone(     )       -       |
| Best time to contact and/or comments:       |
| **Notes**:       |

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| **LIVING SITUATION** |
| **Current Residence**  |
| **Own Home or Apartment**[ ]  Alone [ ]  With Spouse/Partner/Family[ ]  With Non-Relatives/Roommates [ ]  With Live-in Paid Caregiver(s) **Someone Else’s Home or Apartment**[ ]  Family[ ]  Non-relative[ ]  Home or Apartment for which lease is held by support services provider **Group Residential Care Setting**[ ]  Certified Adult Family Home (1-2 bed AFH) [ ]  Licensed Adult Family Home (3-4 bed AFH)[ ]  CBRF 5-8 beds[ ]  CBRF more than 8 beds[ ]  Children’s Group Home[ ]  Residential Care Apartment Complex (RCAC) | **Health Care Facility/Institution**[ ]  Nursing Home[ ]  FDD/ICF-IID[ ]  DD Center/State Institution for Developmental Disabilities[ ]  Mental Health Institute/State Psychiatric Institution[ ]  Other IMD[ ]  Child Caring Institution[ ]  Hospice Care Facility[ ]  **No Permanent Residence** [ ]  **Correctional Facility—** **List Facility:**      \_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  **Other —Specify:**      \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **Prefers to Live**  |
| [ ]  Stay at current residence[ ]  Move to their own home or apartment [ ]  Move to someone else’s home or apartment[ ]  Move to an apartment with onsite services  | [ ]  Move to a group residential care setting[ ]  Move to a health care facility or institution[ ]  No permanent residence [ ]  Unsure, or unable to determine person’s preference for living arrangement |
|  |  |
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| **Guardian/Family’s Preference for this Individual**  |
| [ ]  Not applicable[ ]  Stay at current residence[ ]  Move to their own home or apartment [ ]  Move to someone else’s home or apartment[ ]  Move to an apartment with onsite services  | [ ]  Move to a group residential care setting [ ]  Move to a health care facility or institution [ ]  No consensus among multiple parties[ ]  No response or no preference from guardian or family |
|  |
| **Notes**:       |

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| **DIAGNOSES** |
| [ ]  **No current diagnoses** | **FSIQ:** Score       [ ]  Unknown |
| **A. DEVELOPMENTAL DISABILITY**[ ]  1 Intellectual Disability[ ]  2 Autism[ ]  3 Brain Injury with onset BEFORE age 22[ ]  4 Cerebral Palsy[ ]  5 Prader-Willi Syndrome[ ]  6 Seizure Disorder with onset BEFORE age 22[ ]  7 Other Congenital Disorders similar to intellectual disability List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  8 Down Syndrome[ ]  9 Other Congenital Disorders, that may meet state or federal definitions of DDList diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  10 Unspecified Diagnoses, that may meet state or federal definitions of DDList diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**B. ENDOCRINE/METABOLIC**[ ]  1 Diabetes Mellitus[ ]  2 Hypothyroidism/Hyperthyroidism[ ]  3 Dehydration/Fluid and Electrolyte Imbalances[ ]  4 Liver Disease (hepatic failure, cirrhosis)[ ]  5 Other Disorders of Digestive System (mouth, esophagus, stomach, intestines, gall bladder, pancreas)List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  6 Other Disorders of the Metabolic System (For example, B-12 deficiency, high cholesterol, Hyperlipidemia)List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  7 Other Disorders of the Hormonal System (For example, adrenal insufficiency or Addison’s Disease)List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  8 Obesity[ ]  9 Malnutrition[ ]  10 Eating Disorders**C. HEART/CIRCULATION**[ ]  1 Anemia/Coagulation Defects/Other Blood Diseases[ ]  2 Angina/Coronary Artery Disease/Myocardial Infarction (MI)[ ]  3 Disorders of Heart Rate or Rhythm[ ]  4 Congestive Heart Failure (CHF)[ ]  5 Disorders of Blood Vessels or Lymphatic System[ ]  6 Hypertension[ ]  7 Hypotension (low blood pressure)[ ]  8 Other Heart/Circulatory Conditions (including valve disorders)List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **D. MUSCULOSKELETAL/NEUROMUSCULAR**[ ]  1 Amputation[ ]  2 Arthritis (For example, osteoarthritis, rheumatoid arthritis)[ ]  3 Hip Fracture/Replacement[ ]  4 Other Fracture/Joint Disorders/Scoliosis/KyphosisList diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  5 Osteoporosis/Other Bone Disease[ ]  6 Contractures/Connective Tissue Disorders[ ]  7 Multiple Sclerosis/ALS[ ]  8 Muscular Dystrophy[ ]  9 Spinal Cord Injury[ ]  10 Paralysis Other than Spinal Cord Injury[ ]  11 Spina Bifida[ ]  12 Other Chronic Pain Or Fatigue [For example, fibromyalgia, migraines, headaches, back pain (including disks), chronic fatigue syndrome]List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  13 Other Musculoskeletal, Neuromuscular, or Peripheral Nerve DisordersList diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**E. BRAIN/CENTRAL NERVOUS SYSTEM**[ ]  1 Alzheimer’s Disease[ ]  2 Other Irreversible DementiaList diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  3 Cerebral Vascular Accident (CVA, stroke) with onset at age 22 or AFTER[ ]  4 Brain Injury at age 22 or AFTER[ ]  5 Seizure Disorder with onset at age 22 or AFTER[ ]  6 Other brain disorders with onset at age 22 or AFTERList diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  7 Other Neurological DisordersList diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  8 Memory Loss by Provider[ ]  9 Memory Loss by Memory ScreeningList Date and Results:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**F. RESPIRATORY**[ ]  1 Chronic Obstructive Pulmonary Disease (COPD)/Emphysema/Chronic Bronchitis[ ]  2 Pneumonia/Acute Bronchitis/Influenza[ ]  3 Tracheostomy[ ]  4 Ventilator Dependent[ ]  5 Other Respiratory ConditionList diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  6 Asthma |
| **DIAGNOSES (Continued)** |
| **G. DISORDERS OF GENITOURINARY/REPRODUCTIVE SYSTEM**[ ]  1 Renal Failure, other Kidney Disease[ ]  2 Urinary Tract Infection, current or recently recurrent[ ]  3 Other Disorders of GU System (For example, bladder or urethra)List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  4 Disorders of Reproductive System**H. DOCUMENTED MENTAL ILLNESS**[ ]  1 Anxiety Disorder (For example, phobias, post-traumatic stress disorder, obsessive-compulsive disorder)[ ]  2 Bipolar/Manic-Depressive[ ]  3 Depression[ ]  4 Schizophrenia[ ]  5 Other Mental Illness Diagnosis (For example, personality disorder)List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**I. SENSORY**[ ]  1 Blind[ ]  2 Visual Impairment (For example, cataracts, retinopathy, glaucoma, macular degeneration)[ ]  3 Deaf[ ]  4 Other Sensory DisordersList diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **J. INFECTIONS/IMMUNE SYSTEM**[ ]  1 Allergies[ ]  2 Cancer in Past 5 Years[ ]  3 Diseases of Skin[ ]  4 HIV - Positive[ ]  5 AIDS Diagnosed[ ]  6 Other Infectious DiseaseList diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  7 Auto-Immune Disease (other than rheumatism)**K. OTHER**[ ]  1 Substance Use Issue[ ]  2 Behavioral Diagnoses (not found in part H above)[ ]  3 Terminal Illness (prognosis < or = 12 months)[ ]  4 Wound/Burn/Bedsore/Pressure Ulcer[ ]  5 OtherList diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  6 Additional DiagnosesList diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Notes**:       |

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| **ADLS (ACTIVITIES OF DAILY LIVING)** |
| **Coding for Level of Help Needed toComplete Task Safely** | **Coding for Who Will Help in NextEight (8) Weeks** (check all that apply) |
| **0:** Person is **independent** in completing the activity safely.**1:** Help is needed to complete the task safely but **helper DOES NOT have to be physically present throughout the task**. “Help” can be supervision, cueing, or hands-on assistance.**2:** Help is needed to complete the task safely and **helper DOES need to be physically present throughout the task**. “Help” can be supervision, cueing, and/or partial or complete hands-on assistance. | **U:** Current **UNPAID** caregiver will continue**PF:** Current **PUBLICLY FUNDED** paid caregiver will continue**PP:** Current **PRIVATELY PAID** caregiver will continue**N: Need** to find new or additional caregiver(s) |
| **ADLs**  | **Help Needed**  | **Who Will Help in Next Eight Weeks?** |
| **BATHING** | **Adaptive Equipment Options**[ ]  **No Equipment**[ ]  **Uses Adaptive Equipment**  | [ ]  0[ ]  1[ ]  2 | [ ]  U[ ]  PF[ ]  PP[ ]  N |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **DRESSING** |  | [ ]  0[ ]  1[ ]  2 | [ ]  U[ ]  PF[ ]  PP[ ]  N |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **EATING** |  | [ ]  0[ ]  1[ ]  2 | [ ]  U[ ]  PF[ ]  PP[ ]  N |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **MOBILITY IN HOME** | **Adaptive Equipment Options**[ ]  **No Equipment**[ ]  **Uses Cane, Crutches, or Walker in Home**[ ]  **Uses Wheelchair or Scooter in Home**[ ]  **Has Prosthesis** | [ ]  0[ ]  1[ ]  2 | [ ]  U[ ]  PF[ ]  PP[ ]  N |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **TOILETING** | **Adaptive Equipment Options**[ ]  **No Equipment**[ ]  **Uses Grab Bar, Commode, or Other Adaptive Equipment**[ ]  **Uses Urinary Catheter**[ ]  **Has Ostomy**[ ]  **Receives Regular Bowel Program** | [ ]  0[ ]  1[ ]  2 | [ ]  U[ ]  PF[ ]  PP[ ]  N |
| **INCONTINENCE**: *Do not include stress incontinence* [ ]  **Does not have incontinence or has incontinence less often than weekly**[ ]  **Has incontinence less than daily but at least once per week**[ ]  **Has incontinence daily** |  |  |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |

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|  | **ADLs** | **Help Needed** | **Who Will Help in Next Eight Weeks?** |
| **TRANSFERRING** | **Adaptive Equipment Options**[ ]  **No Equipment**[ ]  **Uses Grab Bar(s), Bed Bar, or Bed Railing**[ ]  **Uses Transfer Board or Pole**[ ]  **Uses Trapeze**[ ]  **Uses Mechanical Lift,** including stander or pivot disc | [ ]  0[ ]  1[ ]  2 | [ ]  U[ ]  PF[ ]  PP[ ]  N |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **Notes**:       |

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| **IADLS (INSTRUMENTAL ACTIVITIES OF DAILY LIVING)** |
| **KEY: Coding for Who Will Help in Next Eight (8) Weeks –See ADLs** |
| **IADL** | **Level of Help Needed** | **Who Will Help in Next Eight Weeks?** |
| **MEAL PREPARATION** | [ ]  0: Independent[ ]  1: Needs help weekly or less [ ]  2: Needs help 2-7 times a week [ ]  3: Needs help with every meal  | [ ]  U[ ]  PF[ ]  PP[ ]  N |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **MEDICATION ADMINISTRATION and MEDICATION****MANAGEMENT**  | [ ]  N/A: Has no medications[ ]  0: Independent [ ]  1: Needs help 1-2 days per week or less. [ ]  2a: Needs help at least once a day 3-7 days per week—CAN direct the task [ ]  2b: Needs help at least once a day 3-7 days per week—CANNOT direct the task | [ ]  U[ ]  PF[ ]  PP[ ]  N |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **MONEY MANAGEMENT** | [ ]  0: Independent[ ]  1: Can only complete small transactions (Needs help to complete some components of Money Management)[ ]  2: Needs help with all transactions | [ ]  U[ ]  PF[ ]  PP[ ]  N |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **LAUNDRY and/or CHORES** | [ ]  0: Independent[ ]  1: Needs help weekly or less[ ]  2: Needs help more than once a week | [ ]  U[ ]  PF[ ]  PP[ ]  N |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **TELEPHONE USE** | **1. Ability to Use Phone** [ ]  1a: Independent—has cognitive and physical abilities to use a phone [ ]  1b: Lacks cognitive or physical abilities to use phone independently**2. Access to Phone** [ ]  2a: Currently has working phone or access to one [ ]  2b: Has no phone and no access to a phone |  |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **TRANSPORTATION** | **[ ]** 1a: Person drives **regular** vehicle**[ ]** 1b: Person drives **adapted** vehicle**[ ]** 1c: Person drives **regular** vehicle but there are serious safety concerns**[ ]** 1d: Person drives **adapted** vehicle but there are serious safety concerns[ ]  2: **Person cannot drive due to physical, psychiatric, or cognitive impairment**. [ ]  3: **Person does not drive due to other reasons** |  |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **Notes**:       |

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| **ADDITIONAL SUPPORTS** |
| **Overnight Care or Overnight Supervision Information**Does the person require overnight care or overnight supervision? |
| [ ]  0: No[ ]  1: Yes; caregiver can get at least six hours of uninterrupted sleep per night[ ]  2: Yes; caregiver cannot get at least six hours of uninterrupted sleep per night |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
|  |
| **Employment Information** |
| **A. Current Employment Status** |
| [ ]  1: Retired (Does not include people under 65 who stopped working for health or disability reasons)[ ]  2: Not working (No paid work)Is the individual interested in employment? [ ]  Yes or [ ]  No[ ]  3: Working full-time (Paid work averaging 30 or more hours per week)[ ]  4: Working part-time (Paid work averaging fewer than 30 hours per week) |
|  |
| **B. If Paid Work, Where? (Check all that apply)** |
| [ ]  1: Facility-Based SettingIs the individual interested in working in the community? [ ]  Yes or [ ]  No[ ]  2: Group-Supported employment in the community (two or more) or individual employment in the community, with or without employment services, paid at a subminimum wage[ ]  3: Individual employment in the community, with or without employment services, paid at a competitive wage (minimum wage or higher)[ ]  4: At home or self-employed |
|  |
| **C. Need for Assistance to Work**  |
| [ ]  0: Independent (with assistive devices if uses them)[ ]  1: Needs help weekly or less (e.g., if a problem arises)[ ]  2: Needs help every day but does not need the continuous presence of another person[ ]  3: Needs the continuous presence of another person[ ]  4: Not applicable (please explain) |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **Educational Information**  |
| Is the individual currently participating in an educational program? |
| [ ]  Yes [ ]  No |
| Does the individual need assistance from another person to participate in an educational program? |
| [ ]  Yes [ ]  No |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **Guardianship**  |
| Does this individual have a guardianship? |
| [ ]  Yes [ ]  No |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **I/DD Diagnoses with Onset before Age 22**  |
| Was the onset of at least one of the A1-A10 diagnosis(es) before the age of 22? |
| [ ]  Yes [ ]  No |
| **Expected Diagnosis Duration and Disability Determination**  |
| Are the needs that are caused by the individual’s primary and secondary diagnosis(es) expected to last more than 90 days? |
| [ ]  Yes [ ]  No |
| Are the needs that are caused by the individual’s primary and secondary diagnosis(es) expected to last more than 12 months OR does the individual have a terminal illness? |
| [ ]  Yes [ ]  No |
| Does the individual have a disability determination from the Social Security Administration? |
| [ ]  Yes [ ]  No [ ]  Pending |
|  |
| **Notes**:       |

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| **HEALTH RELATED SERVICES** |
| Check only one box per row—Leave row blank if not applicable |
| Health-Related Services | Person is Independent | Frequency of Help/Services Needed from Other Persons |
| 1-3 times/ month | Weekly | 2-6 times/ week | 1-2 times/ day | 3-4 times/ day | 5+ times a day |
| **Behaviors** **Requiring Interventions**  |  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Exercises/Range of Motion** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **IV Medications**, **Fluids or IV Line Flushes** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Medication Administration** **(not IV) or Assistance with Pre-Selected or Set-Up Medications** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Medication Management**—**Set-up and/or Monitoring Medications (for Effects, Side Effects, Adjustments, Pain Management)—and/or Blood Levels**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Ostomy-Related Skilled Services** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Positioning** **in Bed or Chair Every 2-3 Hours** |  |  |  |  |  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Oxygen and/or Respiratory Treatments: Tracheal Suctioning, C-PAP, Bi-PAP, Nebulizers, IPPB Treatments (Does NOT include inhalers**) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Dialysis** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **TPN (Total Parenteral Nutrition)** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Transfusions** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Tracheostomy Care** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Tube Feedings** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Ulcer – Stage 2** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **HEALTH RELATED SERVICES (Continued)** |
| **Ulcer – Stage 3 or 4** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Urinary Catheter-Related Skilled Tasks (Irrigation, Straight Catheterizations)** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Other Wound Cares** **(Not Catheter Sites, Ostomy Sites, IVs or Ulcer - Stage 2, 3, or 4)** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Ventilator-Related Interventions** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Requires** **Nursing Assessment and Interventions** |  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Primary Diagnosis:       | Secondary Diagnosis:       |
|  |
| **Other—Specify**:       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Skilled Therapy—PT, OT, SLP** (Any One or Combination at Any Location) [ ]  1-4 sessions/week [ ]  5+ sessions/week |
|

|  |  |
| --- | --- |
| Primary Diagnosis:       | Secondary Diagnosis:       |

 |
| **Who will help with all health-related needs in next eight (8) weeks** (check **all** that apply) |
| **[ ]  U** | Current **UNPAID** caregiver will continue |
| **[ ]  PP** | Current **PRIVATELY PAID** caregiver will continue |
| **[ ]  PF** | Current **PUBLICLY FUNDED** paid caregiver will continue |
| **[ ]  N** | **Need** to find new or additional caregiver(s) |

**Notes:**

|  |
| --- |
| **COMMUNICATION AND COGNITION** |
| **Communication**  |
| [ ]  0: Can fully communicate with no impairment or only minor impairment [ ]  1: Can fully communicate with the use of assistive device[ ]  2: Can communicate ONLY BASIC needs to others[ ]  3: No effective communication |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **Memory Loss** |
| [ ]  0: No memory impairments evident during screening process[ ]  1: Short-Term Memory Loss [ ]  2: Unable to remember things over several days or weeks[ ]  3: Long-Term Memory Loss [ ]  4: Memory impairments are unknown or unable to determine. Explain why:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **Cognition for Daily Decision Making**  |
| [ ]  0: Person makes decisions consistent with their own lifestyle, values, and goals [ ]  1: Person makes safe, familiar/routine decisions but cannot do so in new situations[ ]  2: Person needs help with reminding, planning, or adjusting routine, even with familiar routine[ ]  3: Person needs help from another person most or all of the time |
| **Primary Diagnosis:**       | **Secondary Diagnosis:**       |
| **Physically Resistive to Care**  |
| [ ]  0: No[ ]  1: Yes, person is physically resistive to cares due to a cognitive impairment |
|  |
| **Notes**:       |

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| **BEHAVIORAL HEALTH** |
| **Wandering** |
| [ ]  0: Does not wander[ ]  1: Daytime wandering, but sleeps nights[ ]  2: Wanders during the night, or during both day and night |
|  |
| **Self-Injurious Behaviors** |
| [ ]  0: No injurious behaviors demonstrated[ ]  1: Some self-injurious behaviors require interventions weekly or less[ ]  2: Self-injurious behaviors require interventions 2-6 times per week OR 1-2 times per day[ ]  3: Self-injurious behaviors require intensive one-on-one interventions more than twice each day List behavior:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **Offensive or Violent Behavior to Others** |
| [ ]  0: No offensive or violent behaviors demonstrated[ ]  1: Some offensive or violent behaviors that require interventions weekly or less[ ]  2: Offensive or violent behaviors that require interventions 2-6 times per week OR 1-2 times per day[ ]  3: Offensive or violent behaviors that require intensive one-on-one interventions more than twice each day List behavior:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **Mental Health Needs**  |
| [ ]  0: No mental health problems or needs evident[ ]  1: No current diagnosis. Person may be at risk and in need of mental health services [ ]  2: Person has a current diagnosis of mental illness  |
|  |
| **Substance Use Disorder**  |
| [ ]  0: No substance use issues or diagnosis evident [ ]  1: No current diagnosis. Person may be at risk of recurrence or evidence suggests current problem [ ]  2: Person has a current diagnosis of substance use disorder |
| **Notes**:       |

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| **RISK** |
| **Part A – Current APS or EAN Client** |
| [ ]  A1: Person is known to be a current client of Adult Protective Services (APS)[ ]  A2: Person is currently being served by the lead Elder Adult/Adult at Risk (EA/AAR) agency |
|  |
| **Part B – Risk Evident During Screening Process** |
| [ ]  0: No risk factors or evidence of abuse, neglect, or exploitation apparent at this time |
| [ ]  1: The individual is currently failing or is at high risk of failing to obtain nutrition, self-care, or safety adequate to avoid significant negative health outcomes |
| [ ]  2: The person is at imminent risk of institutionalization (in a nursing home or FDD/ICF-IID) if they do not receive needed assistance or person is currently residing in a nursing home or FDD/ICF-IID and needs that level of care or supervision |
| [ ]  3: There are statements of, or evidence of, possible abuse, neglect, or exploitation [ ]  Not Applicable [ ]  Referring to APS and/or EA/AAR now |
| [ ]  4: The person’s support network appears to be adequate at this time, but may be fragile within the next 4 months |
| **Notes**:       |
| **SCREEN TIME**  |
| **Screen Time Information****Screen Completion Date** (mm/dd/yyyy): |       |  |
|  |  |  |
| Time to Complete Screen | Hours | Minutes |
| **Face-to-Face Contact with Person**  |       |       |
| **Collateral Contacts**  |       |       |
| **Paper Work**  |       |       |
| **Travel Time** |       |       |
| **Total Time to Complete Screen** |       |       |

|  |
| --- |
| **NO ACTIVE TREATMENT (NAT)** |
| **No Active Treatment** Part A Statements:1. The person has a terminal illness.

 [ ]  Yes [ ]  No1. The person has a FSIQ greater than 75.

 [ ]  N/A [ ]  Yes [ ]  No1. The person is ventilator dependent.

 [ ]  Yes [ ]  NoPart B Statements:1. The person has physical and mental incapacitation, typically but not always due to advanced age, such that their needs are similar to those of geriatric nursing home residents.

 [ ]  Yes [ ]  No1. The person is age 65 or older and would no longer benefit from active treatment.

 [ ]  Yes [ ]  No1. The person has severe chronic medical needs that require skilled nursing care.

 [ ]  Yes [ ]  No |
| **Notes**:       |