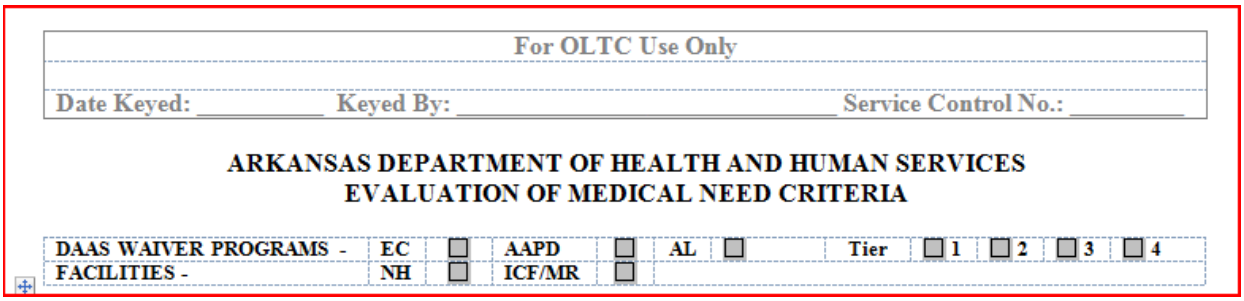
Incomplete applications cannot be processed. Failure to answer <u>all</u> questions completely may result in a request for missing or additional information and will delay the processing of this application.
This assessment should be completed and signed by a RN or LPN for all Nursing Facility admissions.



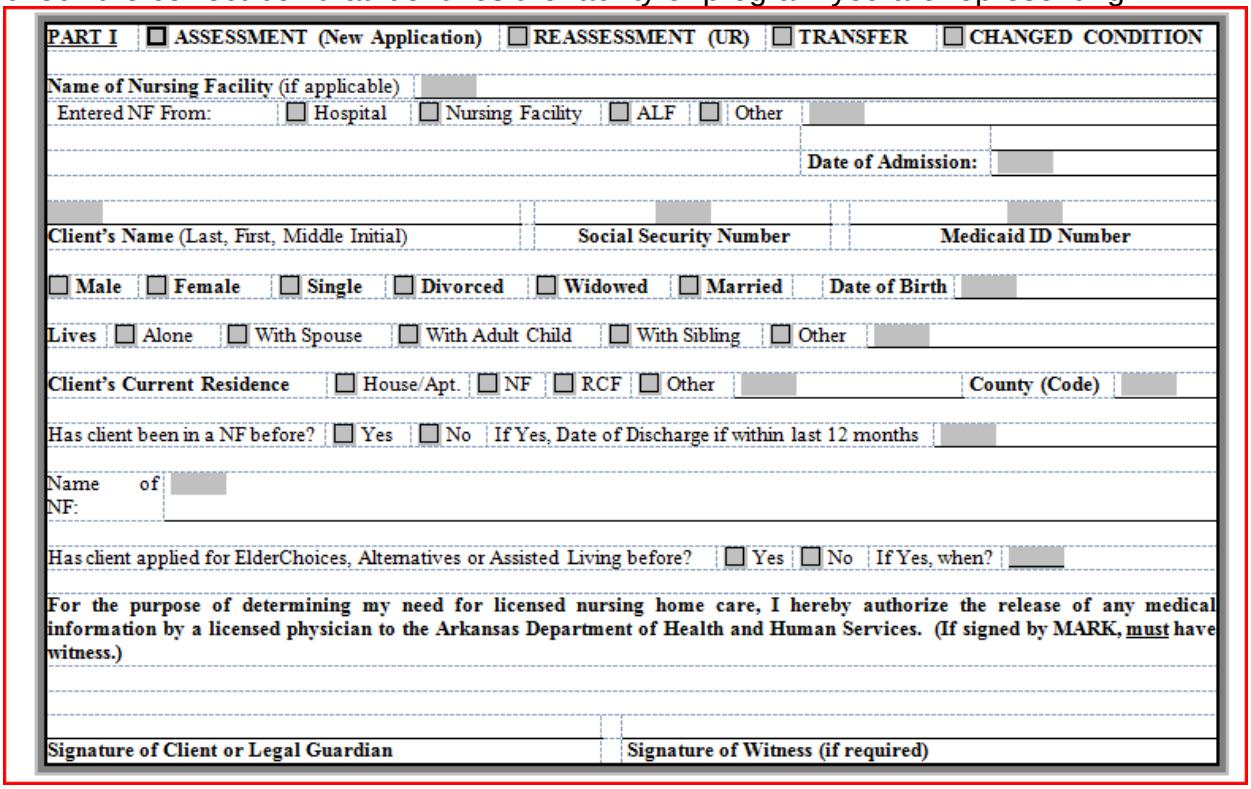
For OLTC Use Only

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	☐							

The first line, which has date keyed, keyed by, and service control number, is used by OLTC staff only. Leave this line blank.
Put an **X** in the correct box that identifies the program you are applying. For nursing homes, select NH. If you have a master copy, place the **X** by NH on the master copy prior to making the other copies. This form is used for multiple programs. They are the Elders Choice, Alternatives for Adults with Physical Disabilities and Assisted Living, Nursing Homes and Intermediate Care Facilities/Mental Retardation facilities. Please check the correct box that identifies the facility or program you are representing.



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 I
Indicate the type of application you are applying for. Select new assessment if this is a new application. Select reassessment if the Office of Long Term Care has sent you a

704 requesting a Utilization Review. (hospice, convalescent or medical review). Select Transfer if the resident transferred from another nursing home, or from a nursing home to hospital, now to your nursing home, without going to any other facility or resident's home. Select change of condition if you are sending in the application because the resident has a significant improvement or decline in his condition.

Enter the **full name** of your nursing facility. Please do not use initials. Multiple facilities have the same initials. If your facility has the same name as another facility, then list the name of your facility and the city. i. e. Same Name Nursing Facility – Hope, or Same Name Nursing Facility – Little Rock. If you have a master copy, enter the name of your nursing facility on the master copy prior to making the other copies.

If you are a hospital and are completing the forms for a nursing home admission, you can put the name of the nursing facility you think they are going to, but put pending in the slot for date of admission.

Indicate where the resident entered the NF from: Hospital, Nursing Facility, Assisted Living Facility or Other (indicate if from home or other place)

Enter the date resident entered the nursing facility. If the resident has not entered the nursing facility, enter "PENDING".

