

### 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

Telephone – Home

( ) -

Telephone – Work

( ) -

Telephone – Cell

( ) -

County of Residence

County/Tribe of Responsibility

Directions:

Notes:

**SCREEN INFORMATION**

**Source of Information**

**Referral Source**

- |   |  |
|---|--|
| <input type="checkbox"/> Self                     | <input type="checkbox"/> RCAC (Residential Care Apartment Complex) |
| <input type="checkbox"/> Family/Significant Other | <input type="checkbox"/> FDD/ICF-IID                               |
| <input type="checkbox"/> Friend/Neighbor/Advocate | <input type="checkbox"/> State Center                              |
| <input type="checkbox"/> Physician/Clinic         | <input type="checkbox"/> Home Health Agency                        |
| <input type="checkbox"/> Hospital Discharge Staff | <input type="checkbox"/> Community Agency                          |
| <input type="checkbox"/> Nursing Home             | <input type="checkbox"/> Other—Specify: _____                      |
| <input type="checkbox"/> CBRF (Group Home)        |  |
| <input type="checkbox"/> AFH (Adult Family Home)  | <input type="checkbox"/> Guardian or other legal representative    |

**Primary Source for Screen Information**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Self   | <input type="checkbox"/> Child              | <input type="checkbox"/> ICF-IID/Center Staff                                      |
| <input type="checkbox"/> Guardian or other legal representative       | <input type="checkbox"/> Advocate           | <input type="checkbox"/> Residential Care Staff                                    |
| <input type="checkbox"/> Family Member                                | <input type="checkbox"/> Case Manager       | <input type="checkbox"/> Home Health, Personal Care, or Supportive Home Care Staff |
| <input type="checkbox"/> Spouse/Significant Other                     | <input type="checkbox"/> Hospital Staff     |  |
| <input type="checkbox"/> Parent                                       | <input type="checkbox"/> Nursing Home Staff |  |
| <input type="checkbox"/> Other—Specify: _____ Indicate name(s): _____ |   |  |

**Location Where Screen Interview was Conducted**

- |  |  |
|--|--|
| <input type="checkbox"/> Person's Current Residence              | <input type="checkbox"/> Hospital                      |
| <input type="checkbox"/> Temporary Residence (non-institutional) | <input type="checkbox"/> Agency Office/Resource Center |
| <input type="checkbox"/> Nursing Home                            |  |
| <input type="checkbox"/> Other—Specify: _____                    |  |

**HCB Waiver Group Information**

- Advocates4U
- Connections
- Consumer Direct for Wisconsin
- First Person Care Consultants
- Midstate Independent Living Choices (MILC)
- Progressive Community Services (PCS)
- TMG

**Notes:**

**DEMOGRAPHICS**

**Medical Insurance** (Check all boxes that apply)

- Medicare Policy Number: \_\_\_\_\_
  - Part A Effective Date (mm/dd/yyyy): \_\_\_\_\_
  - Part B Effective Date (mm/dd/yyyy): \_\_\_\_\_
  - 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
- Spanish
- Vietnamese
- Hmong
- Russian
- A Native American Language
- Other—Specify: \_\_\_\_\_

**Contact Information 1**

- Adult Child
- Ex-Spouse
- Guardian of Person
- Parent/Step-Parent
- Power of Attorney
- Sibling
- Spouse
- Other Informal Caregiver/Support: \_\_\_\_\_

|              |                  |        |
|--------------|------------------|--------|
| Name (First) | (Middle Initial) | (Last) |
|--------------|------------------|--------|

Address

|      |       |          |
|------|-------|----------|
| City | State | Zip Code |
|------|-------|----------|

|                     |                     |                     |
|---------------------|---------------------|---------------------|
| Home Phone<br>( ) - | Work Phone<br>( ) - | Cell Phone<br>( ) - |
|---------------------|---------------------|---------------------|

Best time to contact and/or comments:

**Contact Information 2**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Adult Child        | <input type="checkbox"/> Parent/Step-Parent | <input type="checkbox"/> Spouse                            |
| <input type="checkbox"/> Ex-Spouse          | <input type="checkbox"/> Power of Attorney  | <input type="checkbox"/> Other Informal Caregiver/Support: |
| <input type="checkbox"/> Guardian of Person | <input type="checkbox"/> Sibling            | _____  |

|              |                  |        |
|--------------|------------------|--------|
| Name (First) | (Middle Initial) | (Last) |
|--------------|------------------|--------|

