13

Uniform Assessment Instrument

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UAI

13.1 Introduction

The Uniform Assessment Instrument (UAI) is a multidimensional, standardized document, which is used to assess an individual's social, physical health, mental health, and functional abilities, in order to provide a comprehensive look at an individual. Information gathered on the UAI helps determine an individual's needs and eligibility for services, and it is used to plan and monitor an individual's care across various agencies and long-term care services. The UAI fosters the sharing of information among providers, and individuals who use the UAI are encouraged to share information about an individual in an attempt to avoid duplication of services.

The UAI is used by public services agencies throughout Virginia, including local departments of social services (LDSS), area agencies on aging (AAA), community services boards (CSB), as well as Preadmission screening (PAS) teams.

This manual provides general instructions regarding the use of the UAI, followed by specific instructions for the administration of each section. Assessors who use the UAI should become familiar with this manual and use it as a reference document. Every assessor should obtain the most complete and accurate information during each assessment.

The UAI Manual appendices include supplemental information and referral indicators. Referral indicators are designed to provide guidelines for situations when a more specialized assessment may be required. The indicators do not cover every individual need nor are they intended to be comprehensive.

For additional information regarding the assessment of individuals residing in or applying for admission to an Assisted Living Facility (ALF), assessors should refer to the following manuals located at http://www.dss.virginia.gov/family/as/servtoadult.cgi:

- ALF Public Pay Assessment Manual
- ALF Private Pay Assessment Manual

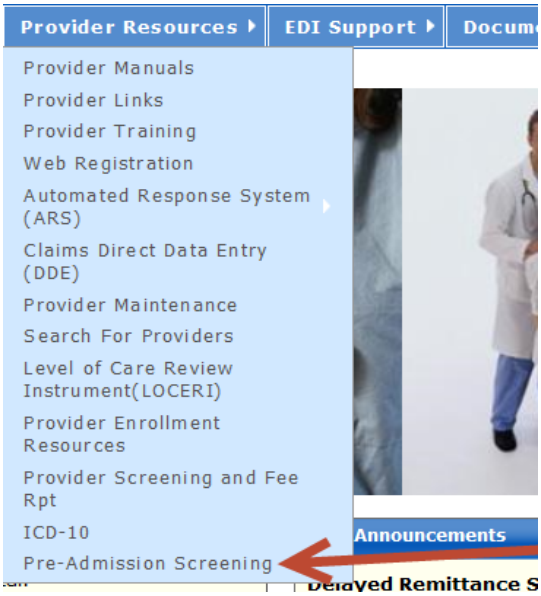
The PAS Provider Manual located on the Department of Medical Assistance (DMAS) portal provides guidance for hospital and community-based PAS teams and addresses the requirements for functional eligibility for Medicaid-funded long-term care services and supports (LTSS).

Note: Effective July 1, 2015, all PAS shall be entered into the Electronic Pre-Admission Screening system or "ePAS" the Department of Medical Assistance Services' automated system for submission of electronic UAIs. **Note:** ALF assessments and reassessments shall not be entered into ePAS. ALF assessments and reassessment shall be completed pursuant to current protocols (e.g. the assessor may complete a paper UAI).

The DMAS web portal contains the following resources:

- Preadmission Screening FAQ
- Preadmission Screening User Guide
- Preadmission Screening Tutorial

To access these materials, once on the DMAS portal home page, select Provider Resources and then select Preadmission Screening.



There are other PAS materials located on the DMAS website at:
http://www.dmas.virginia.gov/Content_pgs/ltc-home.aspx

Throughout this manual the term "assessor" is used to describe the person or persons (e.g. both members of the PAS team) who conduct assessments using the UAI. Additionally, the term "assessment" refers to PAS and assessments of individuals in ALFs.

Appendix H lists forms that may need to be completed in addition to the UAI.

13.2 Screenings for children

When assessing a child in need of Medicaid LTSS such as the Elderly or Disabled with Consumer Direction (EDCD) waiver, assessors shall refer to guidance in the DMAS PAS Provider Manual, Appendix B.

13.3 Legal basis

Section 63.2-1804 of the Code of Virginia and regulations, 22 VAC 30-110-20, require that all individuals, prior to admission to an ALF, and individuals residing in an ALF must be assessed, at least annually, using the UAI to determine the need for residential or assisted living care, regardless of payment source or length of stay. Additionally individuals residing in an ALF must be assessed using the UAI whenever there is a significant change in the individual's condition that may warrant a change in level of care.

Section 32.1-330 of the Code of Virginia describes PAS requirements including the composition of the PAS teams.

> (§ 32.1-330 of the Code of Virginia). All individuals who will be eligible for community or institutional long-term care services as defined in the state plan for medical assistance shall be evaluated to determine their need for nursing facility services as defined in that plan. The Department shall require a preadmission screening of all individuals who, at the time of application for admission to a certified nursing facility as defined in § 32.1-123, are eligible for medical assistance or will become eligible within six months following admission. For community-based screening, the screening team shall consist of a nurse, social worker or other assessor designated by the Department, and physician who are employees of the Department of Health or the local department of social services or a team of licensed physicians, nurses, and social workers at the Wilson Workforce and Rehabilitation Center (WWRC) for WWRC clients only. For institutional screening, the Department shall contract with acute care hospitals. The Department shall contract with other public or private entities to conduct required community-based and institutional screenings in addition to or in lieu of the screening teams described in this section in jurisdictions in which the screening team has

> been unable to complete screenings of individuals within 30 days of such individuals' application.

Section 32.1-330.4 of the Code of Virginia requires screenings for individuals seeking Program for All-Inclusive Care for the Elderly (PACE) services regardless of payment source.

> (§ 32.1-330.4 of the Code of Virginia). Every individual who requests a screening for the purpose of enrollment in a PACE plan, as defined in § 32.1-330.3, shall be eligible for such screening, regardless of whether the individual is eligible under the state plan for medical assistance.

DMAS regulations, 12 VAC 30-60-303, address PAS criteria for Medicaid-funded long-term care services and supports.

13.4 Definitions

The following words and terms are defined in state regulations.

Term	Definition
Activities of Daily Living (ADLs)	Bathing, dressing, toileting, transferring, bowel control, bladder control, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and services. 22 VAC 30-110-10.
Assisted Living Care	A level of service provided by an assisted living facility for individuals who may have physical or mental impairments and require at least moderate assistance with the activities of daily living. Moderate assistance means dependency in two or more of the activities of daily living. Included in this level of service are individuals who are dependent in behavior pattern (i.e., abusive, aggressive, disruptive) as documented on the uniform assessment instrument. 22 VAC 30-110-10.
Assisted Living Facility (ALF)	Any public or private ALF that is required to be licensed as an ALF by the Department of Social Services under Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia, specifically, any congregate residential setting that provides or coordinates personal and health care services, 24-hour supervision, and assistance (scheduled and unscheduled) for the maintenance or care of four or more adults who are aged,

Term	Definition
	infirm or disabled and who are cared for in a primarily residential setting, except (i) a facility or portion of a facility licensed by the State Board of Health or the Department of Behavioral Health and Developmental Services, but including any portion of such facility not so licensed; (ii) the home or residence of an individual who cares for or maintains only persons related to him by blood or marriage; (iii) a facility or portion of a facility serving infirm or disabled persons between the ages of 18 and 21, or 22 if enrolled in an educational program for the handicapped pursuant to § 22.1-214 of the Code of Virginia, when such facility is licensed by the Department of Social Services as a children's residential facility under Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia, but including any portion of the facility not so licensed; and (iv) any housing project for persons 62 years of age or older or the disabled that provides no more than basic coordination of care services and is funded by the U.S. Department of Housing and Urban Development, by the U.S. Department of Agriculture, or by the Virginia Housing Development Authority. Included in this definition are any two or more places, establishments or institutions owned or operated by a single entity and providing maintenance or care to a combined total of four or more aged, infirm or disabled adults. Maintenance or care means the protection, general supervision and oversight of the physical and mental well-being of an aged, infirm or disabled individual. Assuming responsibility for the well-being of individuals, either directly or through contracted agents, is considered general supervision and oversight. 22 VAC 30-110-10. **Note: The term "Adult Care Residence" when used in the UAI, means ALF.**
Auxiliary Grants Program	A state and locally funded assistance program to supplement the income of an individual who is receiving Supplemental Security Income (SSI) or an individual who would be eligible for SSI except for excess income, and who resides in an ALF or in adult foster care with an approved rate. 22 VAC 30-110-10.
Dependent	For ADLs and instrumental activities of daily living (IADLs), the individual needs the assistance of another person or needs the assistance of another person and equipment or a device to safely complete the activity. For medication administration,

Term	Definition
	dependent means the individual needs to have medications administered or monitored by another person or professional staff. For behavior pattern, dependent means the individual's behavior is aggressive, abusive, or disruptive. 22 VAC 30-110-10.
Instrumental activities of daily living (IADLs)	Meal preparation, housekeeping, laundry, and money management. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and services. 22 VAC 30-110-10.
Medication Administration	The degree of assistance an individual requires to take medications in order to determine the individual's appropriate level of care. 22 VAC 30-110-10.
Preadmission Screening	The process to: (i) evaluate the functional, nursing, and social supports of individuals referred for preadmission screening for certain long-term care services requiring nursing facility eligibility; (ii) assist individuals in determining what specific services the individuals need; (iii) evaluate whether a service or a combination of existing community services are available to meet the individuals' needs; and (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facility or home and community-based care for those individuals who meet nursing facility level of care. 12 VAC 30-120-900
Reassessment	An update of information on the uniform assessment instrument at any time after the initial assessment. In addition to an annual reassessment, a reassessment shall be completed whenever there is a significant change in the individual's condition. 22 VAC 30-110-10. **Note**: Reassessment only refers to the annual ALF reassessment. It does not refer to a rescreening of an individual who was denied access to Medicaid-fund long term care services and supports.
Residential Living Care	A level of service provided by an ALF for individuals who may have physical or mental impairments and require only minimal assistance with the activities of daily living. Minimal assistance means dependency in only one ADL or dependency in one or more of the selected IADLs as documented on the uniform

Term	Definition
	assessment instrument. Included in this level of service are individuals who are dependent in medication administration as documented on the uniform assessment instrument. This definition includes the services provided by the facility to individuals who are assessed as capable of maintaining themselves in an independent living status. (22 VAC 30-110-10).
Significant Change	A change in an individual's condition that is expected to last longer than 30 days. It does not include short-term changes that resolve with or without intervention, a short-term acute illness or episodic event, or a well-established, predictive, cyclic pattern of clinical signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress. (22 VAC 30-110-10).
Total Dependence	The individual is entirely unable to participate in the performance of an activity of daily living. 22 VAC 30-110-10.

13.5 Short assessment

The UAI is comprised of a short assessment and a full assessment.

The short form includes the first four pages of the UAI plus an assessment of the individual's medication management ("How do you take your medicine?" question on page 5 of the UAI) and behavior ("Behavior Pattern" section on page 8 of the UAI) must be completed. The short form is only used during an ALF assessment or reassessment if the individual meets residential level of care.

13.6 Full assessment

The full assessment is a multi-dimensional evaluation of individual functioning, and it is designed to gather sufficient information about the individual, including needs and strengths. It encompasses the short assessment and has 4 major content areas: Identification/Background, Functional Status, Physical Health Assessment and Psychosocial Assessment. The final section of the UAI is an Assessment Summary, which includes a Caregiver Assessment. The full assessment is used during a PAS and when it is determined that a person will need assisted living level of care.

13.7 Consent and Confidentiality

Consent forms are not part of the ePAS system. Prior to completing the UAI, assessors should obtain a written release of information statement signed by the individual or his or her authorized representative. In doing so, it is important to discuss with individuals about the importance of sharing information from the UAI and engaging in collaborative relationships with other service providers (who are also bound by laws of confidentiality). Information sharing:

- Ensures that individuals get the help they need;
- Ensures the continuity of services;
- Avoids duplication and achieves efficiency; and
- Ensures coordinated services.

When authorizing the release of confidential information, the decision of how widely the information shall be shared resides solely with the individual. It is critical that agencies respect and protect the individual's interests. However, efforts to safeguard information should not unnecessarily restrict an individual's access to services when state and federal laws and regulations allow for appropriate exchange of information. A consent form is located at http://www.dss.virginia.gov/family/as/servtoadult.cgi. The signed consent should be maintained in the individual's case record. Hospital teams should use their hospital's approved consent form.

13.8 Interview Process

Prior to beginning the interview, the assessor should take time to establish rapport (i.e., building trust) with the individual and/or caregiver. The assessor may engage the individual in "small talk" such as discussing the weather or something positive and lighthearted. If the individual feels comfortable, he or she will speak more openly, allowing the assessor to gather valuable, necessary information. Developing rapport with the individual will also result in a better understanding of him or her. Knowledge of the individual will help the assessor direct the conversation and know when to ask additional questions.

The preferred source of information is the individual. If there is another person in the room when the individual is being interviewed, questions should continue to be directed to the individual. If others who are present try to answer questions for the individual, they should be asked not to assist with responses or provide reminders or hints. This is particularly important when asking the individual subjective questions such as how satisfied he or she is with family relationships.

When assessing an individual with a cognitive disability, it will be necessary to speak with other individuals such as the primary caregiver, family members, other helpers, friends, neighbors or provider staff. In some instances the assessor may need to interview other professional staff such as physicians, nurses, or social workers. The assessor should note on the UAI when sources other than the individual provided information. Also, it may be necessary to obtain a translator or some other spokesperson for individuals who are non-English speaking or who have difficulty communicating. The following resources provide information on communicating with individuals with disabilities.