Enter the resident's last name, then the first name followed by the middle initial. Enter the **resident's** social security number. **Do not** enter the social security number of the person they are claiming benefits from.

Insert the Medicaid number. If unknown, leave this line blank.

Select Male or Female. Select the correct answer between Single, Divorced, Widowed or Married.

Enter the resident's date of birth.

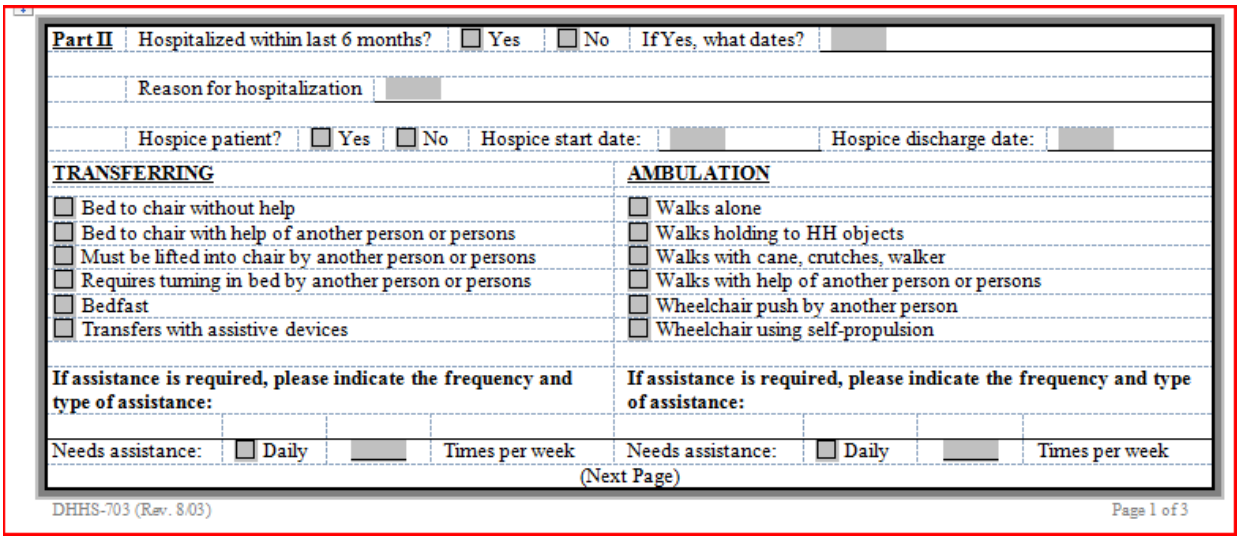
Check the correct box for the person resident lives with and enter additional information by "Other" if none applies

Select between the options for resident's current residence between House, NF, or RCF, and enter additional information by Other if none applies.

If resident has been in a NF before, select yes, and if not select no. If resident discharged from a nursing facility within the last 12 months, enter the date of discharge. Enter the name of any NF resident has resided in previously.

If resident has applied for ElderChoices, Alternatives or Assisted Living programs before, select yes. If not, select no.

In order for this application to be processed, **the resident or legal guardian must sign this form.** DHS must have permission to review the medical records of the resident. If the resident makes a mark, one witness signature is 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	AMBULATION
☐ Bed to chair without help	☐ Walks alone
☐ Bed to chair with help of another person or persons	☐ Walks holding to HH objects
☐ Must be lifted into chair by another person or persons	☐ Walks with cane, crutches, walker
☐ Requires turning in bed by another person or persons	☐ Walks with help of another person or persons
☐ Bedfast	☐ Wheelchair push by another person
☐ Transfers with assistive devices	☐ Wheelchair using self-propulsion
If assistance is required, please indicate the frequency and type of assistance:	**If assistance is required, please indicate the frequency and type of assistance:**
Needs assistance: ☐ Daily ____ Times per week	Needs assistance: ☐ Daily ____ Times per week

(Next Page)

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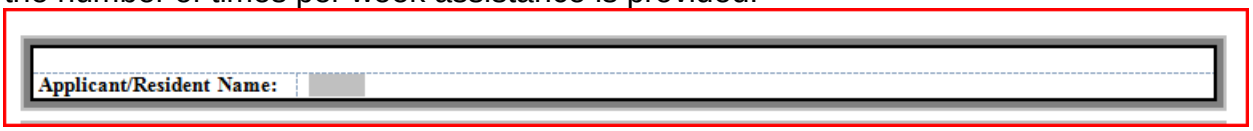
Part II

If the resident has been hospitalized in the past 6 months, select yes and enter the dates for each hospitalization in the past 6 months including the current hospitalization if applicable. Brief entries for the reason are acceptable.

Is the resident on hospice? Select yes and enter the hospice start date. If no, select no. If the resident is discharging from hospice, enter the hospice discharge date. If you need a hospice 704 and a non-hospice 704, make a note in this area of the form. If the resident is no longer on hospice due to death, please indicate that the resident has expired in this area of the form.

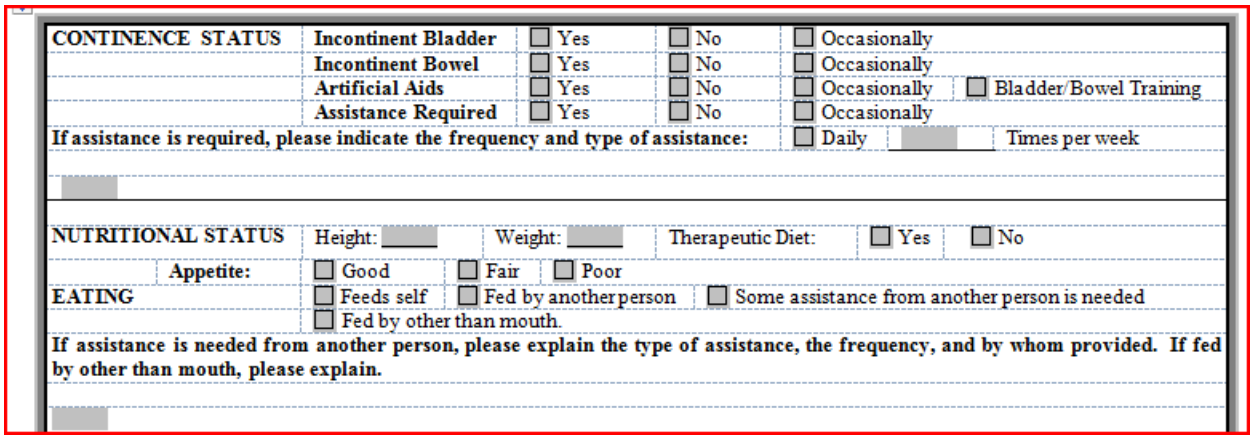
Under Transferring, check the proper response. More than one selection may be appropriate. If assistance is required for transferring, indicate the frequency and type of assistance i.e. supervision, stand by assist, extensive assistance of two, limited assistance of one, uses Hoyer lift, etc. Describe the care staff provides. If assistance is provided at least once a day select daily or enter the number of times per week assistance is provided.