Address

|      |       |          |
|------|-------|----------|
| City | State | Zip Code |
|------|-------|----------|

|                     |                     |                     |
|---------------------|---------------------|---------------------|
| Home Phone<br>( ) - | Work Phone<br>( ) - | Cell Phone<br>( ) - |
|---------------------|---------------------|---------------------|

Best time to contact and/or comments:

**Contact Information 3**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Adult Child        | <input type="checkbox"/> Parent/Step-Parent | <input type="checkbox"/> Spouse                            |
| <input type="checkbox"/> Ex-Spouse          | <input type="checkbox"/> Power of Attorney  | <input type="checkbox"/> Other Informal Caregiver/Support: |
| <input type="checkbox"/> Guardian of Person | <input type="checkbox"/> Sibling            | _____  |

|              |                  |        |
|--------------|------------------|--------|
| Name (First) | (Middle Initial) | (Last) |
|--------------|------------------|--------|

Address

|      |       |          |
|------|-------|----------|
| City | State | Zip Code |
|------|-------|----------|

|                     |                     |                     |
|---------------------|---------------------|---------------------|
| Home Phone<br>( ) - | Work Phone<br>( ) - | Cell Phone<br>( ) - |
|---------------------|---------------------|---------------------|

Best time to contact and/or comments:

**Notes:**

**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
- Certified Adult Family Home (1-2 Bed AFH) or other paid caregiver's home
- Home or Apartment for which lease is held by support services provider

**Apartment with Onsite Services**

- Residential Care Apartment Complex (RCAC)
- Independent Apartment Community-Based Residential Facility (CBRF)

**Group Residential Care Setting**

- Licensed Adult Family Home (3-4 bed AFH)
- CBRF 1-20 beds
- CBRF more than 20 beds
- Children's Group Home

**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**

**Other (includes jail)—Specify:** \_\_\_\_\_

**Prefers to Live**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Stay at current residence</li> <li><input type="checkbox"/> Move to their own home or apartment</li> <li><input type="checkbox"/> Move to someone else's home or apartment</li> <li><input type="checkbox"/> Move to an apartment with onsite services</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Move to a group residential care setting</li> <li><input type="checkbox"/> Move to a health care facility or institution</li> <li><input type="checkbox"/> No permanent residence</li> <li><input type="checkbox"/> Unsure, or unable to determine person's preference for living arrangement</li> </ul> |
|---|--|

**Guardian/Family's Preference for this Individual**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Not applicable</li> <li><input type="checkbox"/> Stay at current residence</li> <li><input type="checkbox"/> Move to their own home or apartment</li> <li><input type="checkbox"/> Move to someone else's home or apartment</li> <li><input type="checkbox"/> Move to an apartment with onsite services</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Move to a group residential care setting</li> <li><input type="checkbox"/> Move to a health care facility or institution</li> <li><input type="checkbox"/> No consensus among multiple parties</li> <li><input type="checkbox"/> No response or no preference from guardian or family</li> </ul> |
|--|--|

**Notes:**

**DIAGNOSES** No current diagnosesIQ: 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 \_\_\_\_\_

**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:**

**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)  |
|---|--|
| <p><b>0:</b> Person is <b>independent</b> in completing the activity safely.</p> <p><b>1:</b> Help is needed to complete task safely but <b>helper DOES NOT have to be physically present throughout the task.</b> "Help" can be supervision, cueing, or hands-on assistance.</p> <p><b>2:</b> Help is needed to complete task safely and <b>helper DOES need to be present throughout task.</b> "Help" can be supervision, cueing, and/or partial or complete hands-on assistance.</p> | <p><b>U:</b> Current <b>UNPAID</b> caregiver will continue</p> <p><b>PF:</b> Current <b>PUBLICLY FUNDED</b> paid caregiver will continue</p> <p><b>PP:</b> Current <b>PRIVATELY PAID</b> caregiver will continue</p> <p><b>N:</b> <b>Need</b> to find new or additional caregiver(s)</p> |