US Department of Labor, Office Disability Employment Policy, Communicating With and About People with Disabilities

Communicating Effectively With People Who Have a Disability

Disability Etiquette

13.8.1 Asking questions

It is important to obtain valid and reliable information. The following suggestions are designed to ensure that responses to questions will be accurate and useful.

- Always remain neutral. Do not make statements or offer nonverbal cues that might suggest that a particular response is correct or incorrect, good or bad, or similar to or different from other respondents. Be careful not to show surprise at certain responses; this reaction might suggest that the response given was unusual or inappropriate.

- If a question is applicable, ask it exactly as it is worded. Deviations from the original wording, even subtle ones, can lead to changes in the responses.

- Read each question slowly and in a clear voice. With practice, it is possible to read the questions in a conversational tone that helps to maintain the individual's interest.

- Be careful to properly follow any skip patterns. Ask every question, with the exception of those that the instructions require you to skip.

- Repeat questions that are misunderstood or misinterpreted by reading them again exactly as worded.

- Keep the respondent focused, perhaps by asking the next question, or by repeating the last one if an appropriate answer has not been provided.

- Shield the questions from the respondent's vision, unless instructed otherwise. Respondents tend to try to read ahead and look at how past responses were recorded, and these actions tend to make them less attentive to the questions being asked.

- Before accepting a "don't know" response, use a neutral probe to help stimulate an answer.

13.8.2 Using probes

Many times respondents say they do not know the answer to a question when, in reality, they are still thinking about it. At other times, they give answers that do not really seem to fit the question or give answers that are very general when a more specific response is required. On these occasions use a neutral probe to help the respondent answer or get back on track. Neutral probes are questions or actions that are meant to encourage a response, or a more complete response, without suggesting what the answer should be.

- Repeat all questions that are misunderstood or that lead to "don't know" responses.

- Give the respondent time to answer. An "expectant" pause can signal the person that a more complete response is needed and give him time to organize his thoughts.

- Ask a neutral question, such as "Do you have more to say about that?" or "Is there anything else?"

- If the question has specific response categories, read the categories and ask the respondent which is more appropriate to him or which fits him best.

- Ask the respondent to provide further clarification, such as "Please tell me a little more about that" or "Please explain that a little further for me."

Probes must not give the individual any clues about what the response should be. Probes that begin "Don't you think that . . ." or "Most people have told me . . ." or "I assume what you're trying to get at is . . ." direct respondents toward particular answers, and are less likely to represent the individual's true response.

13.9 Assessment process

Each page of the UAI contains an essential set of minimum data to be recorded in the spaces provided. Assessors may wish to use the spaces in the comments sections to record additional information that is helpful.

- **For paper UAIs only:** If a paper UAI is completed, the assessor may also attach additional pages to expand on the comments entered, if necessary. Some specific points about completing a paper UAI follow:

    - The UAI must be legible and maintained in accordance with accepted professional standards and practices. All UAIs must be signed with the name and professional title of the assessor and completely dated with month, day, and year.

    - Any changes made to the UAI must be legible and made with a single line to cross out old information and with new information neatly entered and initialed.

The UAI must be completed in its entirety.

Some of the questions are closed-ended with a fixed set of responses, which are incorporated into an individual level database. As a result, only "codable" responses are acceptable, and assessors may have to probe respondents for answers.

Most questions call for one answer; if two or more are given, probe for the response which comes closest to the individual's situation. In probing for answers, the assessor should take care not to influence the answer or irritate the respondent.

- Occasionally an accurate answer may not completely fit one of the answer options. In this case, determine which option best fits the situation. If a question provides for a "yes" or "no" response, each response must be selected appropriately. If "yes" is selected, use the space available to provide additional information if needed.

- **For ePAS Users:** The assessor is not able to enter "unknown" as a response unless "unknown" is an answer that can be selected (e.g. education level question on page 1 of the UAI). The assessor must select a response from the choices provided.

- Some of the closed-ended questions have an "Other" category. Please use the space next to "Other" to specify/describe an answer which does not fit one of the categories listed. "Other" should be used on a limited basis. Most answers should fit into one of the provided categories.

- Some questions are open-ended and are important for gathering information about the individual. These questions are followed by blank spaces rather than a list of possible answers. Responses to open-ended questions should always be probed to make clear exactly what the respondent has in mind, to be sure the answer is relevant and to get additional ideas on the subject.

- Some of the questions are preceded by pre-worded questions or prompts. This is most common in the Psycho-Social Assessment section. Please follow the pre-worded suggestions in order to ensure that all assessors ask the questions in the same way.

- The psychosocial section of the assessment contains an optional set of questions, in italics, which can be used to give the individual a score on the modified Mini-Mental State Examination (MMSE).

Note: If completing a paper UAI, assessors should:

- Use a check or an "X" to mark the appropriate response.

- Read down lists to familiarize the respondent with the range of responses.

- Where an answer consists of several options separated by a slash, circle the specific answer, or both if appropriate. An example of this is the Communication of Needs question on page 1. If the third response (Sign Language/Gesture/Device) is the correct answer, put a check next to this line and specify the appropriate option with a circle.

- Make sure every question has the appropriate number of responses recorded.

13.10 Changing assessment information

Information on the UAI may be revised prior to submission in order to change incorrect or inaccurate information. Any information collected over the phone (during the intake/screen) will need to be verified and possibly changed at the time of the in-person assessment.

13.11 ALF reassessments

An ALF reassessment is an update of information at any time after the initial assessment. It is a formal review of the individual's status to determine whether his or her situation and functioning have changed. Reassessments are required at least annually on individuals who reside in an ALF.

An individual's situation and functional abilities can rapidly change. Temporary changes in an individual's condition are those that can be reasonably expected to last less than 30 days. Such changes do not require a new assessment. Examples of such changes are short-term changes that resolve with or without intervention, changes that arise from easily reversible causes such as a medication change, short-term acute illness or episodic event, or a well established, predictive, cyclic pattern of signs and symptoms

associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

A reassessment should be completed whenever there is a permanent, significant change in the resident's condition. A permanent change is one, which is expected to last 30 days or more. All reassessments are to be completed with the individual and, if possible, the appropriate informal caregiver(s). All services in place are to be reviewed for quality and appropriateness. If the individual's needs have changed, the service delivery or care plan is adjusted based on information from the reassessment.

For additional information on reassessments see the Public Pay and Private Pay Assessment Manuals located at http://www.dss.virginia.gov/family/as/servtoadult.cgi.

Note: A reassessment only refers to an ALF reassessment and not a PAS "rescreening."

13.12 Section 1 of the UAI: Identification/Background

In the upper right-hand corner of the UAI is space to record the date of the screen, date of the assessment, date of the reassessment, and the date of the initial request. **Note:** The current version of the paper UAI does not have a space for initial request date.

The **initial request date** appears on the ePAS UAI and is the date that an individual or the individual's representative calls to request an assessment. The initial request date must be entered if the assessment is completed in ePAS.

The **screen date** refers to the date when initial sections (e.g. pages 1 and 2) of the UAI may be completed. If the individual or family member provides initial information about the individual over the phone when the request for services is made, the screen date may be the same date as the initial request date. If the individual or family member provides information after the initial request but prior to the assessment, the screen date will be after the initial request date.

The **assessment date** is the date the assessor meets with the individual to conduct the assessment. The screen and assessment date may be the same or the assessment date may be later than the screen date.

A **reassessment date** only applies to ALF reassessments. The reassessment date is the date when the individual is reassessed, either during an annual ALF reassessment or when there is a change in the condition of an individual who is residing in an ALF. However, ALF assessments and reassessments are NOT entered into ePAS. **Note:** A reassessment date is **never** entered if a PAS is being conducted.

- Example 1: Mrs. Williams calls the LDSS on May 1, 2015 to request waiver services. 05/01/2015 is entered as the initial request date. During the initial

phone call the LDSS intake worker completes pages 1 through 3 of the UAI. 05/01/2015 is entered as the screen date. The PAS team visits Mrs. Williams to conduct the assessment on May 10, 2015. 05/10/2015 is entered as the assessment date. The reassessment date is left blank.

- Example 2: Mr. Smith's daughter, Rebecca, calls the LDSS on June 3, 2015 to request nursing facility placement for Mr. Smith. 06/03/2015 is entered as the initial request date. On June 6, 2015, the LDSS representative calls Rebecca to obtain some additional information about Mr. Smith as he is unable to answer questions due to his dementia. 06/06/2015 is entered as the screen date. The PAS team visits Mr. Smith and Rebecca on June 25, 2015 to conduct the assessment. 06/25/2015 is entered as the assessment date. The reassessment date is left blank.

- Example 3: Mr. Thompson and his CSB case manager agree he needs to live in an ALF. The date they agree to this plan is the date of the initial request. The CSB case manager completes the ALF assessment on February 3, 2015. That date is entered in both the screen and assessment date as CSB case manager did not gather any demographic information prior to the assessment. The reassessment date would remain blank. Approximately one year from the date of the assessment, the CSB case manager will conduct a reassessment of Mr. Thompson and at that time will enter the date in the reassessment date area on the UAI. The assessment is not entered into ePAS.

13.12.1 Name and vital information

Record the full name of the individual (last, first, and middle initial); the individual's full address (street, city, state and zip); the phone number at the individual's home address (area code and number) and the city/county code of the individual's home. I If the individual currently resides in a facility, record the address of the facility no just the name of the facility. The telephone number recorded on the form should be the number at which the individual can be reached. It is appropriate to enter a cell phone number if the individual does not have a landline. If this number is not the individual's own number, the assessor should note this (e.g., neighbor's number). Assessors should refer to the list of codes in Appendix E to obtain city/county codes. There is space after this question to record directions to the individual's home and the presence of pets. It is important to be as specific as possible when recording directions.

The SSN is a nine-digit number, which will be used to track information on all individuals who are assessed. It is important that every person have a **unique** number. Most individuals should have a SSN, but you will find that some female individual's use their Medicare number as their SSN and/or their husband's SSN as their own. Medicare numbers are SSNs with an additional letter added. A Medicare

number ending with the letters A, J, M, or T is equal to the female individual's own SSN. However, a Medicare number ending in B or D is the husband's SSN. B means the husband is still alive and D means the husband is deceased. Assessors can use the Medicare number ending in D as the wife's SSN since the husband is deceased.

On occasion, the assessor will need to generate a dummy social security number for an individual. This will happen when a female individual only has her husband's number and he is still alive, or when there is no number to be found. In the cases where the wife is using the husband's SSN, generate a dummy number for the wife in the following way: 777XXXXXX. The 7's are the dummy numbers and the Xs are the remaining numbers of the husband's SSN.

In some cases it may be necessary to dummy the entire SSN. In this instance, the assessor should enter the SSN beginning with three zeros followed by the individual's date of birth in the following format: 000MMDDYY. For example, Becky a toddler was born on October 5, 2013. As she lacks an SSN, the assessor would enter 000100513 as her SSN.

13.12.2 Demographics

Record the individual's date of birth (month, day and year), age and gender.

13.12.2.1 Marital status

Choose the answer that best describes the individual's current status relative to the civil rite or legal status of marriage.

- **Married** includes those who have been married only once and have never been widowed or divorced, as well as those currently married persons who remarried after having been widowed or divorced.
- **Widowed** includes individuals, whether female or male, whose most recent spouse has died.
- **Separated** includes persons legally separated, living apart, or deserted.
- **Divorced** includes those whose most recent marriage has been dissolved by decree of a court of competent jurisdiction.
- **Single** includes persons who have never married, who have had their only marriage annulled and who claim a common law marriage, which is not recognized as a legal status in the Commonwealth of Virginia.

13.12.2.2 Race

Information about race is important for both epidemiological reasons and for comparisons with the population characteristics for the area served. Issues of accessibility, appropriateness of service and equity can be examined. The concept of race reflects self-identification and self-classification by the individual according to the race with which he identifies. A suggested question is "Would you say that you are . . ." at which point the assessor reads the race categories. For persons who cannot provide a single response to the race question, use the first race reported by the person. In the space provided for Ethnic Origin, assessors may wish to record more specific information on an individual's ethnicity, especially if this affects service eligibility and delivery. It should also be used to record Hispanic Origin, such as Mexican, Puerto Rican, Cuban, Central American or South American.

- **White** refers to any person having origins in any of the original peoples of Europe, North Africa or the Middle East. This category includes, but is not limited to, respondents who identify themselves as White, Canadian, German, Italian, Lebanese or Polish.

- **Black/African American** includes, but is not limited to, respondents who identify themselves as Black, African American, Afro-American, Jamaican, Black Puerto Rican, West Indian, Haitian or Nigerian.

- **American Indian** includes, but is not limited to, respondents who identify themselves as part of an Indian tribe, Canadian Indian, French-American Indian or Spanish-American Indian.

- **Oriental/Asian** includes, but is not limited to, respondents who identify themselves as Japanese, Chinese, Filipino, Korean, Vietnamese, Asian Indian, Hawaiian, Guamanian, Samoan, Cambodian, Laotian and Fiji Islander.

- **Alaskan Native** refers to a person having origins in any of the original people of Alaska.

13.12.2.3 Education

Education means the highest level of schooling attained by the individual.

- **Less than High School** means some schooling at the elementary/middle school level or less.

- **Some High School** means education at the secondary level without attaining a high school diploma.

- **High School Graduate** means a high school diploma or equivalency certificate was received.

- **Some College** means education at an institution of higher learning without attaining a baccalaureate or associate degree.

- **College Graduate** means a baccalaureate or associate degree was received.

- **Unknown**

Space is provided to specify the level and/or type of education (i.e., special education, trade school, post-graduate work).

13.12.2.4 Communication of needs

Communication of needs is the individual's ability to express his or her requests, needs, opinions, problems and social concerns (whether in speech, in writing, in sign language, or a combination of methods) in a way that is readily and clearly understood. It is important to evaluate the individual's ability to communicate with the provider(s) of care.

- **Verbally, English** means the individual expresses himself or herself effectively through the use of the English language.

- **Verbally, Other Language** means the individual makes himself or herself understood effectively through the use of a language other than English. Specify the other language.

- **Sign Language/Gestures/Device** means the individual expresses himself or herself by pointing, using sign language, using a communication board, and/or through written or electronic means. This category includes individuals who communicate in a language other than English which is not understood by the provider of care, but whose gestures or written symbols are understood. On paper UAI, circle how the individual makes himself or herself understood and describe as needed. In ePAS the assessor may clarify the means of communication by entering it in the space provided.

- **Does Not Communicate** means the individual does not convey information about his needs either verbally or non-verbally (e.g., comatose individuals do not communicate their needs).

Space is provided to record whether the individual is hearing impaired. If individuals do not speak English and/or have hearing problems, it may be

necessary to make alternative arrangements, such as using an interpreter, for effective communication while completing the full assessment.

13.12.3 Primary caregiver/emergency contact/primary physician

Record the name, address, relationship and phone numbers (home and work) of caregivers mentioned by the individual. These may include formal and informal caregivers. The first person listed should be the primary caregiver, emergency contact or the person who helps the most. If there is another helper or an emergency contact, record this person on the second line. Use the space for Relationship to record the person's relationship to the individual and whether the person is the primary caregiver, emergency contact or both. Inform the individual that it is necessary to have this information in the event that you are unable to reach the individual or if there is an emergency or crisis that requires immediate attention.

Note: As many individuals no longer have a landline, it is appropriate to enter a cell phone number in the home phone space. An alternate number may be entered in the work phone space in the event the caregiver or emergency contact does not work.

Record the name (first and last), phone number and address of the individual's primary physician. The primary physician is the doctor the person sees most often, the doctor who manages the person's overall medical care, or the doctor who would be called in case of an emergency.

13.12.4 Initial contact

Record the name, relation and phone number of the person making the initial contact or call. This person may actually be the individual. If the person making the contact is from an agency, the relation to the individual would be "professional." In these cases, the individual at the referral agency should be contacted for a follow-up on the referral disposition. If the person calling asks to remain anonymous, enter "anonymous." This information will become part of the individual's file and, as such, will be accessible to the individual and others involved in assisting the individual.

13.12.4.1 Presenting Problem/Diagnosis

Record the reason for the contact or call and, if applicable, the individual's medical diagnosis. It is important to record the presenting problem as described by the caller and the duration of the problem(s) in order to know if the problem is a recent development or perceived to be a crisis.

13.12.5 Current formal services

Formal services are those provided by an agency or organization and are usually paid services. Individuals may not pay directly for the service, but if it is provided and/or organized by an agency or organization, it is considered formal. A list of services is provided, and the assessor should read the entire list to the individual. It may also be necessary to describe some of the services to assist individuals in determining what they receive. Record whether or not the individual currently receives the service, the provider of each service (including complete name and phone number), and the frequency of the service. Days of the weeks and the time of day are also valuable information to include. Formal service definitions are found in Appendix A. When coding services, focus on the type of service rather than the label or name a particular agency might give the service, or the setting where the service is provided.

13.12.6 Financial resources

13.12.6.1 Annual monthly/income

Questioning individuals about their financial status can be difficult. If the individual does not want to discuss income information, then inform him or her that this information is needed to determine the available programs and services for which the individual may be eligible. These questions are general, and it may be necessary to ask additional, more detailed financial questions when actually planning services. Where possible, work with other providers (such as the LDSS eligibility worker) who may have already received this information from the individual to avoid duplicative questions.

- Family Income is the total annual (or monthly) gross income for the family unit. Annual and monthly incomes are provided to help those who may know one amount but not the other. Also, individuals may feel more comfortable saying their income is within a certain range rather than giving a specific amount.

- Family Unit is the basis for determining family income. A minor is a person who is less than 18 years of age whose parent(s) is/are responsible for his or her care. A single family unit may consist of:

    - Spouses with or without their minor dependents;

    - A single individual and his/her minor dependents; or

    - An individual with no minor dependents.

When individuals reside with other persons who are not their spouses and their minors, each shall be considered a separate family unit. Examples of separate family units include:

- Elderly person(s) are considered a separate family unit even when they live in the home of their adult children or a relative;
- A mother (18 and over) and her dependents although living with her parents or another relative;
- The child of an unemancipated minor who lives with her mother and grandparent/s;
- A minor placed in foster care;
- A minor living with a legal guardian is considered a separate family unit if the guardian does not have financial responsibility;
- Unrelated individuals living together or as co-habitating partners, and
- Spouses who are separated are considered separate family units when they are not living together or when they are living together and are not dependent on each other for financial support. This determination can generally be used for the provision of services, but may not be allowable for the determination of financial benefits.

Space is provided to record the number of people in the family unit. There is also space to record, as an option, the actual amount of the monthly income for the family unit.

13.12.6.2 Income sources

Record all sources of income for the family unit. As an option, the assessor may wish to record the amount received from each income source.

- **Black Lung** is a disability trust fund administered by the Department of Labor. This federal compensation program is designed to aid coal workers who have been determined to suffer from pneumoconiosis (Black Lung). Benefit payments can also be made to dependents or survivors.
- **Pension** is a sum of money paid regularly as a retirement benefit from a job.
- **Social Security** includes Social Security retirement, survivors' benefits made by the Social Security Administration (SSA).

- **SSI/SSDI** are payments made by SSA to low income persons who are aged (65 years old or over), blind or disabled (SSI) or to individuals who recently worked but who can no longer work because they have a medical condition that is expected to last at least one year or result in death (SSDI).

- **VA Benefits** include Veterans Administration (VA) pensions and disability payments.

- **Wages/Salary** means wages, salary, commissions, bonuses, or tips for all jobs (before deduction for taxes, etc.) including sick leave pay.

- **Other** may include income from rental, interest from investments, unemployment compensation, regular assistance from family members and regular financial aid from private organizations and churches.

13.12.6.3 Legal representatives

Check all legal representatives the individual has, and record names in the space provided. If someone else has legal authority to make decisions regarding the individual's care, it is essential to include this person in the individual's service delivery or care plan development. It is also helpful to read or obtain a copy of the legal documents which describe the authority given to the representative.

- **Guardian.** Court-appointed individual who is responsible for the personal affairs of an incapacitated person, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, therapeutic treatment, and, if not inconsistent with an order of commitment, regarding the person's residence.

- **Conservator.** Court-appointed individual who is responsible for managing the estate and financial affairs of an incapacitated person.

- **Power of Attorney.** A Power of Attorney is a written authorization for one person to act on behalf of another person (called the principal) for whatever purposes are spelled out in the written document. The Power of Attorney automatically ends upon the mental incapacity of the principal unless the document specifically states that it continues to be valid even after the onset of mental incapacity.

- **Representative Payee**. A person or organization authorized by a government agency to receive and manage a government benefit for a person deemed incapable of managing his own benefit.

13.12.6.4 Benefits/entitlements

- **Auxiliary Grant** is financial assistance for certain needy, aged, blind or disabled persons in adult foster care homes or ALFs whose income is insufficient to cover the cost of their care.

- **Food Stamps** is a federal program to supplement the food budgets of low-income households to help assure eligible persons receive a nutritionally adequate diet. **Note:** This program is currently referred to as the Supplemental Nutrition Assistance Program (SNAP).

- **Fuel Assistance** helps eligible households with the costs of heating their homes.

- **General Relief** is a state/local program that offers limited financial assistance to persons who meet requirements set by each locality.

- **State and Local Hospitalization** is assistance to income resource eligible persons who need to be or have been hospitalized, received emergency room treatment or outpatient hospitalization services.

- **Subsidized Housing** includes rent reduction, rent subsidies, and the state tax credit program.

- **Tax Relief** refers to property tax relief provided by local jurisdictions.

13.12.6.5 Health insurance

Health insurance benefits cover the costs of health care and other related services. Record all types of insurance and the ID numbers.

- **Medicare** number is the social security account number or the health insurance (HI) benefits number issued to the individual who has coverage under Title XVIII, Social Security Amendments of 1965.

- **Medicaid** number is the 12-digit benefit number assigned by the LDSS to an individual who has coverage under Title XIX, Social Security Amendments of 1965. For those who have applied for Medicaid and are awaiting a final decision on eligibility, mark "No" for Medicaid and "Yes" for **Pending.** For individuals who are on spend-down, mark "No" for Medicaid and enter "Spend-Down" in the space next to Medicaid.

- **Other** refers to any public or private insurance coverage other than Medicare or Medicaid.

Also record whether the individual is a Qualified Medicare Beneficiary (QMB) or a Specified Low Income Medicare Beneficiary (SLMB). An individual who is QMB or SLMB has a Medicaid number but is not eligible for the full range of Medicaid reimbursed services. An individual who qualifies as QMB is eligible for Medicaid to pay his Medicare premiums and Medicare co-insurance and deductibles only. An individual who qualifies as a SLMB is eligible for Medicaid to pay his or her Medicare Part B premiums only.

Recipients of QMB receive a Medicaid card, and the QMB status is clearly indicated. Recipients of SLMB do not receive a Medicaid card. Verification of SLMB Medicaid can be obtained by viewing the individual's notification letter issued by the LDSS or with a proper release of information requesting the information from the LDSS.

13.12.7 Physical environment

13.12.7.1 Living arrangement

Record the type of place in which, and the people with whom, the individual is or has been residing. If the individual will be moving to a permanent living arrangement that is different from the one from which he or she is being assessed, record the place where the individual will be permanently residing. For example, if the assessment takes place in a hospital, but the individual will be transferred to an ALF, record the ALF as the living arrangement, not the hospital. If the permanent residence has not yet been chosen, note this. The UAI should be updated with the correct information as soon as it is known. For individuals residing in ALFs, adult foster homes, nursing facilities, facilities operated by the Department of Behavioral Health and Developmental Services or other institutional settings, record the name of the place, the approximate date of admission, and the National Provider Identifier (NPI) or the provider is unable to obtain an NPI, the provider will be assigned an Atypical Provider Identifier (API) by DMAS.

If the individual's usual living arrangement is a facility that is Medicaid certified, it is necessary to obtain the number regardless of the individual's payment status.

- **House** refers to a private residence, including mobile homes. Specify whether this is owned or rented by the individual. Ownership by the individual means the individual's name is on the deed. The "Other" category includes situations where the individual lives in a house owned by family/friends and does not pay rent, or the individual lives in a house for which he or she has lifetime rights, but does not pay rent.

- **Apartment** is a private residence, rented by the individual or by another person.

- **Rented Room(s)** are rooms with or without board, such as motels, hotels, YMCA/YWCA, and private residences. Rented rooms may include a private bath, but the inclusion of a private kitchen for preparing meals would constitute an apartment and should be coded as such.

- **Adult Care Residence** is a residential setting licensed by DSS Division of Licensing Programs, to provide care of four or more adults who are aged, infirm or disabled. **Note:** Adult Care Residence = Assisted Living Facility (ALF).

- **Adult Foster Care (AFC)** is a home setting for three or fewer individuals needing care that has received approval from an LDSS that offers an AFC program.

- **Nursing Facility** refers to a nursing facility licensed by the Department of Health.

- **Mental Health/Mental Retardation (Intellectual Disability) Facility** is a residential or institutional facility licensed by the Department for Behavioral Health and Developmental Services.

- **Other** may include individuals who are transient, living in a shelter or who are homeless.

If the place of residence is house, apartment or rented rooms, the assessor must record with whom the individual lives. Individual names of persons with whom the individual lives are not necessary (though space is provided to record this information), but the relationship should be noted. Assessors may also wish to record ages and relationships of these persons in order to evaluate current/potential sources of informal care.

- **Alone** means no one else lives with the individual.

- **Spouse** means the only person living with the individual is his spouse.

- **Other** includes individuals who live with the spouse and children; individuals who live with relatives other than the spouse and/or children, individuals who live with non-relatives, and any combination of these.

13.12.7.2 Problems

Improvements in the physical condition of the individual's place of residence can be cost-effective in the long run because they help sustain autonomous functioning and decrease dependence. Based on observation and the individual's opinion, the assessor should evaluate the safety, security and support of the environment. Indicate the specific areas in which actual or potential safety or accessibility problems exist by selecting "yes" or checking the relevant item (ePAS). If the individual does not have a problem with an item on the list, select "no" or leave the relevant item blank (ePAS).

It is important to assess physical environment in terms of the individual's particular situation. For example, look for visual smoke alarms for the hearing impaired. Use the space provided to record details about the problem. For example, if the problem is unsanitary conditions, specify if there is insect and/or rodent infestation.

- **Barriers to Access** includes features which make the living arrangement inaccessible to the individual. For example, an individual cannot use stairs and lives in a building with no elevator; the individual cannot use stairs and lives in a 2-story home and the bedrooms are upstairs; the individual is in a wheelchair and the entrance has no ramp, or doorways are too narrow and rooms are too small to maneuver.

- **Electrical Hazards** include frayed electrical cords; over-use of extension cords; plugs partially hanging out of the wall, or poor wiring in the home.

- **Fire Hazards/No Smoke Alarm** includes wall-to-wall clutter; the individual is a smoker and appears to be careless; the individual forgets to turn off the stove; or there are no smoke alarms or an un-vented space heater is used.

- **Insufficient Heat/Air Conditioning** means the temperature is too hot or cold inside the individual's home, or the room is stuffy during summer months.

- **Insufficient Hot Water/Water** could be indicated by an excessive amount of dirty dishes from lack of water; a individual who is dirty and has unpleasant body odor, or a individual who is wearing dirty clothing.

- **Lack of/Poor Toilet Facilities** means the individual has no toilet facilities or toilet facilities exist but are in poor working condition. Specify whether the problem refers to toilet facilities inside or outside the home.

- **Lack of/Defective Stove, Refrigerator, Freezer** means the individual either has no stove, refrigerator, or freezer, or the appliances exist but are in poor working condition.
- **Lack of/Defective Washer/Dryer** means the individual either has no washer or dryer, or they exist but are in poor working condition.
- **Lack of/Poor Bathing Facilities** means the individual either has no bathing facilities or bathing facilities exist but are sub-standard.
- **Structural Problems** include ceilings that have water leaks, dangerous floors, doors that open with difficulty, windows that cannot be opened, or an outside structure that looks crooked.
- **Telephone Not Accessible** means the individual has no telephone and cannot access one from a neighbor or friend.
- **Unsafe Neighborhood** means the individual lives in an area which is unsafe with frequent crime problems.
- **Unsafe/Poor Lighting** includes situations where the home is dark even with the lights on, or there is no or poor lighting outside the house.
- **Unsanitary Conditions** means there is any one or more of the following: an obvious odor in the home, the home is excessively dirty, there is a dirty and odorous bathroom, there is evidence of rodent and/or insect infestation, and/or carpet or furniture are soiled.
- **Other** means any other physical environment problems not categorized above.

13.13 Section 2 of the UAI: Functional Status

Measurements of functional status are commonly used as a basis for differentiating among levels of long-term care giving. Functional status is the degree of independence with which an individual performs ADLs, Ambulation, and IADLs.

ADLs indicate the individual's ability to perform daily personal care tasks. The ADLs include:

- Bathing
- Dressing
- Toileting

- Transferring
- Eating/Feeding
- Bowel and Bladder Control (Continence)

Ambulation is the individual's ability to get around indoors and outdoors, climb stairs and wheel.

IADLs indicate the individual's ability to perform certain social tasks that are not necessarily done every day but which are critical to living independently. The IADLs include:

- Meal Preparation
- Transportation
- Housekeeping
- Shopping
- Laundry
- Using the Telephone
- Money Management
- Home Maintenance

The following information is important to remember when assessing functional status:

- Functional status is a measure of the individual's level of impairment **and** need for personal assistance. Sometimes, level of impairment and need for personal assistance are described by the help received, but this could lead be misleading. For example, a person with a disability who **needs** help to perform an activity in a safe manner, but lives alone, has no formal supports may be described as "receiving no help." Coding the individual's performance as "independent" because no help is received is very misleading in terms of the actual level of need. In order to avoid this type of distortion, interpret the ADLs in terms of what is usually needed to perform the entire activity safely.

- Functional status is based on what the individual is **able** to do, not what he prefers to do. In other words, assess the individual's ability to do particular activities, even if he doesn't usually do the activity. Lack of capacity should be distinguished from lack of motivation, opportunity, choice, or for the convenience

of a caregiver. This is particularly relevant for the IADLs. For example, when asking someone if he can prepare light meals, the response may be "no" he or she does not prepare meals, even though he or she may be able to do so. This person should be coded as not needing help. If an individual refuses to perform an activity, thus putting himself or herself at risk, it is important to probe for the reason why the individual refuses in order to code the activity correctly. The emphasis in this section is on assessing whether ability is impaired. Physical health, mental health, or cognitive or functional disability problems may manifest themselves as the inability to perform ADL, ambulation, and IADL activities. If a person is mentally and physically free of impairment, there is no safety risk to the individual, and the person chooses not to complete an activity due to personal preference or choice, indicate that the person does not need help.

- Functional activities should be coded as to how the individual usually performed the activity over the past two weeks. For example, if an individual usually bathes himself with no help, but on the date of the interview requires some assistance with bathing, code the individual as requiring no help unless the individual's ability to function on the date of the assessment accurately reflects ongoing need.

There are several components to each functional activity, and the coded response is based on the individual's ability to perform **all** of the components. For example, when assessing the individual's ability to bathe, it is necessary to ask about or observe his or her ability to do all of the bathing activities such as getting in and out of the tub, preparing the bath, washing and towel drying. Interviewers will need to probe in detail in order to establish actual functional level. The definitions of each ADL and other functional activities that follow should serve as a guide when probing for additional information. Self reporting on ADLs and other functional activities should be verified by observation or reports of others. This is especially critical when individuals report that they do activities by themselves, but the individual's level of performance or the ability to safely perform the activity is in question.

Some questions in this section are personal and the individual may feel somewhat embarrassed to answer (e.g., toileting, bladder and bowel control). Ask these questions in a straightforward manner and without hesitation. If you ask the questions without embarrassment or hesitation, the individual will be more likely to feel comfortable. If the individual is embarrassed, acknowledge that some of these questions are embarrassing to answer. Let the individual know that answers to these questions are important because they will help you better understand his or her needs and provide a service delivery or care plan that is right for him or her.

There is space at the end of the Functional Status section to record comments. Use this space to comment on functioning in the areas of ADLs, Ambulation, and IADLs.

Comments should include the type of equipment used/needed to perform the activity and/or information about caregivers.

Each item in the functional status section is critical to determining level of care needs; therefore every functional question in this section must have a valid answer. If "yes" is checked in the "Needs Help?" column, the type of help must be also be entered. "Unknown" responses are not allowed.

Note for ePAS Users: The "Needs Help?" column does not appear in the Functional Status section. The assessor selects the type of help for each ADL from the dropdown menu.

Dependence in functional status is used to differentiate among levels of long-term care. The total number of dependencies an individual has will determine the type of care appropriate to meet his or her needs. Dependence includes a continuum of assistance, which ranges from minimal to total.

"Mechanical help only" means an individual is **semi-dependent (d)** in a functional area.

Dependence (D) means an individual needs at least the assistance of another person (human help only) **OR** needs at least the assistance of another person and equipment or a device (mechanical help and human help) to safely complete the activity. Human assistance includes supervision (verbal cues, prompting) or physical assistance (set-up, hands-on-care).

For purposes of **ALF assessment**, an individual would be considered **Totally Dependent (TD)** in each level of functioning when the individual is entirely unable to participate or assist in the activity performed. For purposes of **PAS** the individual would be considered **Dependent (D)** in each level of functioning when the individual is entirely unable to participate or assist in the activity performed.

13.13.1 Levels of functioning

The definitions and/or scoring options for each ADL, ambulation, and IADLs are specifically defined and must be used to obtain an accurate assessment of each of the functional activities. Only ONE choice can be selected for each question. If more than one option applies, record the most dependent option.

- **Needs Help** (does not apply to ePAS) means whether or not the individual needs help (equipment or human assistance) to perform the activity. If the individual does need help, score the specific type of help in the boxes to the right.

- **Mechanical Help Only** means the individual needs equipment or a device to complete the activity, but does not need assistance from another human.

Mechanical Help Only is not a dependency ("D") but rather a small "d" or semi-dependent.

- **Human Help Only** means the individual needs help from another person but does not need to use equipment in order to perform the activity. A need for human help exists when the individual is unable to complete an activity due to cognitive impairment, functional disability, physical health problems, or safety. An unsafe situation exists when there is a negative consequence from not having help (e.g., falls, weight loss, skin breakdown), or there is the potential for a negative consequence to occur within the next 3 months without additional help. The decision that potential exists is based on some present condition such as a situation where the individual has never fallen when transferring but shakes or has difficulty completing the activity. The assessor should not assume that any person over 60 and without help has the potential for negative consequences. Within the human help category, specify whether the assistance needed is supervision or physical assistance. If both supervision and physical assistance are required, the category that should be used is the one reflecting the greatest degree of need, physical assistance. **(D=Dependent)**

  - **Supervision (Verbal Cues, Prompting).** The individual is able to perform the activity without hands-on assistance of another person, but must have another person present to prompt and/or remind him or her to safely perform the complete activity. This code often pertains to people with cognitive impairment, but may include those who need supervision for other reasons.

  - **Physical Assistance (Set-Up, Hands-On Care)**. Physical assistance means hands-on help by another human, including assistance with set-up of the activity.

- **Mechanical Help and Human Help** means the individual needs equipment or a device and the assistance of another person to complete the activity. For this category, specify whether human help is supervision or physical assistance as defined above. **(D=Dependent)**

- **Performed by Others** means another person completes the entire activity and the individual does not participate in the activity at all. **(D=Dependent/TD =Totally Dependent)**

- **Is Not Performed** means that neither the individual nor another person performs the activity. **(D=Dependent/TD=Totally Dependent)**

Note: Guidelines for screening children and evaluating their level of functioning are available in the DMAS PAS Provider Manual, Appendix B on the DMAS portal at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

13.13.2 Activities of daily living

13.13.2.1 Bathing

Bathing entails getting in and out of the tub, preparing the bath (e.g., turning on the water), actually washing oneself, and towel drying. Some individuals may report various methods of bathing that constitute their usual pattern. For example, they may bathe themselves at a sink or basin five days a week, but take a tub bath two days of the week when an aide assists them. The questions refer to the method used **most or all of the time** to bathe the entire body.

- **Does Not Need Help.** Individual gets in and out of the tub or shower, turns on the water, bathes entire body, or takes a full sponge bath at the sink and does not require immersion bathing, without using equipment or the assistance of any other person. **(I = Independent)**

- **Mechanical Help Only.** Individual usually needs equipment or a device such as a shower/tub chair/stool, grab bars, pedal/knee controlled faucet, long-handled brush, and/or a mechanical lift to complete the bathing process. **(d = semi-dependent)**

- **Human Help Only (D=Dependent)**

    - **Supervision (Verbal Cues, Prompting)**. Individual needs prompting and/or verbal cues to safely complete washing the entire body. This includes individuals who need someone to teach them how to bathe.

    - **Physical Assistance (Set-up, Hands-On Care).** Someone fills the tub or brings water to the individual, washes part of the body, helps the individual get in and out of the tub or shower, and/or helps the individual towel dry. Individuals who only need human help to wash their backs or feet would not be included in this category. Such individuals would be coded as "Does Not Need Help".

- **Mechanical and Human Help.** Individual usually needs equipment or a device and requires assistance of other(s) to bathe. **(D=Dependent)**

- **Performed by Others.** Individual is completely bathed by other(s) and does not take part in the activity at all. **(D=Dependent/TD=Totally Dependent)**

13.13.2.2 Dressing

Dressing is the process of getting clothes from closets and/or drawers, putting them on, fastening, and taking them off. Clothing refers to clothes, braces and artificial limbs worn daily. Individuals who wear pajamas or gown with robe and slippers as their usual attire are considered dressed.

- **Does Not Need Help.** Individual usually completes the dressing process without help from others. If the only help someone gets is tying shoes, do not count as needing help. **(I = Independent)**

- **Mechanical Help Only**. Individual usually needs equipment or a device such as a long-handled shoehorn, zipper pulls, specially designed clothing or a walker with an attached basket to complete the dressing process. **(d = semi-dependent)**

- **Human Help Only (D=Dependent)**

    - **Supervision (Verbal Cues, Prompting)**. Individual usually requires prompting and/or verbal cues to complete the dressing process. This category also includes individuals who are being taught to dress.

    - **Physical Assistance (Set-up, Hands-On Care).** Individual usually requires assistance from another person who helps in obtaining clothing, fastening hooks, putting on clothes or artificial limbs, etc.

- **Mechanical and Human Help.** Individual usually needs equipment or a device and requires assistance of other(s) to dress. **(D=Dependent)**

- **Performed by Others**. Individual is completely dressed by another individual and does not take part in the activity at all. **(DD=Dependent/Totally Dependent)**

- **Is Not Performed.** Refers only to bedfast individuals who are considered not dressed. **(D=Dependent/TD=Totally Dependent)**

13.13.2.3 Toileting

Toileting is the ability to get to and from the bathroom, get on/off the toilet, clean oneself, manage clothes and flush. A commode at any site may be

considered the "bathroom" only if in addition to meeting the criteria for "toileting" the individual empties, cleanses, and replaces the receptacle, such as the bed pan, urinal or commode, without assistance from other(s).

- **Does Not Need Help.** Individual uses the bathroom, cleans self, and arranges clothes without help. **(I = Independent)**

- **Mechanical Help Only**. Individual needs grab bars, raised toilet seat or transfer board and manages these devices without the aid of other(s). Includes individuals who use handrails, walkers, or canes for support to complete the toileting process. Also includes individuals who use the bathroom without help during the day and use a bedpan, urinal, or bedside commode without help during the night and can empty this receptacle without assistance. **(d = semi-dependent)**

- **Human Help Only. (D=Dependent)**

    - **Supervision (Verbal Cues, Prompting)**. Individual requires verbal cues and/or prompting to complete the toileting process.

    - **Physical Assistance (Set-up, Hands-On Care).** Individual usually requires assistance from another person who helps in getting to/from the bathroom, adjusting clothes, transferring on and off the toilet, or cleansing after elimination. The individual participates in the activity.

- **Mechanical and Human Help.** Individual usually needs equipment or a device and requires assistance of other(s) to toilet. **(D=Dependent)**

- **Performed by Others.** Individual does use the bathroom, but is totally dependent on another's assistance. Individual does **not** participate in the activity at all. **(D=Dependent/TD=Totally Dependent)**

- **Is Not Performed**. Individual does not use the bathroom. **(D=Dependent/TD=Totally Dependent)**

13.13.2.4 Transferring

Transferring means the individual's ability to move between the bed, chair, and/or wheelchair. If a person needs help with some transfers but not all, code assistance at the highest level.

- **Does Not Need Help.** Individual usually completes the transferring process without human assistance or use of equipment. **(I= Independent)**

- **Mechanical Help Only**. Individual usually needs equipment or a device, such as lifts, hospital beds, sliding boards, pulleys, trapezes, railings, walkers or the arm of a chair, to safely transfer, and individual manages these devices without the aid of another person. **(d = semi-dependent)**

- **Human Help Only (D=Dependent)**

    - **Supervision (Verbal Cues, Prompting).** Individual usually needs verbal cues or guarding to safely transfer.

    - **Physical Assistance (Set-up, Hands-On Care).** Individual usually requires the assistance of another person who lifts some of the individual's body weight and provides physical support in order for the individual to safely transfer.

- **Mechanical and Human Help.** Individual usually needs equipment or a device and requires the assistance of other(s) to transfer. **(D=Dependent)**

- **Performed By Others.** Individual is usually lifted out of the bed and/or chair by another person and does not participate in the process. If the individual does not bear weight on any body part in the transferring process he/she is not participating in the transfer. Individuals who are transferred with a mechanical or Hoyer lift are included in this category. **(D=Dependent/TD=Totally Dependent)**

- **Is Not Performed.** The individual is confined to the bed. **(D=Dependent/TD=Totally Dependent)**

13.13.2.5 Eating/Feeding

Eating/Feeding is the process of getting food/fluid by any means into the body. This activity includes cutting food, transferring food from a plate or bowl into the individual's mouth, opening a carton and pouring liquids, and holding a glass to drink. This activity is the process of eating food after it is placed in front of the individual.

- **Does Not Need Help**. Individual is able to perform all of the activities without using equipment or the supervision or assistance of another. **(I = Independent)**

- **Mechanical Help Only**. Individual usually needs equipment or a device, such as hand splints, adapted utensils, and/or nonskid plates, in order to complete the eating process. Individuals needing mechanically adjusted diets (pureed food) and/or food chopped are included in this category. **(d = semi-dependent)**

- **Human Help Only (D=Dependent)**
    - **Supervision (Verbal Cues, Prompting)**. Individual feeds self, but needs verbal cues and/or prompting to initiate and/or complete the eating process.
    - **Physical Assistance (Set-up, Hands-On Care)**. Individual needs assistance to bring food to the mouth, cut meat, butter bread, open cartons and/or pour liquid due to an actual physical or mental disability (e.g., severe arthritis, Alzheimer's). This category must **not** be checked if the individual is able to feed himself but it is more convenient for the caregiver to complete the activity.
- **Mechanical and Human Help.** Individual usually needs equipment or a device and requires assistance of other(s) to eat. **(D=Dependent)**
- **Performed By Others.** Includes individuals who are spoon fed; fed by syringe or tube, or individuals who are fed intravenously (IV). Spoon fed means the individual does not bring any food to his mouth and is fed completely by others. Fed by syringe or tube means the individual usually is fed a prescribed liquid diet via a feeding syringe, NG-tube (tube from the nose to the stomach) or G-tube (opening into the stomach). Fed by I.V. means the individual usually is fed a prescribed sterile solution intravenously. **(D=Dependent/TD=Totally Dependent)**

13.13.2.6 Continence

Continence is the ability to control urination (bladder) and elimination (bowel). Incontinence may have one of several different causes, including specific disease processes and side effects of medications. Helpful questions include, "Do you get to the bathroom on time?"; "How often do you have accidents?", and "Do you use pads or adult diapers?"

Bowel continence is the physiological process of elimination of feces.

- **Does Not Need Help.** The individual voluntarily controls the elimination of feces. If the individual on a bowel program never empties his or her bladder without stimulation or a specified bowel regimen, he or she is coded as "Does not need help," and the bowel/bladder training is noted under medical/nursing needs. In this case, there is no voluntary elimination; evacuation is planned. If a individual on a bowel regimen also has occasions of bowel incontinence, then he or she would be coded as incontinent, either less than weekly or weekly or more. **(I = Independent)**

- **Incontinent Less than Weekly.** The individual has involuntary elimination of feces less than weekly (e.g., every other week). **(d = semi-dependent)**

- **Ostomy - Self Care.** The individual has an artificial anus established by an opening into the colon (colostomy) or ileum (ileostomy) and he completely cares for the ostomy, stoma, and skin cleansing, dressing, application of appliance, irrigation, etc. Individuals who use pads or adult diapers and correctly dispose of them should be coded here. **(d = semi-dependent)**

- **Incontinent Weekly or More.** The individual has involuntary elimination of feces at least once a week. Individuals who use pads or adult diapers and do not correctly dispose of them should be coded here. **(D=Dependent)**

- **Ostomy - Not Self Care.** The individual has an artificial anus established by an opening into the colon (colostomy) or ileum (ileostomy) and another person cares for the ostomy: stoma and skin cleansing, dressing, application of appliance, irrigations, etc. **(D=Dependent/TD=Totally Dependent)**

Bladder continence is the physiological process of elimination of urine.

- **Does Not Need Help**. The individual voluntarily empties his or her bladder. Individuals on dialysis who have no urine output would be coded "Does not need help" as he or she does not perform this process. Dialysis will be noted under medical/nursing needs. Similarly, individuals who perform the Crede method for himself or herself for bladder elimination would also be coded "Does not need help." **(I = Independent)**

- **Incontinent Less than Weekly.** The individual has involuntary emptying or loss of urine less than weekly. **(d = semi-dependent)**

- **External Device, Indwelling Catheter, or Ostomy - Self Care.** The individual has an urosheath or condom with a receptacle attached to collect urine (external catheter); a hollow cylinder passed through the urethra into the bladder (internal catheter) or a surgical procedure that establishes an external opening into the ureter(s) (ostomy). The individual completely cares for urinary devices (changes the catheter or external device, irrigates as needed, empties and replaces the receptacle) and the skin surrounding the ostomy. Individuals who use pads or adult diapers and correctly dispose of them should be coded here. **(d = semi-dependent)**

- **Incontinent Weekly or More.** The individual has involuntary emptying or loss of urine at least once a week. Individuals who use pads or adult diapers and do not correctly dispose of them should be coded here. **(D=Dependent)**

- **External Device - Not Self Care.** Individual has an urosheath or condom with a receptacle attached to collect urine. Another person cares for the individual's external device. **(D=Dependent/TD=Totally Dependent)**

- **Indwelling Catheter - Not Self Care.** Individual has a hollow cylinder passed through the urethra into the bladder. Another person cares for the individual's indwelling catheter. This category includes individuals who self-catheterize, but who need assistance to set-up, clean up, etc. **(D=Dependent/TD=Totally Dependent)**

- **Ostomy - Not Self Care.** Individual has a surgical procedure that establishes an external opening into the ureter(s). Another person cares for the individual's ostomy. **(D=Dependent/TD=Totally Dependent)**

13.13.2.7 Ambulation

Ambulation is the ability to get around indoors (walking) and outdoors (mobility), climb stairs and wheel. Individuals who are confined to a bed or chair must be shown as needing help for all ambulation activities. This is necessary in order to show their level of functioning/dependence in ambulation accurately. Individuals who are confined to a bed or a chair are coded **Is Not Performed** for all ambulation activities. Specific information for each ambulation activity is given below.

Walking is the process of moving about indoors on foot or on artificial limbs.

- **Does Not Need Help**. Individual usually walks steadily more than a few steps without the help of another person or the use of equipment. Do not code here individuals confined to a bed or a chair. **(I = Independent)**

- **Mechanical Help Only**. Individual usually needs equipment or a device to walk. Equipment or device includes splints, braces, crutches, special shoes, canes, walkers, handrails and/or furniture. **(d = semi-dependent)**

- **Human Help Only (D = Dependent)**

    - **Supervision (Verbal Cues, Prompting)**. Individual usually requires the assistance of another person who provides verbal cues or prompting.

- **Physical Assistance (Set-up, Hands-On Care)**. Individual usually requires assistance of another person who provides physical support, guarding, guiding or protection.

- **Mechanical and Human Help.** Individual usually needs equipment or a device and requires assistance of other(s) to walk. **(D = Dependent)**

- **Is Not Performed.** The individual does not usually walk. Individuals who are bedfast would be coded here. The individual may be able to take a few steps from bed to chair with support, but this alone does not constitute walking and should be coded as **Is Not Performed**. **(D = Dependent)**

Wheeling is the process of moving about by a wheelchair. The wheelchair itself is not considered a mechanical device for this assessment section.

- **Does Not Need Help**. The individual usually does not use a wheelchair, or the individual uses a wheelchair and independently propels it. Do not code here individuals confined to a bed or chair. **(I = Independent)**

- **Mechanical Help Only**. Individual usually needs a wheelchair equipped with an adaptation(s) such as an electric chair, amputee chair, one-arm drive, or removable armchair. **(d = semi-dependent)**

- **Human Help Only (D = Dependent)**

  - **Supervision (Verbal Cues, Prompting)**. Individual usually needs a wheelchair and requires the assistance of another person who provides prompting or cues.

  - **Physical Assistance (Set-up, Hands-On Care)**. Individual usually needs a wheelchair and requires assistance of another person to wheel.

- **Mechanical and Human Help.** Individual usually needs an adapted wheelchair and requires assistance of other(s) to wheel. **(D = Dependent)**

- **Performed By Others.** Individual is transported in a wheelchair and does not propel or guide it. The individual may wheel a few feet within his own room or within an activity area, but this alone does not constitute wheeling. **(D = Dependent)**

- **Is Not Performed.** The individual is confined to a chair or a wheelchair that is not moved, or the individual is bedfast. This does not include individuals who usually do not use a wheelchair to move about. **(D = Dependent)**

Stair Climbing is the process of climbing up and down a flight of stairs from one floor to another. If the individual does not live in a dwelling unit with stairs, ask whether he can climb stairs if necessary.

- **Does Not Need Help**. Individual usually climbs up and down a flight of stairs by himself without difficulty. Do not code here individuals confined to a bed or a chair. **(I = Independent)**

- **Mechanical Help Only**. Individual usually needs equipment or a device to climb stairs. Equipment or device includes splints, special shoes, leg braces, crutches, canes, walkers and special hand railings. Regular hand railings are considered equipment if the person is dependent upon them to go up or down the stairs. **(d = semi-dependent)**

- **Human Help Only (D = Dependent)**

    - **Supervision (Verbal Cues, Prompting)**. Individual usually requires assistance, such as guiding and protecting, from another person.

    - **Physical Assistance (Set-up, Hands-On Care)**. Individual usually requires assistance from another person who physically supports the individual climbing up or down the stairs.

- **Mechanical and Human Help.** Individual usually needs equipment or a device and requires assistance of other(s) to climb stairs. **(D = Dependent)**

- **Is Not Performed.** The individual is unable to climb a flight of stairs due to mental or physical disabilities. **(D = Dependent)**

Mobility is the extent of the individual's movement outside his or her usual living quarters. Evaluate the individual's ability to walk steadily and his or her level of endurance.

- **Does Not Need Help**. Individual usually goes outside of his or her residence on a routine basis. If the only time the individual goes outside is for trips to medical appointments or treatments by ambulance, car, or van, do not code the individual here because this is not considered going outside. These individuals would be coded either in the "confined - moves about" or "confined - does not move about" categories. **(I = Independent)**

- **Mechanical Help Only**. Individual usually needs equipment or a device to go outside. Equipment or device includes splint, special shoes, leg

braces, crutches, walkers, wheelchairs, canes, handrails, chairlifts, and special ramps. **(d = semi-dependent)**

- **Human Help Only (D = Dependent)**
    - **Supervision** (Verbal Cues, Prompting). Individual usually requires assistance from another person who provides supervision, cues, or coaxing to go outside.
    - **Physical Assistance** (Set-up, Hands-On Care). Individual usually receives assistance from another person who physically supports or steadies the individual to go outside.
- **Mechanical and Human Help**. Individual usually needs equipment or a device and requires assistance of other(s) to go outside. **(D = Dependent)**
- **Confined - Moves About**. Individual does not customarily go outside of his or her residence, but does go outside of his or her room. **(D = Dependent)**
- **Confined - Does Not Move About**. The individual usually stays in his or her room. **(D = Dependent)**

13.13.3 Instrumental activities of daily living

IADLs are more complex than activities related to personal self-care. Personal motivation may play a very important role in a person's ability to perform IADLs. For example, a depressed person may neglect activities such as cooking and cleaning. IADLs may also measure a person's social situation and environment rather than ability level. For example, the inability to cook, for one who has never cooked, does not necessarily reflect impaired capacity. In both of these situations, the assessor should probe to get information about the type of help needed to do the activity.

- **Does Not Need Help** means the individual does not require personal assistance from another to complete the entire activity in a safe manner. Individuals who need equipment, but receive no personal assistance, are included in this category. **(I = Independent)**
- **Does Need Help** means the individual needs personal assistance, including supervision, cueing, prompts, set-up, and/or hands-on help to complete the entire activity in a safe manner. **(D = Dependent)**
    - **Meal Preparation:** The ability to plan, prepare, cook, and serve food. If it is necessary for someone to bring meals to the individual, which he or she reheats, this is considered needing help.

- **Housekeeping:** The ability to do light housework such as dusting, washing dishes, making the bed, vacuuming, cleaning floors, and cleaning the kitchen and bathroom.

- **Laundry** (washing and drying clothes): This includes putting clothes in and taking them out of the washer/dryer and/or hanging clothes on and removing them from a clothesline, and ironing, folding, and putting clothes away. If the individual lives with others and does not do his or her own laundry, be sure to ask whether he or she could do laundry.

- **Money Management:** This does not refer to handling complicated investments or taxes. It refers to the individual's ability to manage day-to-day financial matters such as paying bills, writing checks, handling cash transactions, and making change.

- **Transportation**: The ability to use transportation as well as access to transportation. It includes the ability to either transport oneself or arrange for transportation, to get to and from, and in and out of the vehicle (i.e., a car, taxi, bus, or van). It is important to make note of the individual's main source of transportation, especially for those who rely on public services.

- **Shopping**: The ability to get to and from the store, obtain groceries and other necessary items such as clothing, toiletries, household goods and supplies, pay for them, and carry them home. Not having access to transportation does not make the person dependent in shopping. It is important to determine whether the individual would be able to shop by himself, regardless of whether he or she currently has help with shopping.

- **Using the Telephone**: The individual's ability to look up telephone numbers, dial, hear, speak on, and answer the telephone. If the individual has no telephone, ask about the ability to use some else's telephone.

- **Home Maintenance:** The ability to do activities such as yard work, making minor repairs, carrying out the trash and washing windows. These activities are less frequent than housework activities.

13.14 Section 3 of the UAI: Physical health assessment

13.14.1 Professional visits/medical admissions

13.14.1.1 Doctors' names

Record the names of all doctors the individual currently sees. This includes psychiatrists or other physicians seen for emotional or mental health conditions. In the spaces provided, list each doctor's telephone number and the date and reason for the last visit to the doctor.

- **Note for ePAS users:** Exact dates are required in ePAS. If the individual has difficultly remembering an exact date, the assessor should prompt the individual. If prompting still does not result in an exact date, the assessor should enter a date and note in an appropriate section of the UAI that this date is a best estimate.

- **Example:** The individual is unable to remember the exact date but can recall the visit "was in early Spring about 2 years ago." The assessor's additional prompting does not help the individual remember the date. Therefore, the assessor should enter 04/01/2013 and note in the comments or summary section of the UAI that "the 4/1/2013 date is an estimate" if the assessor can't determine later the exact date from another source (e.g. hospital records, medical office staff) before the assessment is submitted.

13.14.1.2 Admissions

Record any admissions to hospitals, nursing facilities, or ALFs in the past 12 months for medical or rehabilitation reasons. Record the name of the place, the admission date, and the length of stay, and reason for the admission. If there have been multiple hospital, nursing facility, or ALF admissions in the past 12 months, only record the most recent one in the space provided. Other admissions can be recorded in the Comment Section. Do not include admissions for emotional or psychological conditions here; these are documented in the Psycho-Social Assessment section, page 10. Emergency room visits or "observation status" hospitalizations are not considered admissions; dates of emergency room visits should be recorded in the Comments Section.

13.14.1.3 Advance directives

The Virginia Advance Medical Directive has three components: the Living Will, the Durable Power of Attorney for Health Care, and Appointment of Agent to Make Anatomical Gift. The Living Will and the Durable Power of Attorney for

Health Care allow an individual to name another person to make decisions on his behalf when death is inevitable, when the individual is in a persistent vegetative state, or when the individual is not dying but is unable to make his own decision. Use the space provided to record where any documents are located and/or who has the documents. Other advance directives might include prepaid funeral or burial funds, or in the case of an appointment of an agent to make an anatomical gift, they might include organ donation.

13.14.2 Diagnoses and medication profile

13.14.2.1 Diagnoses

The assessor must record all diseases and injuries that the individual's physician or physicians have diagnosed. A suggested way to gather this information is to say, "Has a doctor told you that you have (review the list)?" The diagnoses include mental illness and intellectual disability (mental retardation) diagnoses. General information on diagnoses is provided in Appendix B. Record the name of each active diagnosis and the date of onset. The objective is to get a sense of how long the problem has existed.

Review the list of diagnoses and codes and enter the codes for the three major, active diagnoses confirmed by a physician.

If there are more than three major, active diagnoses, code the unstable and/or life threatening ones first. Any active diagnosis not listed should be given a code of "42." If the individual currently has no active diagnoses, do not enter any information in this section. The intent of coding only diagnoses that are determined by a physician is to avoid coding ailments, complaints, etc. that have not been verified by a medical professional. However, information about ailments, complaints, and other problems is important and may indicate a need for follow-up and/or a medical evaluation. Assessors do not code this information, but should still note it in the Comment Section of the UAI.

Common long-term care and medical abbreviations can be found in Appendix D.

13.14.2.2 Medications

List all medications, including prescription and over-the-counter (OTC), which the individual currently takes. The assessor should consider using a medication manual such as the Merck Manual or a similar tool when completing this section. Helpful resources are listed in Appendix G.

Prescribed medications include those to be taken regularly and those ordered to be taken as needed (PRN). OTC medications include vitamins, laxatives,

antacids, etc. If possible, record the dose (amount), frequency (number of times per day the medication is taken), route of admission (i.e., by mouth, injection, inhalant, suppository) and reason prescribed. It is helpful to ask to see medication bottles in order to record the information requested and to check the last refill date to confirm that necessary medication is currently being taken.

Record the total number of medications the individual is currently taking. Although the history of medication use is important, only record the number of current medications. For individuals taking multiple medications, it is important to find out about potential interactions between prescribed, over-the-counter, or both types of medications.

Record how many of the individual's medications are tranquilizers and/or psychotropic drugs. Psychotropic drugs include any substances that have an altering effect on the mind.

Note: If the individual is not currently taking any medications, do not enter any medications on the ePAS UAI. Select "Without Assistance for the question "How do you take your medications?" If the assessor is completing a paper UAI write in "0" for "Total number of medications." Enter "no" as the answer to the question "Do you have any problems with medicines?" and check "Without Assistance" for the question "How do you take your medications?" Ignore the instructions on the UAI to "Skip to Sensory Functions."

Record any issues related to either getting or taking medicine. These are not necessarily problems that have been confirmed/diagnosed by a physician. "Taking them as Instructed/Prescribed" should be selected if the individual is non-compliant with his medication regime.

Assess how the individual takes his medicine. Focus on what is needed rather than what is happening. For example, an individual who is able to take his or her medicine without any help, but who uses assistance because it is available should be coded as "Without Assistance." Likewise, an individual who is taking his or her medication without any help, but who clearly needs help because he or she is not taking the medicine correctly, should be coded as one of the other methods of taking medications. For those needing some type of assistance taking medicine, use the space provided to record the type of help and the name of the helper. It is very important to record accurate information here because this question is critical to determining eligibility for some LTSS.

- **Without Assistance or No Medications** means the individual takes medication without any assistance from another person or does not take any medications.

- **Administered/Monitored by lay person(s)** means the individual needs assistance of a person without pharmacology training to either administer or monitor medications. This includes medication aides in ALFs (certified but not licensed).

- **Administered/Monitored by Professional Nursing Staff** means the individual needs licensed or professional health personnel to administer or monitor some or all of the medications.

13.14.3 Sensory functions

13.14.3.1 Vision, Hearing, and Speech

Sensory functions refer to sight, hearing and speech. Code the greatest degree of impairment for each function. If there is an impairment, mark whether or not there is compensation. If there is compensation, record the type/method. If there is no compensation, record the reason for the lack of compensation. Use the space in the box to also record the date of onset of the impairment and the type of impairment. In the last column, record the date of the individual's last eye, ear and speech exam. See Section 13.14.1.1 regarding use of exact dates in ePAS. Individuals, who have difficultly seeing print in a newspaper or book, cannot see faces well enough to recognize people, bump into furniture or other objects, or who have a diagnosis of glaucoma or other vision impairment should be referred to the Department for the Blind and Vision Impaired for a more specialized assessment.

- **No Impairment** means no loss of vision or hearing, or the individual speaks with no impediment.

- **Impairment - Compensation** means seeing/hearing is restricted in one or both eyes/ears and compensation improves sight/hearing, or there are impairments to the normal production of speech and compensation improves speech. Compensation includes the effective use of devices such as glasses, hearing aids and communication boards.

- **Impairment - No Compensation** means seeing/hearing is restricted in one or both eyes/ears and either compensation does not improve sight/hearing or there is no compensation, or there are impairments to the normal production of speech and either compensation does not improve speech or there is no compensation.

- **Complete Loss** means the individual has no vision/hearing abilities and/or has lost the ability to process language/produce speech.

13.14.4 Physical status

13.14.4.1 Joint motion

Assess the individual's ability to move his or her fingers, arms and legs (active Range of Movement (ROM)) or, if applicable, the ability of someone else to move the individual's fingers, arms and legs (passive ROM). If necessary, the assessor may ask the individual to demonstrate if he or she can raise his or her arms above his or her head or wiggle his or her fingers.

- **Within Normal Limits or Instability Corrected** means the joints can be moved to functional motion without restriction, or a joint does not maintain functional motion and/or position when pressure or stress is applied but has been corrected by the use of an appliance or by surgical procedure. **(I = Independent)**

- **Limited Motion** means partial restriction in the movement of a joint including any inflammatory process in the joint causing redness, pain and/or swelling that limits the motion of the joint. **(d = semi-dependent)**

- **Instability Uncorrected or Immobile** means a joint does not maintain functional motion and/or position when pressure or stress is applied and the disorder has not been surgically corrected or an appliance is not used, or there is total restriction in the movement of a joint (e.g., contractures, which are common in individuals who have had strokes). **(D = Dependent)**

13.14.4.2 Fractures/Dislocations

Record whether or not the individual has ever fractured or dislocated bones. If "None" is selected, skip the next two questions in the column. If the individual fractured or dislocated a bone, record the type of fracture/dislocation, whether a rehabilitation program was completed and the date the fracture/dislocation occurred.

- **Hip Fracture** is a fracture that occurs in the proximal end of the thighbone (femur) near the hip.

- **Other Broken Bones** means broken bones in other parts of the body. This category includes compression fractures.

- **Dislocation** is the displacement or temporary removal of a bone from its normal position in the joint.

- **Combination** is a combination of broken bone(s), fractures and dislocation(s).

- **Previous Rehabilitation Program** refers to the completion of a planned therapy and/or other restorative program intended to improve or restore the individual's functional use of the part of the body impaired by the dislocation or fracture.

- **Date** refers to how recently the fracture(s) or dislocation(s) occurred.

13.14.4.3 Missing limbs

Record whether or not the individual is missing all or part of an upper or lower extremity due to trauma, congenital malformation or surgical procedure. If "None" is selected, skip the next two questions in the column. If the individual has a missing limb, record the type of missing limb, whether a rehabilitation program was completed, and the date of the amputation.

- **Fingers or Toes** means the absence of one or more fingers and/or toes.

- **Arm** means the absence of some portion of the hand, lower arm, elbow, or upper arm to the shoulder joint.

- **Leg** means the absence of some portion of the foot, lower leg, or upper leg to the hip joint.

- **Combination** is any combination of missing limbs.

- **Previous Rehabilitation Program** refers to the completion of a planned program of therapy and/or other restorative program intended to improve or restore the individual's ability to perform the functions of the missing body part.

- **Date** refers to how recently the loss of the missing limb occurred.

13.14.4.4 Paralysis/paresis

Record whether or not the individual has ever suffered from paralysis or paresis. **Paralysis** is the loss of voluntary motion of a part of the body with or without the loss of sensation. **Paresis** is partial or incomplete paralysis (i.e., weakness). If "None" is selected, skip the next two questions in the column. If the individual has ever suffered from paralysis or paresis, record the type of paralysis/paresis, whether a rehabilitation program was completed, and the date of onset.

When recording the type of paralysis/paresis, use as much detail as possible.

- Paraplegic means paralysis of the lower half of the body, including both legs;
- Hemiplegic means paralysis of one side of the body, including both the arm and leg; or
- Quadriplegic means paralysis of the body, including all four extremities.

Code paralysis/paresis as follows:

- **Partial Paralysis/Paresis** is the paralysis of a single extremity, part of an extremity, one half of the body, one side of the body and/or a combination of these.
- **Total Paralysis/Paresis** is the paralysis of both sides of the body or the entire body.
- **Previous Rehabilitation Program** refers to the completion of a planned therapy and/or other restorative program intended to improve or restore the individual's functional use of the part of the body paralyzed.
- **Onset** refers to how recently the paralysis/paresis occurred.

13.14.5 Nutrition

13.14.5.1 Height/weight

Record what the individual reports to be his or her height (in inches) and weight (in pounds). If the individual has undergone a bilateral amputation, record his or her height prior to the amputation. Record whether there has been recent weight gain and/or loss over 10 percent. If yes, provide details in the space provided (e.g., indicate whether recent weight change is gain or loss). This question is important because a 10% unintentional weight gain or loss may indicate a health problem.

If the individual is unable to report his weight, the assessor should consult with others who may have this information or use his or her professional judgment to estimate the individual's weight. Height and weight must be recorded.

13.14.5.2 Special diet

Record whether the individual is on a special diet, as prescribed by a physician.

- **Low Fat/Low Cholesterol** - Protein and carbohydrates are increased with a limited amount of fat in the diet. (This diet is often prescribed for

individuals with heart disease, gallbladder disease, disorders of fat digestion, and liver disease.)

- **No/Low Salt** - Either no salt or only a specific amount of sodium (salt) is allowed. (Low sodium diets are often ordered for individuals with heart disease, high blood pressure, liver disease, or kidney disease.)

- **No/Low Sugar** - The amount of carbohydrates, starch, protein and fat, and the number of calories are regulated. (No/Low sugar diets are often ordered for individuals with hypoglycemia, hyperglycemia and diabetes.)

- **Combination/Other** - Combination of low fat/cholesterol and no/low salt/sugar, or some other special diet. An example of a special diet is fluid restriction due to kidney problems. Specify the type of combination/other special diet in the space provided.

13.14.5.3 Dietary supplements

Record whether or not the individual takes food or fluid in addition to regular meals to supplement nutritional intake (e.g., Ensure, Isocal, or Sustacal). Assessors should note whether dietary supplements are prescribed by a physician.

- **Occasionally** - Supplements are taken less than daily.

- **Daily, Not Primary Source** - Supplements are taken daily, but are not the primary source of nutrition. In other words, the individual eats some food, but supplements are taken daily to add nutrients and/or calories.

- **Daily, Primary Source** - Individual may be unable to take oral nutrition, or oral intake that can be tolerated is inadequate to maintain life. Supplements are taken daily and the focus is on maintenance of weight and strength. These individuals may still eat other food. Equipment may be used to take the supplement(s).

- **Daily, Sole Source -** Individual is unable to swallow or absorb any oral nutrition and equipment must be used (nasogastric tube (NG tube) or gastric tube (G-tube)). For these individuals, the supplement is all they take.

13.14.5.4 Dietary problems

- **Food Allergies** refers to specific foods to which the individual is allergic. It is important to distinguish between real food allergies and personal

dislikes. The assessor should note the type of food allergy in the space available.

- **Inadequate Food/Fluid Intake** means the amount of food/fluid intake is not adequate for daily requirements.
- **Nausea/Vomiting/Diarrhea** which occurs before or after eating or another time of day.
- **Problems Eating Certain Foods** means certain foods cannot be eaten or must be eaten very carefully (e.g., small bites chewed thoroughly).
- **Problems Following Special Diets** means the individual does not understand and/or follow the treatment plan resulting in health problems. One example is a diabetic who does not follow his or her diet plan.
- **Problems Swallowing** refers to structural problems with the esophagus (stricture, tumor, or cancer of the palate, mouth, or throat or result of a neurological condition such as a CVA or Parkinson's disease).
- **Taste Problems** means individuals refuse foods because of an inability to taste or taste that is unacceptable.
- **Tooth or Mouth Problems** may include problems which make it difficult to chew. Note dental problems, such as decaying teeth or need for adequately fitting dentures, in the space available. Be specific when asking about dentures (i.e., "Do you have dentures?", "Are they causing pain?", "Do they fit properly?")
- **Other** means to specify other problem(s) that make it difficult for the individual to eat.

13.14.6 Current medical services

13.14.6.1 Rehabilitation therapies

Record all medical-social rehabilitation therapies professionally prescribed and currently administered by qualified trained personnel to maintain the individuals present status or to improve or resolve a complication or condition resulting from an illness or injury. Do not include maintenance activities provided by untrained, non-professional (e.g. the continuation of therapy which is not under direct supervision of a trained therapist).

- **Occupational Therapy** is training in self-care activities to improve functioning in ADLs/IADLs.

- **Physical Therapy** includes treatments of the muscular system to relieve pain, restore function and/or maintain performance.

- **Reality/Re-motivation** includes small group activities to stimulate awareness, interaction, verbalization, self-esteem and self-sufficiency.

- **Respiratory Therapy** includes chest therapy, breathing treatments and inhalation therapy.

- **Speech Therapy** includes services to correct and improve speech and language.

13.14.6.2 Pressure ulcers

A pressure ulcer is ulceration or dead tissue overlying a bony prominence that has been subjected to pressure or friction. Other terms used to indicate this condition include bedsores and decubitus ulcers. If a pressure ulcer(s) is/are present, record the highest stage or most severe ulcer on the individual's body. Note the location and approximate size of the ulcer if known.

It is important to accurately assess pressure ulcers. Additional information about pressure ulcers is located at on the National Pressure Ulcer Advisory Panel website. Descriptions of pressure ulcer stages and categories are also available. The following descriptions of pressure ulcers are very brief and should be used in conjunction with other resources in order to fully assess any pressure ulcers that may be present.

- **Stage I** is a persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Stage I ulcers commonly appear on parts of the body that protrude out, such as elbows.

- **Stage II** is a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

- **Stage III** is a full thickness loss of skin, exposing the subcutaneous tissues which presents as a deep crater with or without undermining adjacent tissue.

- **Stage IV** is when a full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone.

13.14.6.3 Special medical procedures

Record all treatments ordered by the individual's physician(s). These include procedures administered by the individual or family or those provided or

supervised by licensed nursing personnel. If the procedure is not self-administered, make note of the person providing the treatment. For all procedures, record the site, type and frequency.

- **Bowel/Bladder Training** is training to restore control of bowel or bladder functioning. Programs to control the timing of involuntary bowel/bladder emptying are not considered special medical procedures.

- **Dialysis** is the mechanical purification of the blood by filtering toxins or poisons from the blood, a function normally performed by the kidneys.

- **Dressing/Wound Care** is the application of material to any type of wound that is more than a simple redness or abrasion (e.g., pressure ulcer, surgical wound, skin tear, second-degree or third-degree burn) for the purpose of promoting healing, for exclusion of air or for the absorption of drainage.

- **Eye care** refers to the administration of prescribed eye drops or ointment.

- **Glucose/Blood Sugar** is the routine testing or monitoring of sugar level in the blood.

- **Injections/IV Therapy** includes injections (shots) administered by the individual, caregiver, or health care professional, or professional teaching on the administration of injections.

- **Oxygen** is the use of continuous or intermittent oxygen via nasal catheter, mask or oxygen tent.

- **Radiation/Chemotherapy** is the treatment of cancer with radiation or drug therapy.

- **Restraints** are uses of appliances (physical) or medications (chemical) to restrict/confine movement.

- **Range of Motion (ROM) Exercises** are exercises prescribed to move joints through full motion.

- **Trach Care/Suctioning** is the cleaning or changing of an artificial (or mechanical) airway in the trachea.

- **Ventilator** care is the care of ventilator dependent individuals. These individuals are unable to breathe on their own or are unable to breathe deeply or often enough to maintain an adequate level of oxygen in the blood.

13.14.7 Medical/nursing need

Based on the individual's overall condition, the assessor should evaluate whether the individual has ongoing medical or nursing needs. An individual with medical or nursing needs is someone whose health needs require medical or nursing supervision, or care above the level which could be provided through assistance with ADLs, medication administration and general supervision, and is not primarily for the care and treatment of a mental health diagnosis (mental health diagnosis applies to conditions of mental illness; it does not include conditions of dementia/Alzheimer's disease). Medical or nursing supervision or care is required when any one of the following describes the individual's need for medical or nursing supervision:

- 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; or

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

- The individual requires at least one ongoing medical or nursing service. The following is a non-exclusive list of medical or nursing services which may indicate a need for medical or nursing supervision or care:

    - Application of aseptic dressings;

    - Routine catheter care;

    - Respiratory therapy;

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

    - Therapeutic exercise and positioning;

    - Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder;

    - Use of physical (e.g., side rails, posey vests,) and/or chemical restraints (e.g. overuse of sedatives).

- Routine skin care to prevent pressure ulcers for individuals who are immobile;
- Care of small, uncomplicated pressure ulcers and local skin rashes;
- Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;
- Chemotherapy;
- Radiation;
- Dialysis;
- Suctioning;
- Tracheostomy care;
- Infusion therapy; and
- Oxygen.

"Ongoing" means that the medical/nursing needs are continuing, not temporary, or where the patient is expected to undergo or develop changes with increasing severity in status. "Ongoing" refers to the need for daily direct care and/or supervision by a licensed nurse that cannot be managed on an outpatient basis.

Specify the ongoing medical/nursing needs in the space provided. An individual who is receiving rehabilitation services and/or a special medical procedure does not automatically have ongoing medical or nursing needs.

For PAS purposes, individuals in the early stages of dementia/Alzheimer's disease who require some supervision and reminders will NOT have developed medical/nursing needs. However, as the disease progresses, the individual will require daily observation and assessment to prevent destabilization. The areas of observation frequently include supervision for adequate nutrition and hydration due to recent history of weight loss or inadequate hydration or the use of physical/chemical restraints.

In addition, a person with dementia can be determined to have medical/nursing needs even if the individual's current medical condition appears stable. Such individuals are usually unable to self-observe and/or report any physical symptoms of illness, are unable to control adequate food and fluid intake without close supervision, and may require, depending on behavior pattern, the use of a physical or chemical restraint or must be restricted to a secured environment. However, if the

individual being assessed is seeking nursing facility placement or Medicaid-funded waiver services, the screening team must determine that the individual cannot be maintained in an alternative institutional setting.

See the DMAS PAS Provider Manual, Appendix B for additional information on medical/nursing need.

13.14.7.1 Signatures

At the bottom of the UAI is space for the physician's signature. There is also space for the signature of others, such as a facility administrator. Depending on the type of assessment being performed, these signatures may or may not be optional. The purpose of the signature is to certify that the information found in the physical health section of the assessment is accurate and complete.

Note: Signatures shall be typed into the appropriate spaces in ePAS.

13.15 Section 4 of the UAI: Psychosocial assessment

The presence of cognitive and/or mental conditions can affect the ability of an individual to live independently. Cognitive issues are caused by a variety of diseases and conditions. Cognitive impairments can affect a person's memory, judgment, conceptual thinking and orientation. In turn, these can limit the ability to perform ADLs and IADLs. When assessing individuals for possible cognitive impairment, it is important to distinguish between normal minor losses in intellectual functioning and the more severe intellectual impairments caused by cognitive disorders such as Alzheimer's disease or other related dementias. Some cognitive conditions may be caused by a physical disorder such as a stroke or a traumatic brain injury or by side effects or interactions of medications.

In some cases, the assessor may want to ask the cognitive function questions at the beginning of the interview. This may be appropriate for an individual when it becomes apparent during the initial time with him or her that he or she may not be capable of participating in the full assessment process or that the assessor may not be able to obtain meaningful information directly from the individual.

Cognitive function questions should be approached in a very matter-of-fact manner. The assessor should state the following instructions: "Sometimes people have trouble remembering things. If you do not know the answers to some of the next questions, that's okay. On the other hand, some of the answers may seem obvious." Do not make the individual think that answering the questions is a pass/fail situation. If individuals seem disconcerted by the questions, try to reassure them that they are doing fine. Then go on quickly to the next question. If the assessor indicates to the individual that his answers are correct or incorrect, increased anxiety may cause the individual to miss

other questions. The assessor should not assume he knows the individual's answer to a particular question if the question has not been asked.

Remember to pay attention to the individual's appearance, behavior and way of talking throughout the complete interview. This may give clues about his or her cognitive and emotional functioning.

The assessor is not diagnosing the individual, but rather looking for some indicators of the possible need for a referral to the CSB or other mental health professional for a more thorough mental health and/or substance abuse assessment and possible diagnosis. Note: Assessors of individuals who are planning to reside in an ALF shall familiarize themselves with the matrix "Screening for Mental Health/Intellectual Disability/Substance Abuse Needs" also known as "Appendix K." See the ALF Public Pay Assessment Manual at http://www.dss.virginia.gov/family/as/servtoadult.cgi for additional information.

This section includes both required and optional cognitive questions. The required questions assess the individual's cognitive function in a more general manner. The optional questions are from a validated instrument and can be used to develop a cognitive impairment score. This score then can be used to determine when a referral to a mental health provider is needed.

13.15.1 Cognitive function

13.15.1.1 Orientation

Ask the questions on the survey related to the cognitive spheres - person, place, and time - in order to evaluate orientation, or the individual's awareness of his environment.

- **Person:** Alternative questions to assess orientation to person are "Please tell me the name of your next door neighbor" or "Please tell me the name of the staff person who takes care of you." The preference, however, is that the assessor ask the question as written on the assessment instrument. There are no MMSE questions for orientation to person.

- **Place:** For orientation to place, the complete mailing address, excluding zip code, is required. It may be necessary to probe for more details when individuals give answers such as "My house" or "My room." See below for instructions on the optional MMSE question related to Place.

MMSE Question #1 (Place): Where are we now? Give the individual 1 point for each correct response; the maximum number of points is 5. Ask for the (1) state, (2) county, (3) town, (4) street number, and (5) street name. These categories can be modified for individuals in rural areas by substituting route

and box number for street number and name. For hospitalized individuals, substitute hospital and floor for street number and name. For individuals in a community setting, substitute agency and floor for street number and name.

- Time: For orientation to time, the month, day, and year are required. See below for instructions on the optional MMSE question related to Time.

