*Required

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates — Screening:* | Assessment: | Reassessment: | Initial Request:*

1. IDENTIFICATION/ BACKGROUND

Name & Vital Information

Member's Name: Last:* | First:* | MI: | SSN:*
Address: Street:* | City:* | State:* | Zip Code:*
Phone Number:* | City/County Code:* | Zip Code Ext:
Directions to House:
Pets?

Demographics

Member's Date of Birth:* | Age*: | Sex:* | Hearing Impaired*
Marital Status:* | Race:* | (If Race-Unknown, enter Ethnic Origin):
Communication of Needs:* | Other Lanugage, Specify:
Education:* | (If Education - Unknown, please Specify):

Primary Caregiver

Caregiver's Name: Last:* | First:* | MI: | Relationship:*
Address: Street:* | City:* | State:* | Zip Code:*
Phone Number* (Home): | (Work):

Emergency Contact

☐ Check here to populate with Primary Caregiver information (valid if no entry has been made to the Emergency Contact field)

Emergency Contact's Name: Last:* | First:* | MI: | Relationship:*
Address: Street:* | City:* | State:* | Zip Code:*
Phone Number* (Home): | (Work):

Primary Physician

Primary Physician's Name: Last:* | First:* | MI: | Phone:*
Address: Street:* | City:* | State:* | Zip Code:*

Initial Contact - Who Called

Who Called:* | Relationship:* | Phone:*
Presenting Problem/Diagnosis:*

Current Formal Services

☐	Adult Day Care	Provider/Frequency:
☐	Adult Protective	Provider/Frequency:
☐	Case Management	Provider/Frequency:
☐	Chore/Companion/Homemaker	Provider/Frequency:
☐	Congretate Meals/Senior Center	Provider/Frequency:
☐	Financial Management Counseling	Provider/Frequency:
☐	Friendly Visitor/Telephone Reassurance	Provider/Frequency:
☐	Habilitation/Supported Employment	Provider/Frequency:
☐	Home Delivered Meals	Provider/Frequency:
☐	Home Health/Rehabilitation	Provider/Frequency:
☐	Home Repair/Weatherization	Provider/Frequency:
☐	Housing	Provider/Frequency:
☐	Legal	Provider/Frequency:
☐	Mental Health (Inpatient/Outpatient)	Provider/Frequency:
☐	Mental Retardation	Provider/Frequency:
☐	Personal Care	Provider/Frequency:
☐	Respite	Provider/Frequency:
☐	Substance Abuse	Provider/Frequency:
☐	Transportation	Provider/Frequency:
☐	Vocational Rehabilitation/Counseling	Provider/Frequency:
☐	Other — Specify:	Provider/Frequency:

Financial Resources

Where are you on the scale for annual (monthly) family income before taxes?:*
Number in family unit:* | Total Monthly Family Income:

Does anyone cash your check, pay your bills or manage your business? (Check all that apply)

☐	Legal Guardian	Name(s):
☐	Power of Attorney	Name(s):
☐	Representative Payee	Name(s):
☐	Other	Name(s):

Do you receive any benefits or entitlement? (Check all that apply)

- ☐ Auxiliary Grant
- ☐ Food Stamps
- ☐ Fuel Assistance

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT *Required

- ☐ General Relief
- ☐ State & Local Hospitalization
- ☐ Subsidized Housing
- ☐ Tax Relief

Do you receive any benefits or entitlements? (Check all that apply)

- ☐ Black Lung — Amount:
- ☐ Pension — Amount:
- ☐ Social Security — Amount:
- ☐ SSI/SSDI — Amount:
- ☐ VA Benefits — Amount:
- ☐ Wages/Salary — Amount:
- ☐ Other — Amount:

What type of health insurance do you have?: * (Check all that apply)

- ☐ Medicare Insured — Medicare #:
- ☐ Medicaid Insured — Medicaid #:
- ☐ Medicaid - Pending
- ☐ Medicaid - QMB/SLMB
- ☐ All Other Public/Private — Specify:

Physical Environment

Where do you usually live?:*

Does anyone usually live with you?