Under Ambulation, check the proper response or responses. If assistance is required in the area of ambulation, enter the frequency and type of assistance i.e. supervision, stand by assist, extensive assistance of two, limited assistance of one, etc. Describe the care staff provides. If assistance is provided at least once a day select daily or enter the number of times per week assistance is provided.



Applicant/Resident Name:	

Make sure the resident's name is on each page submitted.



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.				

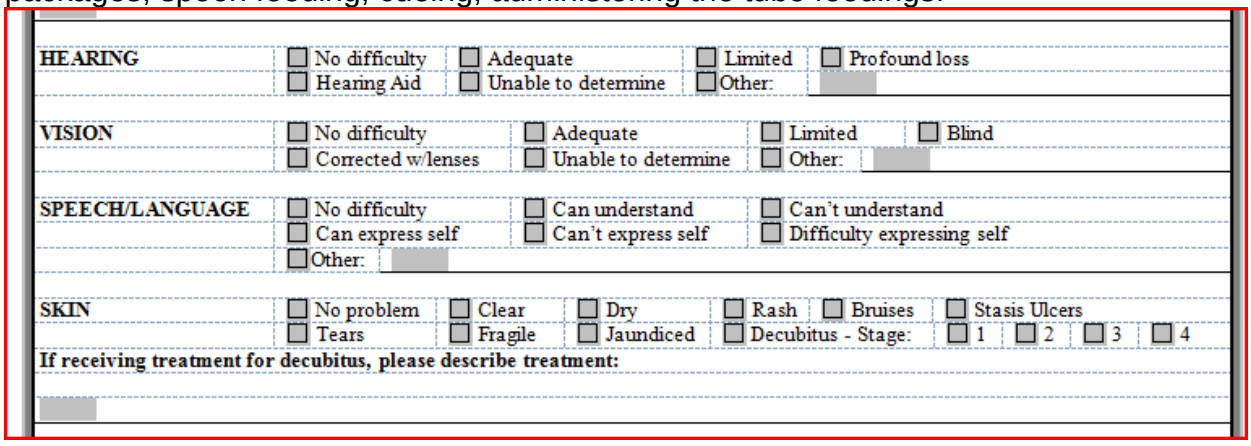
If assistance is needed from another person, please explain the type of assistance, the frequency, and by whom provided. If fed by other than mouth, please explain.

Is the resident incontinent of bowel and bladder all of the time or occasionally? Select the correct continence status. Does the resident have any artificial aids? Catheter, colostomy? Mark an X if the resident participated in the bladder and bowel training program. Indicate the frequency and type of assistance required. Select daily if assistance required every day or list the number of times per week. Type of assistance may be peri care, assistance of 1 or 2 to transfer to the toilet, emptying the bedside commode, emptying the urinal, etc. Please indicate the amount of assistance staff is providing.

Provide the height and weight of the resident. If the resident is on a therapeutic diet, select yes and write in the name of the diet her or in nurses comments on the last page of the 703. If no, select no.

Select the best appetite choice.

Select the correct method by which the patient eats. If fed by other than mouth, please explain. If assistance is provided by another person, explain the type of assistance provided, the frequency and by whom. i.e. set up help, cutting up food, opening packages, spoon feeding, cueing, administering the tube feedings.

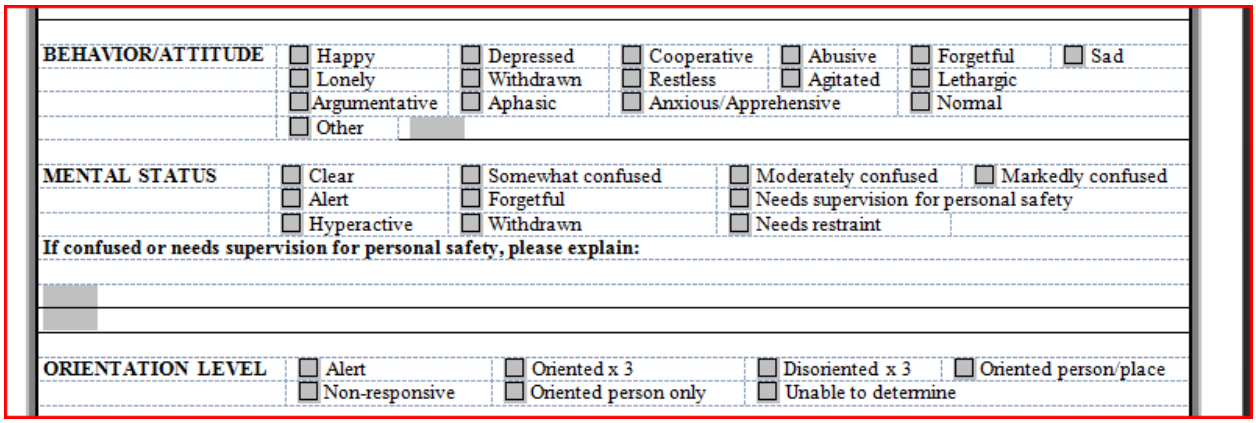


HEARING	☐ No difficulty	☐ Adequate	☐ Limited	☐ Profound loss	
	☐ Hearing Aid	☐ Unable to determine	☐ Other:		
VISION	☐ No difficulty	☐ Adequate	☐ Limited	☐ Blind	
	☐ Corrected w/lenses	☐ Unable to determine	☐ Other:		
SPEECH/LANGUAGE	☐ No difficulty	☐ Can understand	☐ Can't understand		
	☐ Can express 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:

Select the best responses for Hearing, Vision, Speech/Language. These areas provide a picture of the resident's needs and abilities.

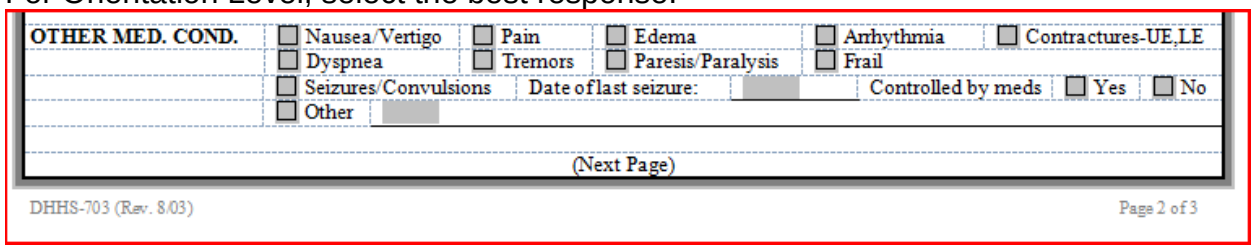
Select the best response for the condition of the skin and describe any treatments the resident is receiving. i.e. dressing changes twice a day, goes to wound clinic, whirlpool tx by PT. Supply any information that may be helpful in describing the wound and the assistance provided by staff.



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			

For Behavior/Attitude and Mental Status, select the responses that apply. If the resident is confused or needs supervision for personal safety, please explain. i.e. wandering, cannot find his room, forgets his name, have to orient to surroundings multiple times a day.

For Orientation Level, select the best response.



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)

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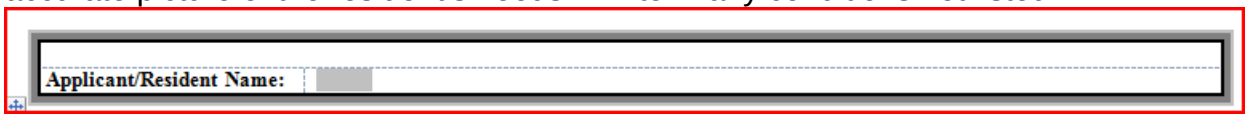
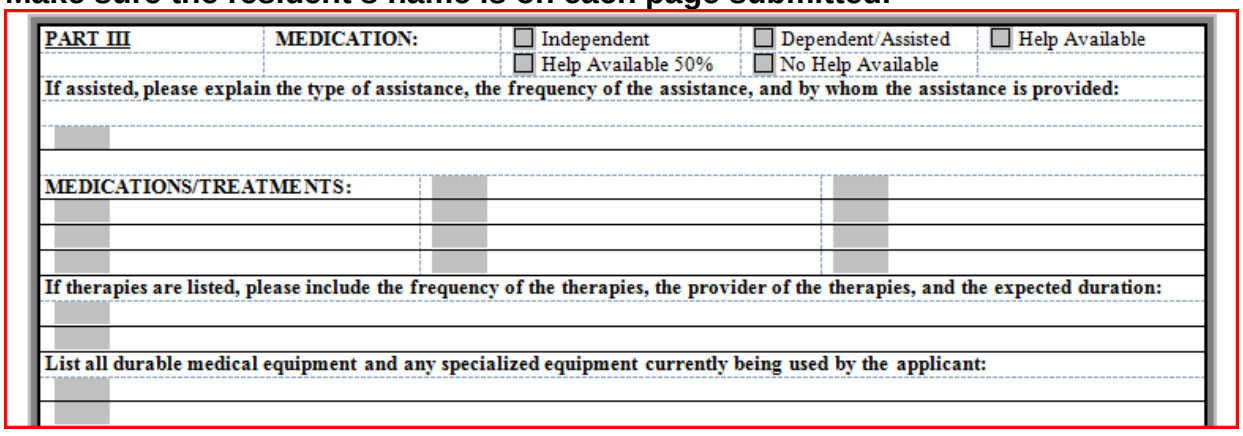
List any of the above medical conditions the resident may have. This will give an accurate picture of the resident's needs. Write in any conditions not listed.



Applicant/Resident Name:

Make sure the resident's name is on each page submitted.

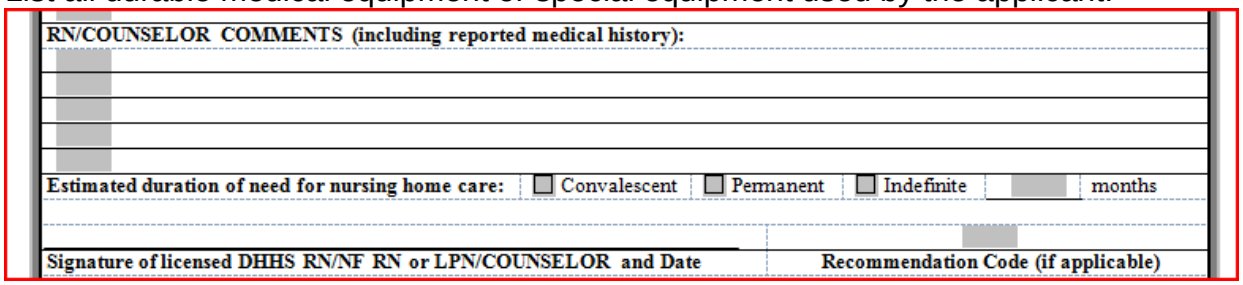


PART III	**MEDICATION:**	☐ Independent	☐ Dependent/Assisted	☐ Help Available
		☐ Help Available 50%	☐ No Help Available	
If assisted, please explain the type of assistance, the frequency of the assistance, and by whom the assistance is provided:				
MEDICATIONS/TREATMENTS:				
If therapies are listed, 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:				

Part III

Indicate whether or not the resident can self administer his medications or if assistance is required. If assistance is required, indicate the type of assistance. Is assistance given based on facility policy or is resident unable to administer own meds? Did the resident have problems with medication administration prior to this admission? Use this space to describe the medication needs. List as many medications as you can in the

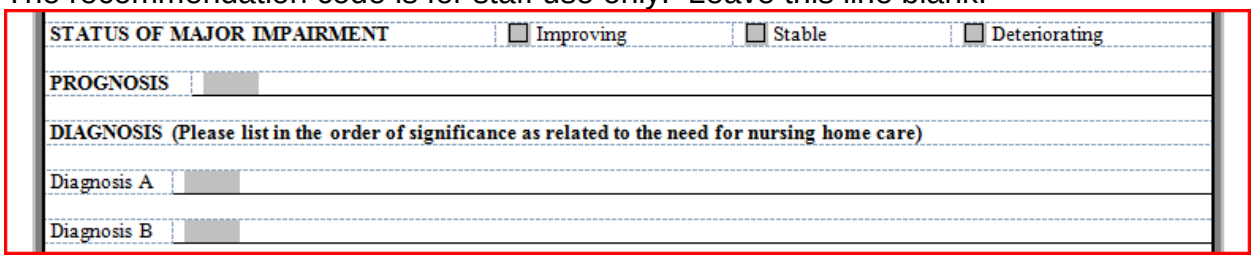
space provided. In addition, you may attach the Physician's Orders or the Medication Administration Record if resident is on multiple medications that cannot be entered in the space provided.
List the names of any treatments the resident is receiving.
List any therapies the resident is receiving, the frequency, the provider, and the expected duration. i. e. P.T. , O. T. 3 x week x 6 weeks.
List all durable medical equipment or special equipment 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)

An RN or LPN must fill out this section for nursing home admissions. It should include a brief medical history and the need for nursing home care. It should be a brief summary of the resident's condition and needs. This is an area to mention additional information not included elsewhere on the form.
Please indicate if the resident is being admitted for a short term convalescent care, determined to need nursing home care forever, or an indefinite period such as 6 months. The RN or LPN signature must be present for this form to be processed. The date the nurse signed must also be entered here.
The recommendation code is for staff use only. Leave this line blank.


STATUS OF MAJOR IMPAIRMENT ☐ Improving ☐ Stable ☐ Deteriorating

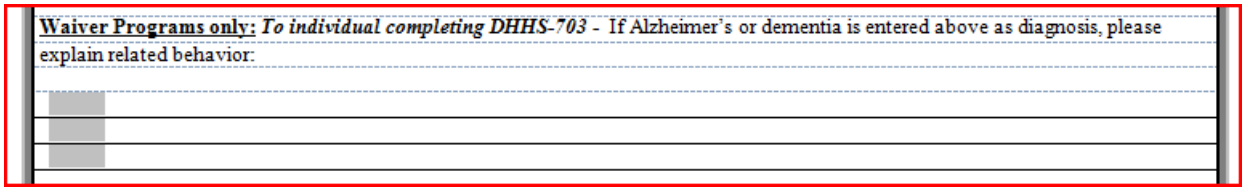
PROGNOSIS

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

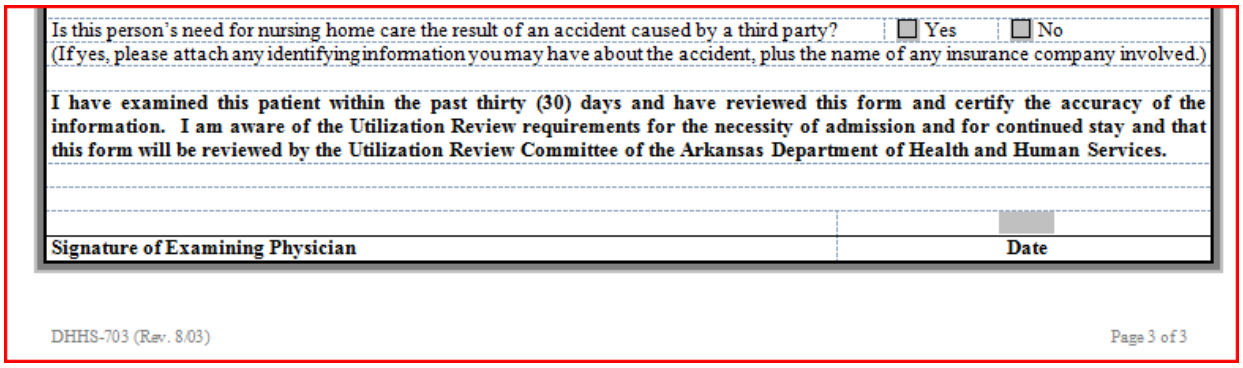
Diagnosis A

Diagnosis B

Indicate the status of the major impairment. Is it improving, stable, or deteriorating?
List the prognosis. i.e. good, fair, grave, etc.
Enter the diagnosis in the order of significance as related to the need for nursing home care.


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

This section is only completed for waiver applications.



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**

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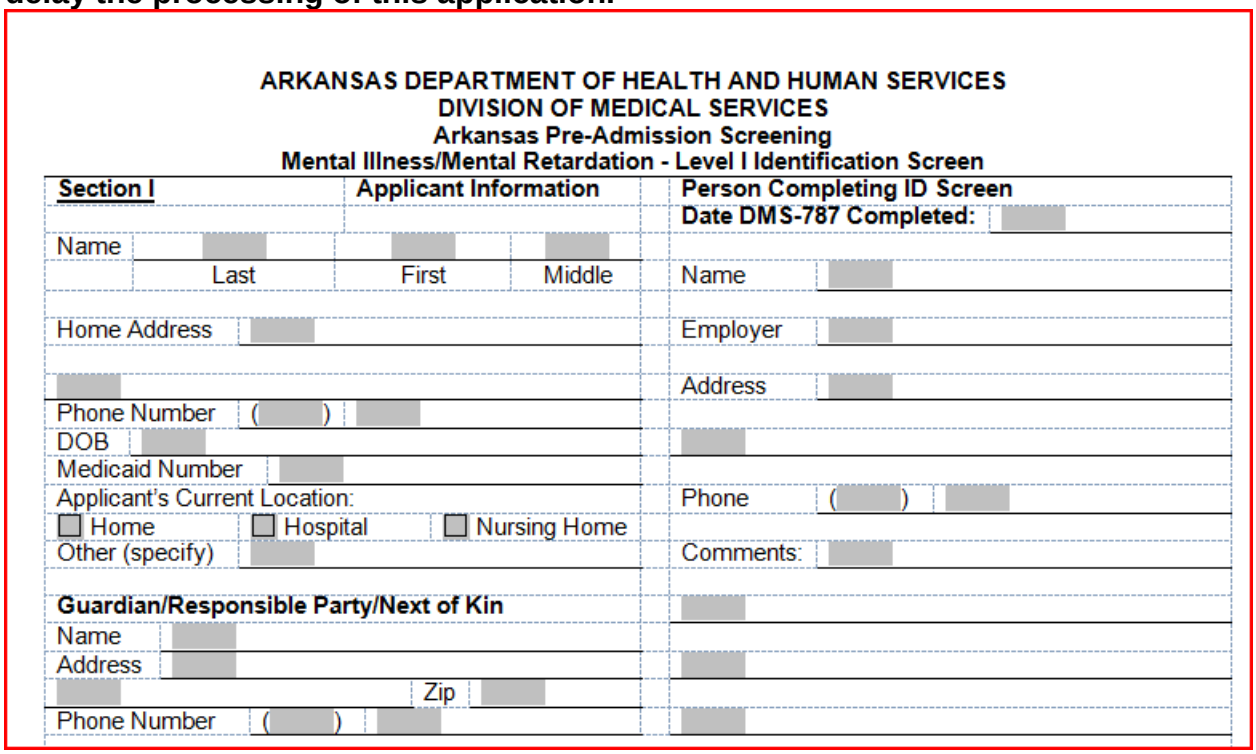
Indicate if nursing home care is the result of an accident caused by a third party. Select yes or no.

