For OLTC Use Only

Date Keyed: __________ Keyed By: ______________________________ Service Control No.: _________

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
EVALUATION OF MEDICAL NEED CRITERIA

DAAS WAIVER PROGRAMS - **EC** ☐ **AAPD** ☐ **AL** ☐ **Tier** ☐ **1** ☐ **2** ☐ **3** ☐ **4**
FACILITIES - **NH** ☐ **ICF/MR** ☐

PART I ☐ **ASSESSMENT (New Application)** ☐ **REASSESSMENT (UR)** ☐ **TRANSFER** ☐ **CHANGED CONDITION**

Name of Nursing Facility (if applicable) ______________________________

Entered NF From: ☐ Hospital ☐ Nursing Facility ☐ ALF ☐ Other ____________

Date of Admission: ____________

Client's Name (Last, First, Middle Initial) ____________ **Social Security Number** ____________ **Medicaid ID Number** ____________

☐ **Male** ☐ **Female** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Married** **Date of Birth** ____________

Lives ☐ Alone ☐ With Spouse ☐ With Adult Child ☐ With Sibling ☐ Other ____________

Client's Current Residence ☐ House/Apt. ☐ NF ☐ RCF ☐ Other ____________ **County (Code)** ________

Has client been in a NF before? ☐ Yes ☐ No If Yes, Date of Discharge if within last 12 months ____________

Name of NF: ______________________________

Has client applied for ElderChoices, Alternatives or Assisted Living before? ☐ Yes ☐ No If Yes, when? _____

For the purpose of determining my need for licensed nursing home care, I hereby authorize the release of any medical information by a licensed physician to the Arkansas Department of Health and Human Services. (If signed by MARK, <u>must</u> have witness.)

Signature of Client or Legal Guardian ____________ **Signature of Witness (if required)** ____________

Part II Hospitalized within last 6 months? ☐ Yes ☐ No If Yes, what dates? ____________

Reason for hospitalization ______________________________

Hospice patient? ☐ Yes ☐ No Hospice start date: ____________ Hospice discharge date: ____________

TRANSFERRING

- ☐ Bed to chair without help
- ☐ Bed to chair with help of another person or persons
- ☐ Must be lifted into chair by another person or persons
- ☐ Requires turning in bed by another person or persons
- ☐ Bedfast
- ☐ Transfers with assistive devices

If assistance is required, please indicate the frequency and type of assistance:

Needs assistance: ☐ Daily _____ Times per week

AMBULATION

- ☐ Walks alone
- ☐ Walks holding to HH objects
- ☐ Walks with cane, crutches, walker
- ☐ Walks with help of another person or persons
- ☐ Wheelchair push by another person
- ☐ Wheelchair using self-propulsion

If assistance is required, please indicate the frequency and type of assistance:

Needs assistance: ☐ Daily _____ Times per week

(Next Page)

Applicant/Resident Name:

CONTINENCE STATUS

Incontinent Bladder	☐ Yes	☐ No	☐ Occasionally	
Incontinent Bowel	☐ Yes	☐ No	☐ Occasionally	
Artificial Aids	☐ Yes	☐ No	☐ Occasionally	☐ Bladder/Bowel Training
Assistance Required	☐ Yes	☐ No	☐ Occasionally	

If assistance is required, please indicate the frequency and type of assistance: ☐ Daily __________ Times per week

NUTRITIONAL STATUS Height: _____ Weight: _____ Therapeutic Diet: ☐ Yes ☐ No

Appetite: ☐ Good ☐ Fair ☐ Poor

EATING ☐ Feeds self ☐ Fed by another person ☐ Some assistance from another person is needed
☐ Fed by other than mouth.

If assistance is needed from another person, please explain the type of assistance, the frequency, and by whom provided. If fed by other than mouth, please explain.

HEARING ☐ No difficulty ☐ Adequate ☐ Limited ☐ Profound loss
☐ Hearing Aid ☐ Unable to determine ☐ Other: ____________________

VISION ☐ No difficulty ☐ Adequate ☐ Limited ☐ Blind
☐ Corrected w/lenses ☐ Unable to determine ☐ Other: ____________________

SPEECH/LANGUAGE ☐ No difficulty ☐ Can understand ☐ Can't understand
☐ Can express self ☐ Can't express self ☐ Difficulty expressing self
☐ Other: ____________________

SKIN ☐ No problem ☐ Clear ☐ Dry ☐ Rash ☐ Bruises ☐ Stasis Ulcers
☐ Tears ☐ Fragile ☐ Jaundiced ☐ Decubitus - Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4