Name of Person(s) in Household:

Name of Provider (Place): Admission Date:

Provider NPI (if applicable):

Where you usually live are there any problems? (Check all problems that apply)

- ☐ Barriers to Access
- ☐ Electrical Hazards
- ☐ Fire Hazards/No Smoke Alarm
- ☐ Insufficient Heat/Air Conditioning
- ☐ Insufficient Hot Water/Water
- ☐ Lack of/Poor Toilet Facilities (Inside/Outside)
- ☐ Lack of/Defective Stove, Refrigerator, Freezer
- ☐ Lack of/Defective Washer/Dryer
- ☐ Lack of/Poor Bathing Facilities
- ☐ Structural Problems
- ☐ Telephone Not Accessible
- ☐ Unsafe Neighborhood
- ☐ Unsafe/Poor Lighting
- ☐ Unsanitiary Conditions
- ☐ Other — Specify:

Describe Problem:

Functional Status

ADLS (Select Appropriate Level):

Bathing:* Dressing:* Toileting:*

Transferring:* Eating/Feeding:*

Continence (Bowel & Bladder)

Bowel:* Bladder:*

Ambulation

Walking:* Wheeling:* Stair Climbing:*

Mobility:*

IADLs

Needs Help?

Meal Preparation:*	O No	O Yes	Housekeeping:*	O No	O Yes	Laundry:*	O No O Yes
Money Mgmt:*	O No	O Yes	Transport:*	O No	O Yes	Shopping:*	O No O Yes
Using Phone:*	O No	O Yes	Home Maintenance:*	O No	O Yes		

Comments:

Screener Name: Agency:

*Required

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT - Part B

Member Information

Member's Last Name:* | First:* | MI: | SSN:*

Physical Health Assessment

Professional Visits/Medical Admissions

Doctor's Name	Phone	Phone Ext	Date of Last Visit	Reason for Last Visit

Admissions: In the past 12 months, have you been admitted to a … for medical or rehabilitation reasons?

	Name of Place	Admit Date	Length of Stay/Reason
☐ Hospital:			
☐ Nursing Facility:			
☐ Adult Care Residence:			

Do you have any advanced directives such as . . . Who has it…Where is it… ?

☐ Living Will:	
☐ Durable Power of Attorney for Health Care:	
☐ Other:	

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions?

Current Diagnoses	Date of Onset

Active Diagnoses: (Enter up to 3 major active diagnoses)

Diagnosis 1:	
Diagnosis 2:	
Diagnosis 3:	

Current Medications (include Over-the-Counter). Include Medication,Dose, Frequency, Route and Reason(s) Prescribed:

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Total Number of Medications:	
Total Number of Tranquilizer/Psychotropic Drugs:	

Do you have any problems with medicine(s)…? (Check all that apply)

- ☐ Adverse reactions/allergies
- ☐ Getting to the pharmacy
- ☐ Understanding directions/schedule
- ☐ Cost of medication
- ☐ Taking them as instructed/prescribed

How do you take your medicine(s)?*	
Describe help:	
Name of helper:	

Sensory Functions

How is your vision, hearing and speech?

	No Impairment	Impairment Compensation	Impairment No Compensation	Complete Loss	Unknown	Record Date of Onset	Type of Impairment	Date of Last Exam
Vision: *	○	○	○	○	○			
Hearing: *	○	○	○	○	○			
Speech: *	○	○	○	○	○			

Physical Status

Joint Motion: How is your ability to move your arms, fingers, and legs?

Have you ever broken or dislocated any bones …. Ever had an amputation or lost any limbs …. Lost voluntary movement of any part of your body? ○ No ○ Yes

Fractures/Dislocation:

Previous Rehab Program? ○ No/Not Completed ○ Yes

Date of Fracture/Dislocation ○ 1 Year or Less ○ More than 1 Year

Missing Limbs:

Previous Rehab Program? ○ No/Not Completed ○ Yes

Date of Amputation ○ 1 Year or Less ○ More than 1 Year

Paralysis/Paresis:

Previous Rehab Program? ○ No/Not Completed ○ Yes

Onset of Paralysis? ○ 1 Year or Less ○ More than 1 Year

Describe:

*Required

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT - Part B

Nutrition

Height (inches):* Weight (lbs):*

Recent Weight Gain/Loss:* ○ Gain No ○ Gain Yes ○ Loss No ○ Loss Yes Describe:

Are you on any special diet(s) for medical reasons?*

Do you take dietary supplements?*

Do you have any problems that make it hard to eat? (Check all that apply)

- ☐ Food Allergies
- ☐ Inadequate Food/Fluid Intake
- ☐ Nausea/Vomiting/Diarrhea
- ☐ Problems Eating Certain Foods
- ☐ Problems Following Special Diets
- ☐ Problems Swallowing
- ☐ Taste Problems
- ☐ Tooth or Mouth Problems
- ☐ Others Other Specify:

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as . . . . ? (Check all services that apply)

- ☐ Occupational Frequency:
- ☐ Physical Frequency:
- ☐ Reality/Remotivation Frequency:
- ☐ Respiratory Frequency:
- ☐ Speech Frequency:
- ☐ Other Frequency:

Do you have any pressure ulcers?* ○ No ○ Yes Stage: Location:

Special Medical Procedures: Do you receive any special nursing care, such as . . . ? (Check all services that apply)

- ☐ Bowel/Bladder Training Site, Type, Frequency:
- ☐ Dialysis Site, Type, Frequency:
- ☐ Dressing/Wound Care Site, Type, Frequency:
- ☐ Eyecare Site, Type, Frequency:
- ☐ Glucose/Blood Sugar Site, Type, Frequency:
- ☐ Injections/IV Therapy Site, Type, Frequency:
- ☐ Oxygen Site, Type, Frequency:
- ☐ Radiation/Chemotherapy Site, Type, Frequency:
- ☐ Restraints Site, Type, Frequency:
- ☐ ROM Exercise Site, Type, Frequency:
- ☐ Trach Care/Suctioning Site, Type, Frequency:
- ☐ Ventilator Site, Type, Frequency:
- ☐ Other Site, Type, Frequency:

Medical/Nursing Needs

Based on member's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? ○ No ○ Yes

Describe ongoing medical/nursing needs:

> Evidence of medical instability
> Need for observation/assessment to prevent destabilization
> Complexity created by multiple medical conditions
> Why member's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis

Comment:

Physician's Name/Title: Date:

Other's Name/Title: Date:

Psycho-Social Assessment

Cognitive Function

Orientation (Note: Information in italics is optional and can be used to give a MMSE Score)

Person: Please tell me your full name (so that I can be sure our record is correct)

Place: Where are we now (*state, county, town, street/route number, street name/box number)? Give the member 1 point for each correct response.*

MMSE Score:

Time: Would you tell me the date today (*year, season, date, day, month*)?

MMSE Score:

Orientation:* Spheres affected:

Recall/Memory/Judgment

Recall: I am going to say three words, and I want you to repeat them after I'm done. (House, Bus, Dog). * Ask the member to repeat them. *Give the member 1 point for each correct response on the first trial.* * Repeat up to 6 trials until member can name all 3 words. Tell the member to hold them in his/her mind because you will ask them again in a minute or so what they were.

MMSE Score:

Attention/Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

MMSE Score:

Total MMSE Score: 0 Note: Score of 14 or below implies cognitive impairment

☐ Short-Term Memory Loss? **Short-Term:** Ask the member to recall the 3 words he/she was to remember.

☐ Long-Term Memory Loss? **Long-Term**: Where were you born (What is your date of birth)?
☐ Judgment Problem? **Judgment**: If you need help at night, what would you do?

Behavior Pattern

Does the member ever wander without purpose (trespass, get lost, go into traffic, etc.) or become agitated and abusive?*

Type of inappropriate behavior:
Source of Information:

Life Stressors

Are there any stressful events that currently affect your life, such as. . .? (Check all that apply)

☐ Change in work/employment
☐ Financial problems
☐ Victim of a crime
☐ Death of someone close
☐ Major illness - family/friend
☐ Failing health
☐ Family conflict
☐ Recent move/relocation
☐ Other Other Specify:

Emotional Status

In the past month, how often did you . . .?

