Community-Based Care Level of Care Review Instrument

Assessment Date: _____/_____/_____

Provider Information

Provider Name: _____

Provider ID#: _____ Add'l Provider ID# (EDCD Only): _____

Provider's Phone: (_____)_____-_____ Provider's Email Address: _____

Provider's Street Address: _____

Provider's City: _____ Provider's State: _____ Provider's Zip: _____

Program Type: ☐ Alzheimer's Assisted Living Waiver ☐ EDCD Waiver ☐ Technology Assisted Waiver ☐ PACE

For PACE Enrollments ONLY:

☐ Initial Enrollment ☐ Unscheduled Assessment ☐ 6-Month Reassessment ☐ Annual Assessment

Enrollment Agreement Signed: _____/_____/_____ UAI Completed Date: _____/_____/_____

For EDCD Enrollments ONLY:

Service Delivery Method: ☐ Agency Directed ☐ Consumer Directed ☐ Both

Individual's Personal Information/ Demographics

Name (Last, First, MI): _____

SSN: ____-_____-_____ Date of Birth: _____/_____/_____ Age: _____ Phone: (_____)_____-_____

Marital Status: ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Unknown ☐ Widowed

Race: ☐ African American ☐ Asian American ☐ Hispanic American ☐ Other ☐ White American

Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: VA Zip: _____

Housing: ☐ ALF ☐ Apartment ☐ Live w/Family ☐ Nursing Facility ☐ Other ☐ Own House
☐ Rent House ☐ Rented Room

Individual's Name: _____ Assessment Date: ___/____/_____

Name of Unpaid Primary Caregiver (Not applicable to Alzheimer's Waiver): _____

Advance Directive: ☐ Yes ☐ No APS/CPS Referral: ☐ Yes ☐ No History of Substance Abuse: ☐ Yes ☐ No

Discharge Information

If the individual has been discharged, expired or transferred – please enter the last date of service: _____/_____/_____

Please provider the service authorization number(s) issued for your Provider ID: _____

Additional Service Authorization (EDCD Only): _____

*Note: If this section is completed, no other information is necessary. Please go to the last page and sign to complete the review.

Service Information

Check all that apply:

☐ Personal Care Number of hours per day: _____

☐ Respite Care Number of hours per day: _____

☐ Private Duty Nursing Number of hours per day: _____

☐ Adult Day Care Number of days per week: _____

☐ DME ☐ Home Delivered Meals ☐ Personal Emergency Response System (PERS)

☐ Home Health

☐ Nursing ☐ Speech ☐ OT ☐ PT ☐ Other

☐ Rehab At Center

☐ Nursing ☐ Speech ☐ OT ☐ PT ☐ Other

☐ Communication of Needs

☐ Speech ☐ Hearing Impaired ☐ Visually Impaired

☐ Language Spoken

☐ English ☐ Other Specify Other: _____

Individual's Name: _____ Assessment Date: ___/____/_____

Financial Resources

Check all that apply:

☐ Medicaid Insured Medicaid ID #: _____

☐ Medicare Insured Medicare #: _____

☐ Private Insurance Company: _____

Policy #: _____

☐ Private Pay

Functional Status

ADLs (Select Appropriate Level)

Bathing:

☐ Needs No Help
☐ Mechanical Help (MH) Only
☐ Human Help - Supervise
☐ Human Help – Physical Assistance
☐ MH & Human Help - Supervise
☐ MH & Human Help - Physical Assistance
☐ Always Performed By Others

Dressing:

☐ Needs No Help
☐ Mechanical Help (MH) Only
☐ Human Help - Supervise
☐ Human Help – Physical Assistance
☐ MH & Human Help - Supervise
☐ MH & Human Help - Physical Assistance
☐ Always Performed By Others
☐ Is Not Performed At All

Individual's Name: _____ Assessment Date: ___/____/_____

Toileting:
- ☐ Needs No Help
- ☐ Mechanical Help (MH) Only
- ☐ Human Help - Supervise
- ☐ Human Help – Physical Assistance
- ☐ MH & Human Help - Supervise
- ☐ MH & Human Help - Physical Assistance
- ☐ Always Performed By Others
- ☐ Is Not Performed At All

Transferring:
- ☐ Needs No Help
- ☐ Mechanical Help (MH) Only
- ☐ Human Help - Supervise
- ☐ Human Help – Physical Assistance
- ☐ MH & Human Help - Supervise
- ☐ MH & Human Help - Physical Assistance
- ☐ Always Performed By Others
- ☐ Is Not Performed At All

Eating/Feeding:
- ☐ Needs No Help
- ☐ Mechanical Help (MH) Only
- ☐ Human Help - Supervise
- ☐ Human Help – Physical Assistance
- ☐ MH & Human Help - Supervise
- ☐ MH & Human Help - Physical Assistance
- ☐ Spoon Fed
- ☐ Syringe/Tube Fed
- ☐ Fed by IV

Continence (Select Appropriate Level)

Bowel:
- ☐ Continent
- ☐ External Device/Indwelling/Ostomy (Self Care)
- ☐ Incontinent (Less Than Weekly)
- ☐ Incontinent (Weekly or More)
- ☐ Ostomy (Not Self Care)

Individual's Name: _____ Assessment Date: ___/____/_____

Bladder:
- ☐ Continent
- ☐ External Device (Not Self Care)
- ☐ External Device/Indwelling/Ostomy (Self Care)
- ☐ Incontinent (Less Than Weekly)
- ☐ Incontinent (Weekly or More)
- ☐ Indwelling Catheter (Not Self Care)
- ☐ Ostomy (Not Self Care)

IADLs (Check all that apply 'yes' = needs assistance)

Meal Preparation:	☐ Yes ☐ No	Housekeeping:	☐ Yes ☐ No	Laundry:	☐ Yes ☐ No
Money Mgmt:	☐ Yes ☐ No	Transport:	☐ Yes ☐ No	Shopping:	☐ Yes ☐ No
Using Phone:	☐ Yes ☐ No	Home Maint:	☐ Yes ☐ No		

Physical Health Assessment (Select Appropriate Level)

Joint Motion:
- ☐ Within normal limits or instability corrected (0)
- ☐ Limited motion (1)
- ☐ Instability uncorrected or immobile (2)

Medicine Administration/ Take Medicine:
- ☐ Without Assistance (0)
- ☐ Administered/monitored by lay person (1)
- ☐ Administered/monitored by professional nursing staff (2)

Orientation:
- ☐ Oriented
- ☐ Disoriented – Some Spheres/Sometimes
- ☐ Disoriented – Some Spheres/All Times
- ☐ Disoriented – All Spheres/Sometimes
- ☐ Disoriented – All Spheres/All Times
- ☐ Semi-Comatose/Comatose

Behavior:
- ☐ Appropriate
- ☐ Wandering/Passive Less Than Weekly
- ☐ Wandering/Passive Weekly or More
- ☐ Abusive/Aggressive/Disruptive Less Than Weekly
- ☐ Abusive/Aggressive/Disruptive Weekly or More
- ☐ Semi-Comatose/Comatose

Individual's Name: _____ Assessment Date: ___/____/_____

Ambulation (Select Appropriate Level)

Walking:

- ☐ Human Help – Physical Assistance
- ☐ Human Help - Supervise
- ☐ Is Not Performed At All
- ☐ MH & Human Help – Physical Assistance
- ☐ MH & Human Help - Supervise
- ☐ Mechanical Help (MH) Only
- ☐ Needs No Help

Wheeling:

- ☐ Always Performed By Others
- ☐ Human Help – Physical Assistance
- ☐ Human Help - Supervise
- ☐ Is Not Performed At All
- ☐ MH & Human Help – Physical Assistance
- ☐ MH & Human Help - Supervise
- ☐ Mechanical Help (MH) Only
- ☐ Needs No Help

Stair Climbing:

- ☐ Human Help – Physical Assistance
- ☐ Human Help - Supervise
- ☐ Is Not Performed At All
- ☐ MH & Human Help – Physical Assistance
- ☐ MH & Human Help - Supervise
- ☐ Mechanical Help (MH) Only
- ☐ Needs No Help

Mobility:

- ☐ Needs No Help
- ☐ Mechanical Help (MH) Only
- ☐ Human Help - Supervise
- ☐ Human Help – Physical Assistance
- ☐ MH & Human Help - Supervise
- ☐ MH & Human Help – Physical Assistance
- ☐ Confined Moves About
- ☐ Confined Does Not Move About

Individual's Name: _____ Assessment Date: ___/____/_____

Medical/Nursing Needs (Complete all sections)

Diagnosis (Check all that apply)

☐ Diabetes ☐ COPD ☐ Cancer ☐Congestive Heart Failure
☐ Dementia ☐ Alzheimer's ☐ ID/DD ☐ Mental Health
☐ Other Diagnosis (Please specify)

Medications

Current Health Status/ Conditions/ Comments

Current Medical Nursing Need(s): ☐ Yes ☐ No

If 'Yes', check all items that apply:

☐ Application of aseptic dressing (a)
☐ Routine catheter care (b)
☐ Respiratory therapy (c)
☐ Therapeutic exercise and positioning (d)
☐ Chemotherapy (e)
☐ Radiation (f)
☐ Dialysis (g)
☐ Suctioning (h)
☐ Tracheotomy care (i)

Individual's Name: _____ Assessment Date: ___/____/_____

☐ Infusion therapy (j)

☐ Oxygen (k)

☐ Routine skin care to prevent pressure ulcers for individual who are immobile (l)

☐ Care of small uncomplicated pressure ulcers, and local skin rashes (m)

☐ Use of physical (e.g., side rails, poseys, locked doors in the PACE Center) and/or chemical restraints (n)

☐ Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability (o)

☐ Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder (p)

☐ Supervision for adequate nutrition and hydration for individuals who show clinical evidence of malnourishment or dehydration or have a recent history of weight loss or inadequate hydration which, if not supervised would be expected to result in malnourishment or dehydration (q)

☐ The individual's medical condition requires observation and assessment to assure evaluation of the person's need for modification of treatment or additional medical procedures to prevent destabilization, and the person has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals (r)

☐ Due to the complexity created by the person's multiple, interrelated medical conditions, the potential for the individual's medical instability is high or exists (s)

☐ Other:

Please specify 'Other'

I acknowledge that by signing my name as the RN completing this form, I will be attesting that all information entered is accurate and correct.

Completed by: _____
(Name of RN/SF completing form)

Community-Based Care Level of Care Review Instrument

Instructions

This form (DMAS-99 series) must be completed in its entirety for each current waiver individual that is admitted under your Medicaid provider number. The instructions to fill out each category correctly are explained below. If you need further instructions about the meaning of a question on this form, look at the UAI manual located at: http://www.dmas.virginia.gov/ltc-Pre_admin_screeners.htm

For PACE Only: The Interdisciplinary Team Plan of Care form is to be mailed to DMAS ten (10) days prior to enrollment as designated by the PACE Agreement.

Regardless of the program type, the provider must complete the annual LOC assessment. The assessment is required to be entered electronically via the DMAS Web Portal within the time frame designated in the Medicaid MEMO. Each provider will receive written notification, including a list of all of their current enrolled individuals by name and Medicaid number and the date the individual was admitted to either waiver or PACE services. All providers will be required to submit the monthly assessments via the Web Portal on or before the last day of the same month as the individual's waiver enrollment date in MMIS. For example: Sally Jones was admitted to the EDCD Waiver on October 1, 2012- the Web Portal LOCERI assessment entry and submission date must occur before 10/31/2012. For additional information concerning the notification process and timely submission refer to the Medicaid MEMO.

Any additional written information will be requested directly from DMAS and will require delivery by regular mail. Due to HIPPA requirements, DMAS cannot accept this information through electronic mail. In addition, due to the volume, fax documents are not permitted. Any paper documentation requested by DMAS may be sent via the U.S. Mail to:
:

Department of Medical Assistance Services,

Quality Assurance Unit

Division of Long Term Care –

Level of Care Reviews,

600 East Broad Street, Richmond, Virginia 23219

Assessment Date: Enter the date of the last 6-month assessment that is being used to fill this form out.

Provider Name: Enter the name of the organization/agency or individual provider

Provider ID#: Enter Provider ID (either NPI or API) related to the service authorization.

Provider Phone #: Enter the phone number associated with the provider's servicing address

Provider E-Mail: Enter the email address of the servicing provider

Provider's Street Address: Enter the street address associated with the provider's servicing address

Provider's City: Enter the city associated with the provider's servicing address

Provider's State: Enter the state associated with the provider's servicing address

Provider's Zip: Enter the zip code associated with the provider's servicing address

Program Type: Select the program/waiver type this form is submitted for

Service Delivery Method (EDCD Waiver only): Select the appropriate service delivery method

For PACE Enrollments ONLY: Select the assessment period for this submission and enter the dates the enrollment agreement was signed and the UAI was completed.

Personal Information/Demographics

- **Last Name:** Enter the last name of the individual receiving services
- **First Name:** Enter the first name of the individual receiving services
- **Middle Initial:** Enter the middle initial of the individual receiving services
- **SSN:** Enter the individual's 9 digit social security number
- **DOB:** Enter the individual's date of birth
- **Age:** Enter the individual's age at the time of the assessment
- **Phone #:** Enter the individual's phone number including area code
- **Marital Status:** Select the individual's current marital status
- **Race:** Select the individual's race
- **Gender:** Select the individual's gender
- **Address:** Enter the individual's street address of residence
- **City:** Enter the individual's city of residence
- **State:** Should be Virginia (VA)
- **Zip:** Enter the individual's zip code of residence
- **Housing:** Select the appropriate housing scenario for the individual
- **Name of Unpaid Caregiver (not applicable to Alzheimer's program types):** Enter the name of an person giving care without payment
- **Advance Directive:** Does the individual have an advance directive? Yes or No
- **APS/CPS Referral:** Does the individual have an APS/CPS referral? Yes or No
- **History of Substance Abuse:** Does the individual have a history of substance abuse? Yes or No

Discharge Information – Complete any discharge information that is applicable for this individual

- **If the patient has been discharged, expired or transferred – please enter the last date of service:** Enter the last day of hands on waiver services care provided by your agency.
- **Service Authorization Numbers:** Enter the service authorization number(s) issued for your provider ID

  NOTE: If individual has been discharged, expired or transferred, service authorization numbers should be entered and no additional data is needed for these forms.

Service Information – Check all service information that is applicable for this individual

- **Personal Care:** Check if individual receives/requests personal care and if checked, complete the following:
  - **Number of hours per day:** Enter the number of personal care hours per day
- **Respite Care:** Check if individual receives/requests respite care and if checked, complete the following:
  - **Number of hours per day:** Enter the number of respite care hours per day
- **Private Duty Nursing:** Check if individual receives/requests private duty nursing and if checked, complete the following:
  - **Number of hours per day:** Enter the number of private duty nursing hours per day
- **Adult Day Care:** Check if individual receives/requests adult day care and if checked, complete the following:
  - **Number of days per week:** Enter the number of adult day care days per week

- **DME:** Check if durable medical equipment is used/needed by the individual
- **Home Delivered Meals:** Check if individual receives home delivered meals
- **Personal Emergency Response System (PERS):** Check if individual utilizes PERS
- **Home Health:** Check if individual is utilizing home health services
    - **Nursing, Speech, OT, PT or Other:** If home health services are being used, check rather the individual is using nursing, speech, OT, PT or other services
- **Rehab at Center:** Check if individual is at a rehab facility
    - **Nursing, Speech, OT, PT or Other:** If Rehab at Center services are being used, check rather the individual is using nursing, speech, OT, PT or other services
- **Communication of Needs:** Check any/all communication impairments – speech, hearing and/or visual
- **Language Spoken:** Select the individual's primary language
    - **Other –** If language spoken selection is 'Other', please specify

Financial Resources: Select any/all options that apply and complete any associated information.

Functional Status: Select the appropriate option in each category.

- ADLs: Select the appropriate option.
- Continence / Bowel & Bladder: Select the appropriate option.
- IADLS: Select the appropriate option. These items pertain to whether the individual needs help in these areas (Yes = Needs Assistance).

Physical Health Assessment: Select the appropriate options

Medical / Nursing Needs: Describe the current health status/condition of the individual and check the medical nursing need or note the nursing need(s) of the individual. Something must be checked to show individual's Medical/Nursing eligibility.

- **Current Health Status/Condition/Comments:** Any information on the individual's care, medical condition, or status that relates to his/her eligibility or utilization of hours.

Completed by: This is the name of the RN completing the Care Review form. By signing, the signature is attesting that all information entered is accurate and correct.