If receiving treatment for decubitus, please describe treatment:

BEHAVIOR/ATTITUDE ☐ Happy ☐ Depressed ☐ Cooperative ☐ Abusive ☐ Forgetful ☐ Sad
☐ Lonely ☐ Withdrawn ☐ Restless ☐ Agitated ☐ Lethargic
☐ Argumentative ☐ Aphasic ☐ Anxious/Apprehensive ☐ Normal
☐ Other ____________________

MENTAL STATUS ☐ Clear ☐ Somewhat confused ☐ Moderately confused ☐ Markedly confused
☐ Alert ☐ Forgetful ☐ Needs supervision for personal safety
☐ Hyperactive ☐ Withdrawn ☐ Needs restraint

If confused or needs supervision for personal safety, please explain:

ORIENTATION LEVEL ☐ Alert ☐ Oriented x 3 ☐ Disoriented x 3 ☐ Oriented person/place
☐ Non-responsive ☐ Oriented person only ☐ Unable to determine

OTHER MED. COND. ☐ Nausea/Vertigo ☐ Pain ☐ Edema ☐ Arrhythmia ☐ Contractures-UE,LE
☐ Dyspnea ☐ Tremors ☐ Paresis/Paralysis ☐ Frail
☐ Seizures/Convulsions Date of last seizure: __________ Controlled by meds ☐ Yes ☐ No
☐ Other ____________________

(Next Page)

Applicant/Resident Name:

PART III **MEDICATION:** ☐ Independent ☐ Dependent/Assisted ☐ Help Available ☐ Help Available 50% ☐ No Help Available

If assisted, please explain the type of assistance, the frequency of the assistance, and by whom the assistance is provided:

MEDICATIONS/TREATMENTS:

If therapies are listed, please include the frequency of the therapies, the provider of the therapies, and the expected duration:

List all durable medical equipment and any specialized equipment currently being used by the applicant:

RN/COUNSELOR COMMENTS (including reported medical history):

Estimated duration of need for nursing home care: ☐ Convalescent ☐ Permanent ☐ Indefinite ________ months

Signature of licensed DHHS RN/NF RN or LPN/COUNSELOR and Date **Recommendation Code (if applicable)**

STATUS OF MAJOR IMPAIRMENT ☐ Improving ☐ Stable ☐ Deteriorating

PROGNOSIS ____________________

DIAGNOSIS (Please list in the order of significance as related to the need for nursing home care)

Diagnosis A ____________________

Diagnosis B ____________________

Waiver Programs only: ***To individual completing DHHS-703 -*** If Alzheimer's or dementia is entered above as diagnosis, please explain related behavior:

Is this person's need for nursing home care the result of an accident caused by a third party? ☐ Yes ☐ No
(If yes, please attach any identifying information you may have about the accident, plus the name of any insurance company involved.)

I have examined this patient within the past thirty (30) days and have reviewed this form and certify the accuracy of the information. I am aware of the Utilization Review requirements for the necessity of admission and for continued stay and that this form will be reviewed by the Utilization Review Committee of the Arkansas Department of Health and Human Services.

Signature of Examining Physician **Date**

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
Arkansas Pre-Admission Screening
Mental Illness/Mental Retardation - Level I Identification Screen

Section I — **Applicant Information**

Name ______________________
Last First Middle

Home Address ______________________

Phone Number ( ) ______________________
DOB ______________________
Medicaid Number ______________________
Applicant's Current Location:
☐ Home ☐ Hospital ☐ Nursing Home
Other (specify) ______________________

Guardian/Responsible Party/Next of Kin
Name ______________________
Address ______________________
Zip ______________________
Phone Number ( ) ______________________

Person Completing ID Screen
Date DMS-787 Completed: ______________________

Name ______________________
Employer ______________________
Address ______________________

Phone ( ) ______________________
Comments: ______________________

COMPLETE BOTH SECTIONS, BOTH SIDES

Section II

Mental Retardation/Developmental Disability

1. Does the individual have a diagnosis or history of mental retardation or a related condition? ☐ Yes ☐ No

   If yes, specify diagnosis/es
   ☐ Mental Retardation ☐ Autism
   ☐ Cerebral Palsy ☐ Epilepsy/Seizure
   ☐ Other ______________________

   A. Did the Mental Retardation develop before the individual reached age 18? ☐ Yes ☐ No
   B. Did the Developmental Disability develop before the individual reached age 22? ☐ Yes ☐ No

2. Has the individual received services from an agency that serves persons with MR/DD ☐ Yes ☐ No

   If yes, please provide the name and addresses of this agency. (Include ICF/MR admissions)

   ____
   ____
   ____

3. Is there presenting evidence (cognitive or behavioral) that may indicate the presence of MR or DD? ☐ Yes ☐ No

   A. If yes, does the condition result in substantial functional limitations in three or more of the following areas of major life activity? ☐ Yes ☐ No

   Check appropriate area(s)
   ☐ Self Care ☐ Language
   ☐ Mobility ☐ Self-Direction
   ☐ Independent Living ☐ Learning

4. Does the individual's behavior or recent history indicate s/he is a danger to self (suicidal or self-injurious) or others (combative)? ☐ Yes ☐ No

   If yes, please comment ______________________
   ____
   ____

Resident: ______________________ ______________________ ______________________
LAST NAME FIRST NAME MIDDLE NAME

MENTAL ILLNESS

1. Does the individual have a diagnosis or history of mental illness? ☐ Yes ☐ No
   If yes, specify diagnosis/es
   ☐ Schizophrenia
   ☐ Schizoaffective
   ☐ Delusional (Paranoia) ☐ Somatoform
   ☐ ☐ Other
   Psychosis
   ☐ Major Depression ☐ Bi-Polar D/O
   ☐ Panic or other Anxiety Disorder

2. Has the individual been prescribed any psychotropic medications on a regular basis in the absence of a confirmed mental disorder? ☐ Yes ☐ No
   If yes, please list medications.
   ____

3. Is there any presenting evidence of disturbance in the orientation, affect, mood or behavior that suggests mental illness?
   ☐ Yes ☐ No

4. Has the individual received treatment within the last two years by any of the following caregivers? ☐ Yes ☐ No
   ☐ Mental Hospital ☐ Hospital Psych. Unit

5. List the name and address of any individual or agency providing diagnosis or treatment for MI. **Important, please list**
   ____

6. Does the individual's behavior or recent history indicate that s/he is a danger to self (suicidal or self-injurious) or others (combative)? ☐ Yes ☐ No
   If yes, please comment.
   ____

7. Is there a diagnosis of Dementia, OBS, Alzheimer's or any related organic disorders. If yes, complete DMS-780 form.
   ☐ Yes ☐ No

Section III **APPLICANT'S STATEMENT**

I understand that as a condition of my admission to or continued stay in a Medicaid certified Nursing Facility, a screen (Level I) for indicators of mental illness and/or mental retardation/developmental disability is required by federal law.

I have been informed that the results of the Level I screen may indicate the need for further evaluation (Level II).

I understand that the Level II evaluation will be performed by Bock Associates for the State of Arkansas and that I will be notified in writing of the results of the Level II evaluation.

______________________ ______________________
Signature of Applicant or Responsible Party/Legal Guardian — Date

______________________ ______________________
Signature of Person Completing Level I Screen (Form DMS-787) — Date

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
DEMENTIA DIAGNOSIS SUBSTANTIATION

SECTION I.

______________________________ ______________________
PATIENT'S NAME (PLEASE PRINT) SOCIAL SECURITY NUMBER

The Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition - (DSM-IV) was utilized to substantiate the following diagnosis of Dementia (including Alzheimer's, cognitive disorder, alcohol/drug and other related disorders).

______________________________ ______________________
Dementia Diagnosis DSM-IV Code

This diagnosis was made on the basis of: (check all that apply)

☐ Mental Status Examination ☐ Other (specify) ______________
☐ Neurological Examination ______________________
☐ History and Symptoms ______________________

Discuss the behavior, history or physical findings that lead to the Dementia diagnosis:

____
____
____

When was this diagnosis of Dementia first made? (Approximate date) ____________

SECTION II.

A. Does the individual's current behavior indicate that he/she is a danger to self (suicidal or self-injurious) or to others (combative)? ☐ Yes ☐ No
If yes, please comment:

____
____

B. Does this individual have a diagnosis, history or other evidence of one of the Serious Mental Illnesses listed below? ☐ Yes ☐ No

☐ Schizophrenia ☐ Schizoaffective ☐ Major Depression
☐ Delusional (Paranoid) ☐ Psychosis ☐ Bi-Polar Disorder
☐ Somatoform ☐ Panic or Anxiety Disorder
☐ Other (specify) ______________________________

Is the Mental Illness the primary diagnosis? ☐ Yes ☐ No
Did the Mental Illness exist prior to the onset of Dementia? ☐ Yes ☐ No

______________________________ ______________
Physician's Signature Date