Feel anxious or worry constantly about things?
Feel irritable, have crying spells or get upset over little things?
Feel alone and that you didn't have anyone to talk to?
Feel like you didn't want to be around other people?
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?
Feel sad or hopeless?
Feel that life is not worth living or think of taking your life?
See or hear things that other people did not see or hear?
Believe that you have special powers that other do not have?
Have problems falling or staying asleep?
Have problems with your appetite. . . that is, eat too much or too little?

Comments:

Social Status

Are there some things that you do that you especially enjoy? (Check all services that apply)

☐ Solitary Activities Describe:
☐ With Friends/Family Describe:
☐ With Groups/Clubs Describe:
☐ Religious Activities Describe:

How often do you talk with your children, family or friends, either during a visit or over the phone?

Children* Other family* Friends/Neighbors*

Are you satisfied with how often you see or hear from your children, other family and/or friends?* ○ No ○ Yes

Hospitalization/Alcohol - Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?*

○ No ○ Yes

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?* How much: How often:

Do (did) you ever use non-prescription, mood altering substances?* How much: How often:

Have you, or someone close to you ever been concerned about your use of alcohol/other mood altering substances? * ○ No ○ Yes

Describe concerns:

Do (did) you ever use alcohol/other mood-altering substances with .... (Check all that apply)

☐ Prescription drugs?
☐ OTC medicine?
☐ Other substances?

Describe what and how often:

Do (did) you ever use alcohol/other mood-altering substances to help you ... (Check all that apply)

☐ Sleep?
☐ Relax?
☐ Get more energy?
☐ Relieve worries?
☐ Relieve physical pain?

Describe what and how often:

Do (did) you smoke or use tobacco products?* How much: How often:

Is there anything we have not talked about that you would like to discuss?* ○ No ○ Yes

*Required

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT - Part B

Describe what and how often:

Assessment Summary

Indicators of Adult Abuse and Neglect: While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 , 55.3 to report this to the local Department of Social Services, Adult Protective Services.

Caregiver Assessment

Does the member have an informal caregiver?* ○ No ○ Yes

Where does the caregiver live?

Is the caregiver's help adequate to meet the members needs?

Has providing care to the member become a burden for the caregiver?

Describe any problems with continued caregiving:

Preferences

Member's preferences for receiving needed care:*

Family/Representative's preferences for member's care:*

Physician's comments (if applicable):

Member's Case Summary

Unmet Needs

Unmet Needs ... (Check all that apply)

- ☐ Finances
- ☐ Home/Physical Environment
- ☐ ADLS
- ☐ IADLS
- ☐ Assistive Devices/Medical Equipment
- ☐ Medical Care/Health
- ☐ Nutrition
- ☐ Cognitive/Emotional
- ☐ Caregiver Support

Assessment Completed By

Assessor's Name	Section(s) Completed	Agency/Provider's Name	Provider's NPI

Case assigned to:

Code #:

*Required

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT
Eligibility Communication Document

To/From

Dept of Social Services Elibility Worker in (City/County responsible for Auxiliar Grant):*

○ To ○ From

Address:* City* State* Zip*

Assessor/Case Manager:*

○ To ○ From

Address:* City* State* Zip*

Resident Identification

Assessor's Provider Number:* Resident Last Name:* First Name:*

ALF and Location:* Social Security Number:* Medicaid Number:

Purpose of Communication

Purpose of Communication (select one):*

○ Annual Assessment Completed

Date of Reassessment: Select appropriate Option:

- ○ Resident Continues to meet Criteria for ALF Placement for Residential Living
- ○ Resident Continues to Meet Criteria for ALF Placement for Assisted Living
- ○ Resident Does Not Meet Criteria for Residential or Assisted Living

○ Resident No Longer Resides in ALF on Record

Resident has been discharged to:

○ Another ALF

Last Date of Service in the ALF: Name of the New ALF:

Provider #: Start of Care Date in New ALF:

New ALF Address: City: State: Zip:

○ Home

Last Date of Service in the ALF:

New Address: City: State: Zip:

○ Other

Please Specify: Last Date of Service in the ALF:

New Address: City: State: Zip:

○ Auxiliary Grant Eligibility Terminated

Effective Date: Reason:

Signatures

Name of Assessor/Case Manager Completing Form:

Last Name:* First Name:*

Date:* Phone:*

Name of Eligibility Worker Completing Form:

Last Name:* First Name:*

Date:* Phone:*

*Required

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT
Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions

A. This section is to be completed by the Pre-Admission Screening Committee. **This form applies to NF Admissions ONLY.**

Name:* | Date of Birth:* | Date PAS Request Received:*
Social Security:* | Medicaid ID: | Responsible CSB:*

1. Does the individual meet nursing facility criteria?* ○ Yes ○ No

   a. Can a safe and appropriate plan of care to be developed to meet all medical/nursing/custodial care needs? ○ Yes ○ No

   If 'Yes', this form must be completed AND the DMAS-96 form LTC services authorization MUST BE COMPLETED.

2. Does the individual have a current serious mental illness (MI)?* ○ Yes ○ No

   (Check 'Yes' only if answers a, b and c below are 'Yes'. If 'No', do not refer for assessment of active treatment needs for MI Diagnosis.)

   a. Is this major mental disorder diagnosable under DSM-IV (e.g. schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic hodisorder; or other mental disorder that may lead to a chronic disability)? ○ Yes ○ No

   b. Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particulary with regard to interpersonal functioning; concentration, persistence, or pace; and adaptation to change? ○ Yes ○ No

   c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced wihtin the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? ○ Yes ○ No

3. Does the Individual have a diagnosis of mental retardation (MR) / Intellectual Disability (ID) which was manifested before age 18?* ○ Yes ○ No

4. Does the individual have a related condition?* ○ Yes ○ No

   (Check 'Yes' only if answers a, b and c below are 'Yes'. If 'No', do not refer for assessment of active treatment needs for MI Diagnosis.)

   a. Is the condition atributable to any other condition (e.g. cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina befida), other than MI, found to be closely related to MR/ID because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of MR/ID persons and requires treatment of services similar to those for these people? ○ Yes ○ No

   b. Has the condition manifested before age 22? ○ Yes ○ No

   c. Is the condition likely to continue indefinitely? ○ Yes ○ No

   d. Has the condition resulted in substantial limitaiton in 3 or more of the following areas of major life activity; self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living? ○ Yes ○ No

      ☐ Self-care understanding and use of language
      ☐ Learning
      ☐ Mobility
      ☐ Self-direction
      ☐ Capacity for independent living

5. Recommendation (Either 'a' or 'b' must be checked.)*

   a. ☐ Refer for secondary assessment (NF Placement = Level II refer to DDM Ascend)
      ☐ MI (#2 above is checked 'Yes')
      ☐ MR or Related Condition (#3 or #4 is checked 'Yes')
      ☐ Dual diagnosis (MI and MR/ID or Related Condition categories are checked)

   ** NOTE: If 5a is checked, the individual may NOT be authorized for Medicaid-funded LTC until the secondary assessment has been completed.

   b. No referral for active treatment needs assessment required because individual:
      ☐ Does not meet the applicable criteria for serious MI or MR/ID or related condition
      ☐ Has a primary diagnosis of dementia (including Alzheimer's disease) and does not have a diagnosis of MR/ID
      ☐ Has a primary diagnosis of dementia (including Alzheimer's disease) AND has a secondary diagnosis of serious MI
      ☐ Has a severe physical illness (e.g., documented evidence of coma, functioning at brain-stem level, or other conditions which results in a level of impairment so severe that the individual could not be expected to benefit from specialized services.)
      ☐ Is terminally ill (Note: a physician must have documented that individual's life expectancey is six (6) month or less)

Name & Title:* | Screening Committee:*
Date:* | Telephone Number:* | Street Address:*

*Required

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT
MI/MR Supplemental: Level II

B. This section is to be completed by the Communiy Services Board or other entity under contract for Level II evaluation process.