| ADLs  |  | Help Needed  | Who Will Help in Next Eight Weeks?   |
|---|--|--|--|
| <b>BATHING</b>  | <p><b>Adaptive Equipment Options</b></p> <p><input type="checkbox"/> No Equipment</p> <p><input type="checkbox"/> Uses Grab Bar(s)</p> <p><input type="checkbox"/> Uses Shower Chair</p> <p><input type="checkbox"/> Uses Tub Bench</p> <p><input type="checkbox"/> Uses Mechanical Lift</p>   | <input type="checkbox"/> 0<br><input type="checkbox"/> 1<br><input type="checkbox"/> 2 | <input type="checkbox"/> U<br><input type="checkbox"/> PF<br><input type="checkbox"/> PP<br><input type="checkbox"/> N |
| Primary Diagnosis:  |  | Secondary Diagnosis:   |  |
| <b>DRESSING</b>   |  | <input type="checkbox"/> 0<br><input type="checkbox"/> 1<br><input type="checkbox"/> 2 | <input type="checkbox"/> U<br><input type="checkbox"/> PF<br><input type="checkbox"/> PP<br><input type="checkbox"/> N |
| Primary Diagnosis:  |  | Secondary Diagnosis:   |  |
| <b>EATING</b>   |  | <input type="checkbox"/> 0<br><input type="checkbox"/> 1<br><input type="checkbox"/> 2 | <input type="checkbox"/> U<br><input type="checkbox"/> PF<br><input type="checkbox"/> PP<br><input type="checkbox"/> N |
| Primary Diagnosis:  |  | Secondary Diagnosis:   |  |
| <b>MOBILITY IN HOME</b>   | <p><b>Adaptive Equipment Options</b></p> <p><input type="checkbox"/> No Equipment</p> <p><input type="checkbox"/> Uses Cane in Home</p> <p><input type="checkbox"/> Uses Wheelchair or Scooter in Home</p> <p><input type="checkbox"/> Has Prosthesis</p> <p><input type="checkbox"/> Uses Quad-Cane in Home</p> <p><input type="checkbox"/> Uses Crutches in Home</p> <p><input type="checkbox"/> Uses Walker in Home</p> | <input type="checkbox"/> 0<br><input type="checkbox"/> 1<br><input type="checkbox"/> 2 | <input type="checkbox"/> U<br><input type="checkbox"/> PF<br><input type="checkbox"/> PP<br><input type="checkbox"/> N |
| Primary Diagnosis:  |  | Secondary Diagnosis:   |  |
| <b>TOILETING</b>  | <p><b>Adaptive Equipment Options</b></p> <p><input type="checkbox"/> No Equipment</p> <p><input type="checkbox"/> Uses Grab Bar(s)</p> <p><input type="checkbox"/> Uses Commode or Other Adaptive Equipment</p> <p><input type="checkbox"/> Uses Urinary Catheter</p> <p><input type="checkbox"/> Has Ostomy</p> <p><input type="checkbox"/> Receives Regular Bowel Program</p>  | <input type="checkbox"/> 0<br><input type="checkbox"/> 1<br><input type="checkbox"/> 2 | <input type="checkbox"/> U<br><input type="checkbox"/> PF<br><input type="checkbox"/> PP<br><input type="checkbox"/> N |
| <p><b>INCONTINENCE: Do not include stress incontinence</b></p> <p><input type="checkbox"/> Does not have incontinence or has incontinence less often than weekly</p> <p><input type="checkbox"/> Has incontinence less than daily but at least once per week</p> <p><input type="checkbox"/> Has incontinence daily</p> |  |  |  |
| Primary Diagnosis:  |  | Secondary Diagnosis:   |  |



|                     | ADLs   | Help Needed   | Who Will Help in Next Eight Weeks?  |
|---------------------|--|---|---|
| <b>TRANSFERRING</b> | <p><b>Adaptive Equipment Options</b></p> <p><input type="checkbox"/> No Equipment</p> <p><input type="checkbox"/> Uses Grab Bar(s), Bed Bar, or Bed Railing</p> <p><input type="checkbox"/> Uses Transfer Board or Pole</p> <p><input type="checkbox"/> Uses Trapeze</p> <p><input type="checkbox"/> Uses Mechanical Lift or Power Stander</p> | <p><input type="checkbox"/> 0</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> | <p><input type="checkbox"/> U</p> <p><input type="checkbox"/> PF</p> <p><input type="checkbox"/> PP</p> <p><input type="checkbox"/> N</p> |

Primary Diagnosis:

Secondary Diagnosis:

Notes:

**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?   |
|--|--|--|
| <b>MEAL PREPARATION</b>                                    | <input type="checkbox"/> 0: Independent<br><input type="checkbox"/> 1: Needs help weekly or less often<br><input type="checkbox"/> 2: Needs help 2-7 times a week<br><input type="checkbox"/> 3: Needs help with every meal  | <input type="checkbox"/> U<br><input type="checkbox"/> PF<br><input type="checkbox"/> PP<br><input type="checkbox"/> N |
| <b>Primary Diagnosis:</b>                                  |  | <b>Secondary Diagnosis:</b>  |
| <b>MEDICATION ADMINISTRATION and MEDICATION MANAGEMENT</b> | <input type="checkbox"/> N/A: Has no medications<br><input type="checkbox"/> 0: Independent<br><input type="checkbox"/> 1: Needs help 1-2 days per week or less often.<br><input type="checkbox"/> 2a: Needs help at least once a day 3-7 days per week—CAN direct the task<br><input type="checkbox"/> 2b: Needs help at least once a day 3-7 days per week—CANNOT direct the task  | <input type="checkbox"/> U<br><input type="checkbox"/> PF<br><input type="checkbox"/> PP<br><input type="checkbox"/> N |
| <b>Primary Diagnosis:</b>                                  |  | <b>Secondary Diagnosis:</b>  |
| <b>MONEY MANAGEMENT</b>                                    | <input type="checkbox"/> 0: Independent<br><input type="checkbox"/> 1: Can only complete small transactions (Needs help to complete some components of Money Management)<br><input type="checkbox"/> 2: Needs help with all transactions   | <input type="checkbox"/> U<br><input type="checkbox"/> PF<br><input type="checkbox"/> PP<br><input type="checkbox"/> N |
| <b>Primary Diagnosis:</b>                                  |  | <b>Secondary Diagnosis:</b>  |
| <b>LAUNDRY and/or CHORES</b>                               | <input type="checkbox"/> 0: Independent<br><input type="checkbox"/> 1: Needs help weekly or less often<br><input type="checkbox"/> 2: Needs help more than once a week   | <input type="checkbox"/> U<br><input type="checkbox"/> PF<br><input type="checkbox"/> PP<br><input type="checkbox"/> N |
| <b>Primary Diagnosis:</b>                                  |  | <b>Secondary Diagnosis:</b>  |
| <b>TELEPHONE USE</b>                                       | <b>1. Ability to Use Phone</b><br><input type="checkbox"/> 1a: Independent—has cognitive and physical abilities to use a phone<br><input type="checkbox"/> 1b: Lacks cognitive or physical abilities to use phone independently<br><b>2. Access to Phone</b><br><input type="checkbox"/> 2a: Currently has working phone or access to one<br><input type="checkbox"/> 2b: Has no phone and no access to a phone  | <input type="checkbox"/> U<br><input type="checkbox"/> PF<br><input type="checkbox"/> PP<br><input type="checkbox"/> N |
| <b>Primary Diagnosis:</b>                                  |  | <b>Secondary Diagnosis:</b>  |
| <b>TRANSPORTATION</b>                                      | <input type="checkbox"/> 1a: Person drives <b>regular</b> vehicle<br><input type="checkbox"/> 1b: Person drives <b>adapted</b> vehicle<br><input type="checkbox"/> 1c: Person drives <b>regular</b> vehicle but there are serious safety concerns<br><input type="checkbox"/> 1d: Person drives <b>adapted</b> vehicle but there are serious safety concerns<br><input type="checkbox"/> 2: <b>Person cannot drive due to physical, psychiatric, or cognitive impairment.</b><br><input type="checkbox"/> 3: <b>Person does not drive due to other reasons</b> | <input type="checkbox"/> U<br><input type="checkbox"/> PF<br><input type="checkbox"/> PP<br><input type="checkbox"/> N |
| <b>Primary Diagnosis:</b>                                  |  | <b>Secondary Diagnosis:</b>  |

**Notes:**

**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
- 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:****Diagnoses with Onset before Age 22**

Was the onset of the condition that caused the diagnosis (A1-A10) 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

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**Notes:**

**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 |
| <b>Behaviors Requiring Interventions</b>  |                       |  |        |                |               |               |                |
| Primary Diagnosis:  |                       | Secondary Diagnosis:                                 |        |                |               |               |                |
| <b>Exercises/Range of Motion</b>  |                       |  |        |                |               |               |                |
| Primary Diagnosis:  |                       | Secondary Diagnosis:                                 |        |                |               |               |                |
| <b>IV Medications, Fluids or IV Line Flushes</b>  |                       |  |        |                |               |               |                |
| Primary Diagnosis:  |                       | Secondary Diagnosis:                                 |        |                |               |               |                |
| <b>Medication Administration (not IV) or Assistance with Pre-Selected or Set-Up Medications</b>   |                       |  |        |                |               |               |                |
| Primary Diagnosis:  |                       | Secondary Diagnosis:                                 |        |                |               |               |                |
| <b>Medication Management—Set-up and/or Monitoring Medications (for Effects, Side Effects, Adjustments, Pain Management)—and/or Blood Levels</b> |                       |  |        |                |               |               |                |
| Primary Diagnosis:  |                       | Secondary Diagnosis:                                 |        |                |               |               |                |
| <b>Ostomy-Related Skilled Services</b>  |                       |  |        |                |               |               |                |
| Primary Diagnosis:  |                       | Secondary Diagnosis:                                 |        |                |               |               |                |
| <b>Positioning in Bed or Chair Every 2-3 Hours</b>  |                       |  |        |                |               |               |                |
| Primary Diagnosis:  |                       | Secondary Diagnosis:                                 |        |                |               |               |                |
| <b>Oxygen and/or Respiratory Treatments: Tracheal Suctioning, C-PAP, Bi-PAP, Nebulizers, IPPB Treatments (Does NOT include inhalers)</b>        |                       |  |        |                |               |               |                |
| Primary Diagnosis:  |                       | Secondary Diagnosis:                                 |        |                |               |               |                |
| <b>Dialysis</b>   |                       |  |        |                |               |               |                |
| Primary Diagnosis:  |                       | Secondary Diagnosis:                                 |        |                |               |               |                |
| <b>TPN (Total Parenteral Nutrition)</b>   |                       |  |        |                |               |               |                |
| Primary Diagnosis:  |                       | Secondary Diagnosis:                                 |        |                |               |               |                |
| <b>Transfusions</b>   |                       |  |        |                |               |               |                |
| Primary Diagnosis:  |                       | Secondary Diagnosis:                                 |        |                |               |               |                |
| <b>Tracheostomy Care</b>  |                       |  |        |                |               |               |                |
| Primary Diagnosis:  |                       | Secondary Diagnosis:                                 |        |                |               |               |                |
| <b>Tube Feedings</b>  |                       |  |        |                |               |               |                |
| Primary Diagnosis:  |                       | Secondary Diagnosis:                                 |        |                |               |               |                |
| <b>Ulcer – Stage 2</b>  |                       |  |        |                |               |               |                |
| 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**

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**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:**



**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 |
|---|-------|---------|
| <b>Face-to-Face Contact with Person</b> |       |         |
| <b>Collateral Contacts</b>              |       |         |
| <b>Paper Work</b>                       |       |         |
| <b>Travel Time</b>                      |       |         |
| <b>Total Time to Complete Screen</b>    |       |         |

**NO ACTIVE TREATMENT (NAT)**

**No Active Treatment**

Part A Statements:

1. The person has a terminal illness.  
 Yes     No
2. The person has an IQ greater than 75.  
 N/A     Yes     No
3. 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
2. The person is age 65 or older and would no longer benefit from active treatment.  
 Yes     No
3. The person has severe chronic medical needs that require skilled nursing care.  
 Yes     No

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**Notes:**