The examining physician or advanced practice nurse must sign all new assessments or transfer applications, certifying the accuracy of the information. The administrator, examining physician or advanced practice nurse can sign reassessment or change of condition applications. The date the application is signed must be entered here. This date is used for the effective date in many instances.

Fax completed application to: Medical Need Determination, 501-682-8052 or 501-683-5306.

Incomplete applications cannot be processed. Failure to answer <u>all</u> questions completely will result in a request for missing or additional information and will delay the processing of this application.



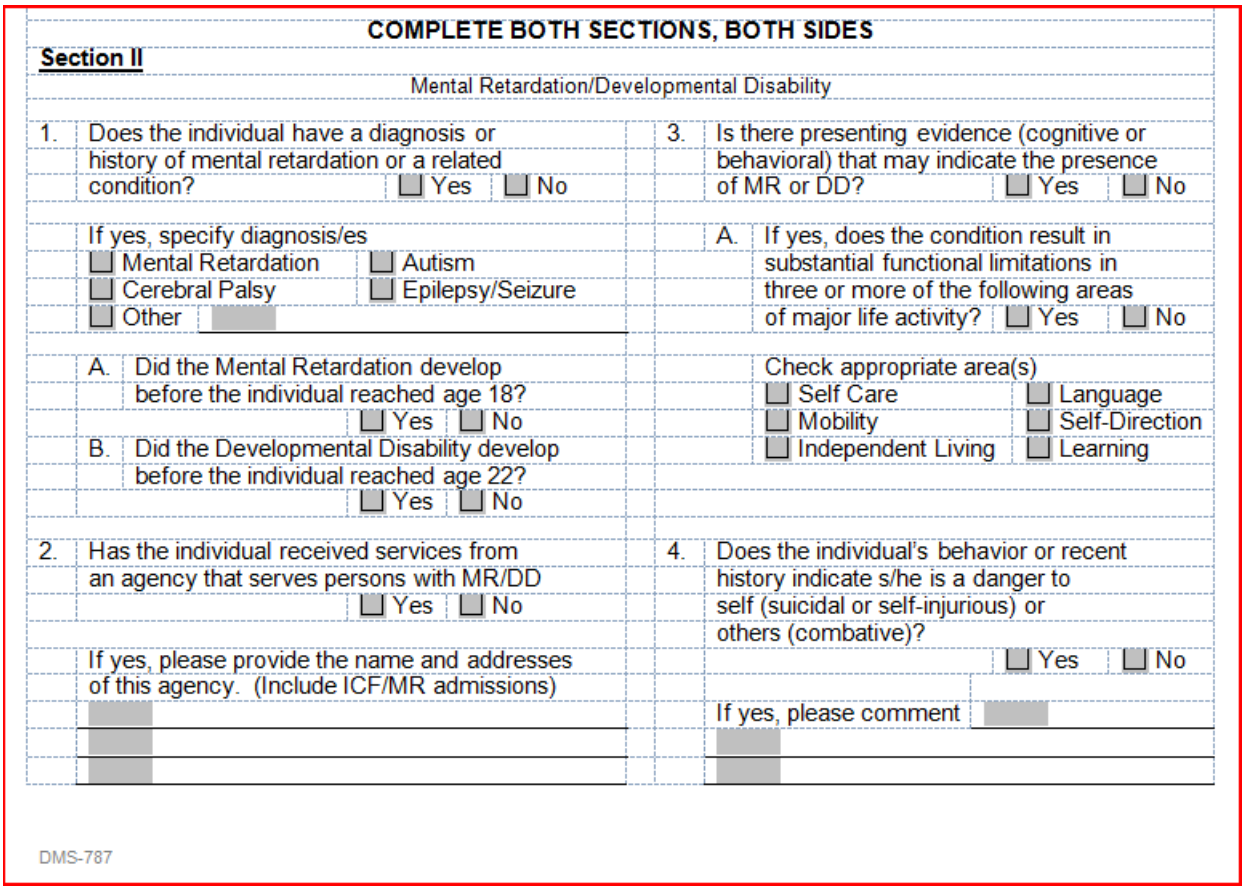
ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
Arkansas Pre-Admission Screening
Mental Illness/Mental Retardation - Level I Identification Screen

Section I	**Applicant Information**	**Person Completing ID Screen**
		Date DMS-787 Completed:
Name	Last First Middle	Name
Home Address		Employer
		Address
Phone Number ( )		
DOB		
Medicaid Number		
Applicant's Current Location:		Phone ( )
☐ Home ☐ Hospital ☐ Nursing Home		
Other (specify)		Comments:
Guardian/Responsible Party/Next of Kin		
Name		
Address		
Zip		
Phone Number ( )		

This form must be completed for every resident in your facility if you have any certified Medicaid beds. This is the form that will help identify a PASRR resident. This form will help identify residents with a Mental Illness, Mental Retardation or Developmental Disability diagnosis. Please answer all questions completely. Provide the resident's complete name, address and telephone number. Add the resident's date of birth. If you know the Medicaid number, please provide it and if unknown, leave it blank or write N/A or pending. Check or list the applicant's current location.

It is important to list the Guardian/Responsible Party/Next of Kin information. If the resident is a PASRR resident, Bock Associate's assessors will need to contact the family for additional information about the resident. The nursing facility staff may need to contact the family for accurate information when completing this form

Insert the date on the top right of the form. Provide the name of the employee completing the form, name of the facility and the address of the facility. If the resident is in a nursing home, supply the telephone number of the facility. If the resident is in a hospital or other facility, provide the telephone number of the contact person in your facility, i. e. discharge planner or social worker, and the fax number where Bock Associates will fax back requests for missing or additional information and the status of the application.



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

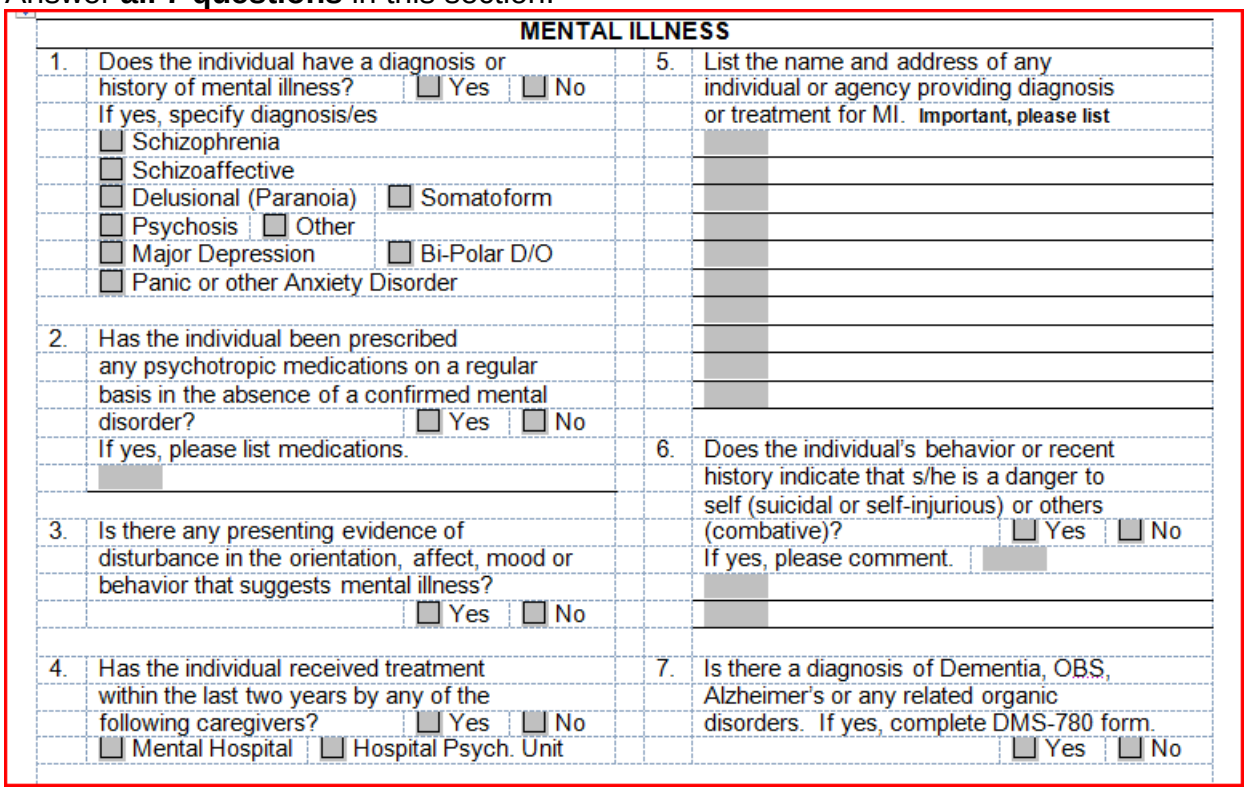
DMS-787

The above area refers to residents that have a diagnosis of Mental Retardation or a Developmental Disability. Answer **all 4 questions** in this section.

1) If the applicant has a diagnosis or history of mental retardation or a related condition, select yes. If not, select no and go to question #2. If yes, answer the second part of the question. If the Developmental Disability such as epilepsy or seizures occurred before age 22, check yes. Any illness or injury such as a Traumatic Brain Injury that occurred before age 22 should be listed here. If the medical conditions developed after age 22, select no. Do not indicate N/A as every question requires a yes or no response.
2) Please indicate yes or no as to whether or not the applicant received services from any agency that serves persons with MR/DD. Please provide the name of the agency.
3) Check yes if you suspect a MR or DD diagnosis and answer 3A. If you do not see any evidence of a MR/DD diagnosis, select no and go to question #4. The resident's medical condition or a diagnosis of dementia could cause functional limitations in the resident's major life activities, but if you do not suspect a MR/DD diagnosis, skip this part and go to question #4.
4) If the resident has a history of being dangerous to self or others, please select yes and provide information about the incident. If not, select no.

All of the above questions can be viewed as ways to help you determine if the resident is a potential PASRR resident. Find creative ways to ask family members if you suspect a developmental disability or mental retardation diagnosis.

This section below refers to residents suspected of having a mental illness diagnosis. Answer **all 7 questions** in this section.