Name: Last Name:* First Name:* MI:

Screening Placement Recommendation:

1. Evaluations required upon receipt of referral. Check evaluations submitted upon receipt of referral.

- ☐ Neurological Evaluation
- ☐ Psychological Assessment
- ☐ Psychiatric Assessment
- ☐ Psychosocial/Functional Assessment
- ☐ History Physcial Examination
- ☐ Other Please Specify:

2. Recommendation

○ Specialized services are not indicated ○ Specialized services are indicated

Comments:

3. Date referral package received: Date package sent to DMRMRSAS:

QMHP Name (MI diagnosis):
Last Name: First Name:
Date: Phone:

Psychologist Name (MR diagnosis):
Last Name: First Name:
Date: Phone:

Case Manager:
Last Name: First Name: Title:
Date: Phone:
Agency/Facility Name: Agency/Facility ID# (if applicable):
Mailing Address: City: State: Zip:

C. This section is to be completed by the department of mental health, mental retardation and substance abuse services.

Date referral package received: Concur with recommendation of specialized services? ○ Yes ○ No
Comments:

Copies of referral package sent to:

	Representative Name	**Date Package Sent**
☐ PAS Representative		
☐ Community Services Board		
☐ Admitting/Retaining Nursing Facility		
☐ Discharging Hospital (if applicable)		
☐ Individual Being Evalulated		
☐ Individual's Family		
☐ Individual's Legal Representative (if any)		
☐ Attending Physician		
☐ Appeals Information Included		

Name of Commonwealth MH/MRA: Title:
Date: Phone:

*Required

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT
Medicaid Funded Long-Term Care Service Authorization Form

Member Information

Last Name:* | First Name:* | Birthdate:*
Social Security:* | Medicaid ID: | Sex:*

Medicaid Eligibility Information

Is Individual currently Medicaid eligible?*
Is Individual currently Auxiliary Grant Eligibility?*
Has individually formally applied for Medicaid? ○ No ○ Yes
Department of Social Services:
Eligibility Responsibility:
Services Responsibility:

Pre-Admission Screening Information: (to be completed only by Level I, Level II, or ALF screeners)

Medicaid Authorization

Medicaid Services Authorized?:* ○ Yes ○ No

Level of Care:
Service Availability:
Reason No Medicaid Services Authorized

Nursing Facility (NF) Services:
Length of Stay:
Progress Notes:

ALF Residential Living/ALF Regular Assisted Living:
Targeted Case Management for ALF? ○ Yes ○ No
ALF Reassessment Completed? ○ Full Reassessment ○ Short Reassessment
ALF Provider Name:
ALF Provider Number:
ALF Admit Date:

Level I/ALF Screening Identification:* ◉ Yes ○ No
Name of Level I/ALF Screener Agency:
Level I/ALF Screener Provider Number:
Additional Level I/ALF Screener Agency:
Add'l Level I/ALF Screener Provider #:

Level II Assessment Determination?:* Note: For NF Authorizaiton Only; Does Not Apply to Waivers ○ Yes ○ No

Complete for the screener who completed the Level II for a diagnosis of MI, MR/ID, or RC:
Name of Level II Screener:
Level II Screener Provider #:
Level II Assessement:

Did the individual expire after the PAS/ALF screening decision but before services were received?:* ○ Yes ○ No

Screening Certification

This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for the member.

☐ By checking this box and entering your name as the Level 1/ALF screener below, you attest that this authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this member. Any person who knowingly submits this form containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Level I/ALF Screener: | Title: | Date:

☐ By checking this box and entering your name as the Level 1/ALF screener below, you attest that this authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this member. Any person who knowingly submits this form containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Level I/ALF Screener: | Title: | Date:

☐ By checking this box and entering your name as the Level 1 Physician below, you attest that this authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this member. Any person who knowingly submits this form containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Level I Physician: | Date:

*Required

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT
Individual Choice - Institutional Care or Waiver Services Form

Member Information

Individual Being Screened:

Last Name:* First Name:* Medicaid ID:

Screening Team Determination

A. Individual Meets Nursing Facility Criteria (Functional Dependency level and Medical/Nursing Needs Present):* ○ Yes ○ No

Application for individual has been made and accepted: ○ Yes ○ No

Date Application was made: Facility:

Contact:

B. Deterioration in individual's health care condition or changes in available supports prevents former care arrangements from meeting needs:* ○ Yes ○ No

Describe:

Evidence is available that demonstrates individual's medical and nursing needs are not being met (e.g. recent physician's documentation of instability finding from medical/social services manager):* ○ Yes ○ No

Describe:

C. Services individual has selected: *

Is Nursing Facility Criteria and Risk of Waiver Services Placement Met?:* ○ Yes ○ No

Choice and Payment Responsibilty

Medicaid will pay for someone to come into your home to care for you as long as in-home services will safely meet your needs and is less costly than a nursing facility care. The screening team does not authorize the amount of services, or time of the day or days of the week on which services will be provided. You may choose to receive in-home services if there is an available provider in your area and you have additional support from family and/or freinds or are able to maintain health, safety and welfare without additional help when in-home services are not being provided.

To stay at home, help in the following areas is needed. (Check all tha apply):

- ☐ Respite
- ☐ Housekeeping
- ☐ Meal Preparation
- ☐ Shopping
- ☐ Laundry
- ☐ Supervision
- ☐ Personal Care
- ☐ ADLS
- ☐ PERS
- ☐ Transportation
- ☐ Skill Nursing Needs/Private Duty Nursing

Documentation of Individual Choice

The following have been presented and discussed with the individual (discussion of each item is required):*

- ☐ The findings and results of the individual's evaluation and needs.
- ☐ A choice between Institutional Care (nursing facility) and the appropriate Home- and Community- Care Based Waiver, PACE (if available in service area) or MCO (if available in service area).
- ☐ The individual understands when a diagnosis of mental illness, mental retardation/intellectual disabilities or related condition exists a secondary screening is required to determne if additional services are necessary. Services can not start until the completion of the secondary assessment. For NF = Level II Screening.
- ☐ The individual's right to a fair hearing and the appeal process.
- ☐ The individual's right to choice of provider(s). If known, insert provider name here:
- ☐ The individual's right of choice of service(s).
- ☐ The individual's potential to have a patient pay amount based on his or her income, regardless of the amount of institutional or community-based care received.
- ☐ The individual understands that, by using Consumer-Directed Services he or she bears the responsibilities associated with employing his or her own personal attendants. Note: DMAS is not the employer for Consumer-Directed Services.
- ☐ The individual's (or authorized representative's) consent to exchange information with the Department of Medical Assistance Services (DMAS) by signing and dating this form. This consent will remain in effect until revoked by the individual (or authorized respresentative) in writing.
- ☐ At Risk: for waiver service authorizations - individuals must also met the 'at risk' definition in order to receive services. At risk is defined according to 42 CFR 441.302(1): '….when there is a reasonable indication that an individual might need the services in the near future (that is, a month or less) unless he or she receives home and community based services'

Signatures

- ☐ The above information has been discussed with me. I understand that the provider will develop a Plan of Care with my assistance based on my needs and my available support. Provider staff is responsible to provide continuous and reliable care. I understand that when there is a lapse in service I am responsible to provider back-up support. *

Individual's Name: Date Reviewed:

Screener's Name: Date Reviewed:

Family Member, Parent, Legal Guardian, or Authorized Representative: Date Reviewed:

Indicate Applicable Designation:

*Required

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT
Attachment to Public Pay Short Form Assessment

Client's Information

Last Name:* First Name:*
Social Security:* Medicaid ID:

Medication Administration

How can you take your medicine?:* Describe Help/Name of Helper:

Psycho-Social Status

Behavior Pattern:* Type of Inappropriate Behavior:
Orientation:* Spheres Affected:

Current Psychiatric or Psychological Evaluation Needed?* Yes No

Assessment Summary

Does Applicant/Resident have a Prohibited Condition?* Yes No
Describe:
Level of Care Approved:*

Assessment Completed By:*

Last Name	First Name	Agency	Provider Number	Date

Comments: