|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-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 |
|  |  |
|  | |
| **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 DD  List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  10 Unspecified Diagnoses, that may meet state or federal definitions of DD  List 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/Kyphosis  List 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 Disorders  List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **E. BRAIN/CENTRAL NERVOUS SYSTEM**  1 Alzheimer’s Disease  2 Other Irreversible Dementia  List 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 AFTER  List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  7 Other Neurological Disorders  List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  8 Memory Loss by Provider  9 Memory Loss by Memory Screening  List 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 Condition  List 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 Disorders  List 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 Disease  List 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 Other  List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  6 Additional Diagnoses  List diagnoses:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Notes**: | | | |

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| **ADLS (ACTIVITIES OF DAILY LIVING)** | | | | | |
| **Coding for Level of Help Needed to Complete Task Safely** | | | **Coding for Who Will Help in Next Eight (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:** | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **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 Setting  Is 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** | | | | |  |  |

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| **NO ACTIVE TREATMENT (NAT)** |
| **No Active Treatment**  Part A Statements:   1. The person has a terminal illness.   Yes  No   1. The person has a FSIQ greater than 75.   N/A  Yes  No   1. The person is ventilator dependent.   Yes  No  Part 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  No   1. The person is age 65 or older and would no longer benefit from active treatment.   Yes  No   1. The person has severe chronic medical needs that require skilled nursing care.   Yes  No |
| **Notes**: |