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
   ☐ Psychosis ☐ Other
   ☐ 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**

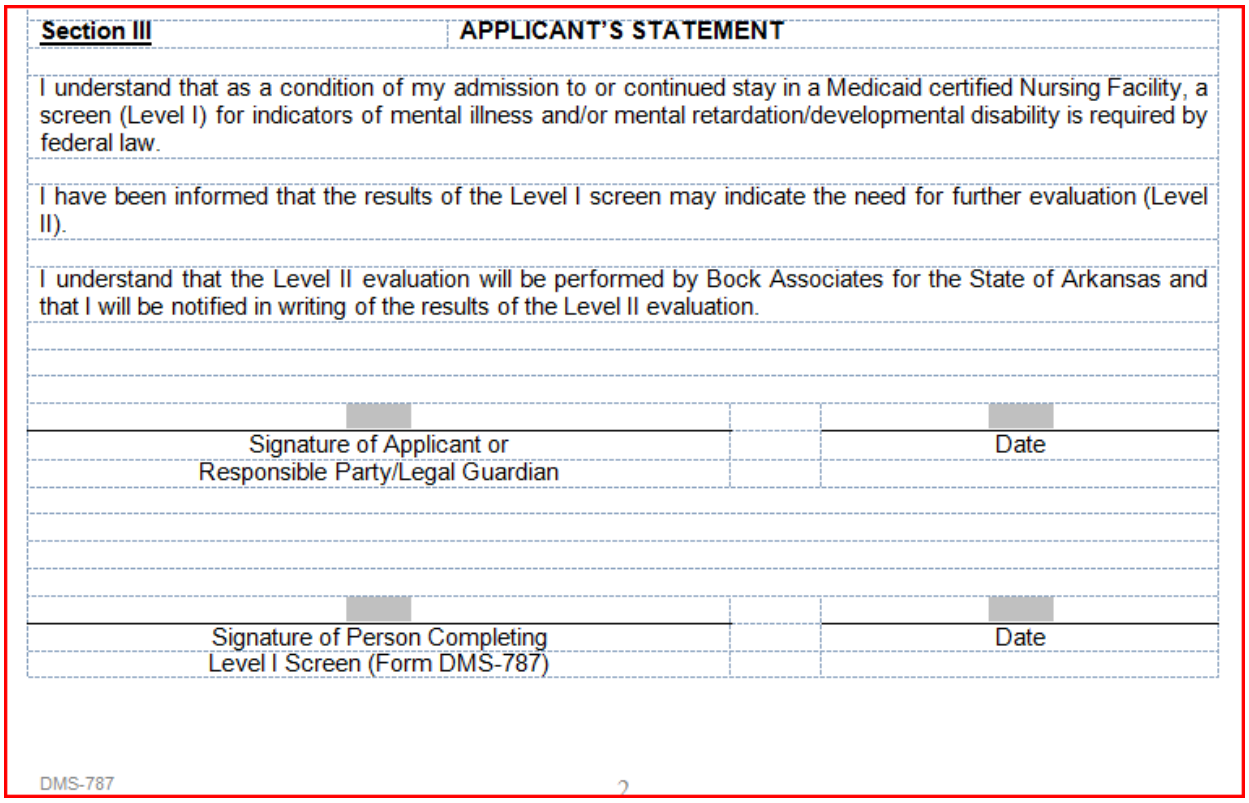
6. Does the individual's behavior or recent history indicate that s/he is a danger to self (suicidal or self-injurious) or others (combative)? ☐ Yes ☐ No
   If yes, please comment.

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

1) Please check yes if resident has a diagnosis or history of mental illness and select or write in the name of mental illness diagnosis. If no mental illness, select no. This list is not inclusive of every possible mental illness diagnosis but is provided to assist you in answering this question.
2) Please list any psychotropic medication the resident is taking or has taken in the past on a regular basis if the resident does not have a confirmed mental disorder.
3) If you have any presenting evidence of a disturbance in the applicant's orientation, affect or mood that suggests mental illness, select yes. If none suspected, select no.
4) Please indicate if the resident has received any treatment within the last 2 years by a Mental Hospital or Hospital Psychiatric Unit. The family may need to be contacted to obtain additional information.
5) List the name and address of any agency or individual that has provided mental illness treatment to the patient in the past.
6) If the resident has a history of being dangerous to self or others, please select yes and provide information about the incident. If not, select no.

7) If there is a diagnosis of Dementia, OBS, Alzheimer's or a related organic disorder, please select yes. If not, please select no. If you select yes, you must attach a completed DMS 780 form.

All of the above questions can be viewed as ways to help you determine if the resident is a potential PASRR resident. Find creative ways to ask family members if you suspect a mental illness diagnosis.



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

DMS-787 2

While obtaining signatures on admission documents, *please obtain the applicant's or responsible party's or legal guardian's signature.* If there is a need for a (PASRR) or Level II evaluation, there must be a signature in this area of the form. This notifies the resident or resident's family that Bock Associates will perform the Level II evaluation. The staff member completing this form must also sign and date the form.
The facility can save time and money by filling this form out completely. Failure to complete this form prior to admission or on the admission date could result in a deficiency and loss of funds to the nursing home.
If in doubt at any time as to whether or not the resident has a diagnosis of MR/DD or MI, please contact Bock Associates or OLTC and they will assist you with this determination.
Please make sure the resident's name is on the **2nd** page of the 787 form.

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 Illness 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
Die the Mental Illness exist prior to the onset of Dementia? ☐ Yes ☐ No

_____ _____
Physician's Signature Date

A. If the individual's current behavior indicates that he/she is a danger to self or others, select yes, and describe the behavior or incident. If no danger to self or others, select no.
B. If the individual has a mental illness diagnosis, please check yes and select the correct box. If the diagnosis is not listed, please write in the correct diagnosis and complete the next two questions. If no mental illness diagnosis, select no and have the physician sign and date the form.

   If the Mental Illness is the primary diagnosis, select yes. If not, select no.
   If the Mental Illness existed prior to the onset of dementia, select yes. If not, select no.

The physician must sign and date the form before it can be processed.
Incomplete applications cannot be processed. Failure to answer <u>all</u> questions completely will result in a request for missing or additional information and will delay the processing of this application.

The form is used to substantiate the diagnosis of dementia. All blanks and questions must be answered before this application can be processed.

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

SECTION 1.

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
☐ Neurological Examination
☐ History and Symptoms
☐ Other (specify) _____

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

_____

_____

_____

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

Please provide the resident's name and social security number.
Provide the dementia diagnosis and the DSM-IV Code.
Check the appropriate box that represents the method used in determining the dementia diagnosis. Write in any additional tests used to determine the diagnosis.
List the behaviors, history or physical findings that led to the dementia diagnosis. If the dementia diagnosis was made prior to admission and you do not know how the diagnosis was made, provide the history or physical findings the resident is exhibiting that support a dementia diagnosis.
List the date the dementia diagnosis was first made. If the dementia diagnosis was made prior to admission, give an approximate date based on symptoms. If the dementia diagnosis was made during the current admission, you may attach the diagnostic materials such as the Mental Status Exam or the H & P.