MMSE Question #2 (Time): Would you tell me the date today? Give the individual 1 point for each correct response; the maximum number of points is 5. Ask for the (1) year, (2) season, (3) date, (4) day, and (5) month. The assessor may state that "date" means "1st, 2nd, etc." and "day" means "Monday, Tuesday, etc."

Based on the individual's answers to the questions on Person, Place, and Time, code the level of orientation/disorientation. An individual is considered disoriented if he or she is unable to answer any of the questions. In order to code the specific type of disorientation, it may be necessary to consult a caregiver about the spheres affected and the frequency (i.e., some of the time or all of the time). Use the space provided to record the sphere(s) in which the individual is disoriented.

- **Oriented** means the individual has no apparent problems with orientation and is aware of who he or she is, where he or she is, the day of the week, the month, and people around him or her. **(I = Independent)**

- **Disoriented, Some Spheres, Some of the Time** means the individual sometimes has problems with one or two of the three cognitive spheres of person, place, or time. Some of the Time means there are alternating periods of awareness-unawareness. **(d = Semi-dependent)**

- **Disoriented, Some Spheres, All of the Time** means the individual is disoriented in one or two of the three cognitive spheres of person, place, and time, All of the time means this is the individual's usual state. **(d = Semi-dependent)**

- **Disoriented, All Spheres, Some of the Time** means the individual is disoriented to person, place, and time periodically, but not always. **(D = Dependent)**

- **Disoriented, All Spheres, All of the Time** means the individual is always disoriented to person, place, and time. **(D = Dependent)**

- **Comatose** means the individual is in a semi-conscious or unconscious state or is otherwise non-communicative. **(D = Dependent)**

13.15.2 Recall/memory/judgment

Recall: After the introductory statement, say the words **HOUSE, BUS, DOG**, and ask the individual to repeat them.

This first repetition determines the score for MMSE Question #3 (Recall). Give the individual 1 point for each correct answer. The maximum number of points is 3.

Repeat the words for up to six trials until the individual can name all three. Tell the individual to hold them in his or her mind because you will ask him or her again in a minute or so what they are. The individual's ability to repeat the words later is the assessment of short-term memory.

Attention/Concentration: This is the only question which is strictly for use in the MMSE.

MMSE Question #4 (Attention/Concentration): Spell the word WORLD. Then ask the individual to spell it backwards. Give 1 point for each correctly placed letter (DLROW). The maximum number of points is 5.

Note: If the individual is unable to spell, serial sevens may be used as an alternative. By this, the assessor asks the individual to subtract by sevens from 100 (i.e., 93, 86, 79, 72, 65. . .). After the individual has completed five subtractions, you can ask him or her to stop. Give 1 point for each of five correct responses.

MINI-MENTAL STATE EXAMINATION SCORING: Compute the MMSE Score as the total number of points for the Place, Time, Recall, and Attention/Concentration questions. Each person's educational and cultural background should be taken into account as to how it might affect the MMSE score. The maximum score is 18. A score of 14 or below implies cognitive impairment, but does not mean that the individual has a diagnosis of dementia. There may be other contributing factors to poor cognitive function, such as physical health or medication problems. If the individual scores 14 or below, information collected during the assessment interview should be verified with a caregiver. When no other source exists, do the best you can with the individual, and note that the information may not be reliable.

- **Short-Term Memory:** Ask the individual to recall the 3 words that you previously asked him or her to remember. If you are not administering the MMSE, you may want to ask the long-term memory question before this question so that some time has passed since you asked the individual to remember the 3 words. A possible short-term memory problem is indicated if the individual is unable to recall all 3 words: **House, Bus, and Dog.**

- **Long-Term Memory:** Long-term memory is the ability to remember the distant past. Ask the individual his or her date of birth in order to evaluate

long-term memory loss. Memory loss is indicated when the individual is unable to give his or her complete date of birth (the month, date, and year).

- **Judgment:** Judgment is the ability to reason and make decisions. Ask the individual to describe the steps he or she would follow to obtain help at night. In assessing the individual's response, look for an answer that is appropriate to where the person resides. It may also be helpful to gain insight from others who know the individual.

13.15.3 Behavior pattern

This question is not designed to be asked directly of the individual. The answer is based on the assessor's judgment and observations of the individual as well as information gathered during the assessment. The question assesses the way the individual conducts himself or herself in his or her environment and focuses on three types of behavior: wandering, agitation, and aggressiveness. Other things to consider include:

- whether the individual ever engages in intrusive or dangerous wandering that results in trespassing, getting lost, or going into traffic;
- whether the individual gets easily agitated (overwhelmed and upset, unpleasantly excited) by environmental demands;
- whether the individual becomes verbally or physically aggressive when frustrated;
- whether the individual becomes resistive or combative toward the caregiver when assisted with ADLs;
- paces but does not wander;
- is passive, oppositional, or restless;
- repeats verbal statements; or
- is combative or destructive.

If several of the responses could describe the individual, code the most dependent.

- **Appropriate** means the individual's behavior pattern is suitable to the environment and adjusts to accommodate expectations in different environments and social circumstances. **(I = Independent)**

- **Wandering/Passive-Less than Weekly** means the individual physically moves about aimlessly, is not focused mentally, or lacks awareness or interest in personal matters and/or in activities taking place in close proximity (e.g., the failure to take medications or eat, withdrawal from self care or leisure activities). The individual's behavior does not present major management problems and occurs less than weekly. **(I = Independent)**

- **Wandering/Passive - Weekly or More** means the individual wanders and is passive (as above), but the behavior does not present major management problems and occurs weekly or more. **(d = Semi-dependent)**

- **Abusive/Aggressive/Disruptive - Less than Weekly** means the individual's behavior exhibits acts detrimental to the life, comfort, safety, and/or property of the individual and/or others. The behavior occurs less than weekly. **(D = Dependent)**

- **Abusive/Aggressive/Disruptive - Weekly or More** means the abusive, aggressive, or disruptive behavior (as defined above) occurs at least weekly. **(D = Dependent)**

- **Comatose** refers to the semi-conscious or unconscious state. **(D = Dependent)**

Specify the type of inappropriate behavior and the source of the information in the space provided.

13.15.4 Life stressors

Record all stressful events currently affecting the individual's life. Stressful events may have an impact on the individual's emotional health and include such things as the death of a spouse or close friend, institutionalization, hospitalization, family conflict, financial problems, changes in living arrangements, or change in recent employment (recent retirement). Record as "Other" any other events mentioned by the individual but not included in the list of responses.

13.15.5 Emotional status

These questions are very personal, and some individuals may feel threatened or insulted by them. If the assessor seems uncomfortable, the individual will sense this and probably feel uncomfortable as well. The assessor might say some things to help ease, or even prevent, any discomfort the individual might feel, such as "Now I need to ask you some questions that may seem unusual, but I want you to know that we ask these questions of everyone. My asking the question does not mean that I think these things are characteristic of you. For example, when I asked if you had a hearing problem, it was not because I thought you had one, but because I need to

know that about everyone I talk with. The only way for me to know whether you have a problem, and be able to help with it, is to ask you. So, I hope you'll help me with these next questions, because I need to ask you, even if they seem unrelated to you."

Be sensitive to and observant of the individual's responses. The individual's reactions to the questions are important, as well as his or her answers.

Ask these questions in a straightforward and direct manner and be sure you and the individual interpret the question in the same way. Record the frequency of each emotional state within the past month. There is space to record when you are Unable to Assess due to an individual's refusal to answer.

- **Rarely/Never** means seldom or never.
- **Some of the Time** means occasionally (1 time per week).
- **Often** means frequently (2-3 times per week).
- **Most of the Time** is nearly always (4 or more times per week).

Answers to these questions may indicate the need for further assessment. As the assessor, it is important to remember that you are not diagnosing the individual, but rather you are looking for some indicators of the possible need for a referral to the local CSB or other mental health professional for a more thorough mental health and/or substance abuse assessment and possible diagnosis.

13.15.6 Social status

13.15.6.1 Activities

This question asks about types of activities which the individual enjoys doing. For each type of activity, use the space provided to describe the specific activity and the frequency. These answers are not mutually exclusive, and activities may fall into more than one category.

- **Solitary Activities** are done alone and may include, but are not limited to, reading, watching T.V. and gardening.
- **Activities with Friends/Family** may include, but are not limited to, talking on the telephone and visiting.
- **Group/Club Activities** may include attending nutrition sites or senior centers and participating in group-sponsored trips.

- **Religious Activities** may include attending religious services or participating in group meetings.

13.15.6.2 Interactions

This question asks about the frequency of the individual's contacts with children, other family, and friends/neighbors. If the individual has children, other family, and friends/neighbors, record how often contact (through a visit or over the telephone) occurs. This information is important in order to assess the individual's contact with others outside the home and his or her potential for being or becoming socially isolated. The last question asks the individual if he or she is satisfied with his or her general level of social contact.

13.15.7 Hospitalization/alcohol drug use

13.15.7.1 Hospitalizations

Record whether or not the individual has been hospitalized or received inpatient/outpatient treatment in the last two years for emotional, mental health, or substance abuse problems. This includes any participation in alcohol or drug rehabilitation programs. If the answer is yes, ask the individual where or from whom he or she received mental health services or counseling.

Record the name of the place, the admission date, the length of stay and reason for admission/treatment. Exact dates are required for ePAS. See Section 13.14.1.1 for more information on exact dates. For outpatient treatment, record the name of the place, the date of the last visit and the reason. If there have been multiple admissions/treatments in the last 2 years, only record the most recent in the space provided. Use the space available to record information about other less recent hospitalizations and/or treatments.

13.15.7.2 Alcohol/drug use

Record whether or not the individual currently drinks, or has ever drunk, alcoholic beverages. If the individual currently drinks, it is important to determine specifics about how much and how often the individual drinks. Determine the average number of drinks per day, week, or month, using probes when necessary to clarify vague answers (e.g., "a few drinks every now and then"). It is very important to determine what "a drink" means to the individual. Ask questions to determine what type of alcohol the individual usually drinks and the average quantity in ounces of each drink. As a guide for what to record, count one drink for every one ounce of liquor, five ounces of wine, or twelve ounces of beer. It is important to also know the amount of ounces in each drink.

In the second question, record whether or not the individual currently uses, or has ever used, nonprescription, mood-altering substances. If the individual currently uses any substances, record how much is used and how often.

Note: If the individual has never used alcohol or other non-prescription, mood altering substances, skip the next three questions and ask the smoking/tobacco question.

13.15.7.3 Smoking/tobacco use

Smoking refers to the individual's status with respect to smoking and/or using tobacco products (cigarettes, snuff, chewing tobacco). Record whether the individual has a history of, or currently, smokes or uses tobacco products. If the individual currently smokes or uses tobacco, record the number of cigarettes/amount of tobacco and the frequency (per day, per week, etc.).

13.15.8 Additional information

The last question in this section asks the individual if there is anything else he or she would like to discuss. This gives the individual the opportunity to raise any issues that have not been addressed directly during the Psychosocial Assessment and/or to elaborate on previously discussed issues.

13.16 Section 5 of the UAI: Assessment summary

13.16.1 Abuse, Neglect or Exploitation

Pursuant to § 63.2-1606 of the Code of Virginia, any person employed by a public or private agency or facility and working with adults is mandated to report suspicion of abuse, neglect, or exploitation of adults. A list of mandated reporters is available at http://www.dss.virginia.gov/abuse/mr.cgi. During the course of the assessment, if the assessor suspects the individual is being abused, neglected, or exploited the assessor must report it to the LDSS or to the 24-hour, toll-free APS hotline at 1-888-83ADULT. Appendix C lists indicators of possible adult abuse, neglect, and exploitation.

13.16.2 Caregiver Assessment

Informal care refers to services the individual's spouse, relative or other person(s) are both physically and mentally able and willing to provide, at all the times the services generally are needed. If the individual does not currently have an informal caregiver who actively provides assistance, note this on the UAI and skip to the Preferences Section.

NOTE: The caregiver questions are not intended to be asked directly of the individual or caregiver. They are to help the assessor determine if caregiving is adequate.

In the first question, record if the caregiver lives with the individual, in a separate residence within 1 hour of the individual's home (close proximity), or in a separate residence over one hour away. In the next question, record whether the caregiver's help is adequate to meet the individual's needs. Adequate means the caregiver is able and willing to provide for all of the individual's needs whenever they are needed. The last question assesses how burdened the caregiver feels in caring for the individual.

Use the space provided to record any problems with continued caregiving. These may include, but are not limited to, poor health of the caregiver, employment of the caregiver, caregiver's lack of knowledge about ways to appropriately care for the individual, or a poor relationship between the individual and the caregiver. The space can also be used to record whether the caregiver has a "backup," or someone else who can provide for the individual when the caregiver is unavailable or unable.

13.16.3 Preferences

Record the type of support or service that the individual and his family choose. There is also space for comments by the individual's physician. People's preferences let the assessor know if there are consistent or differing opinions about the best care for the individual.

13.16.4 Individual case summary

Use this section to explain, describe, and specify important information from the individual that cannot be recorded elsewhere in the assessment tool. This section can also be used to record:

- Relevant detail that does not fit into other spaces;
- Assessor observations which may support or contradict what the respondent answers;
- Assessor's judgment or conclusions;
- Another individual's opinion which differs from the individual's answer; or
- Assessor's notes.

13.16.5 Unmet needs

Record all unmet needs as indicated by the assessment. An unmet need is an identified need that is not currently met in a way that ensures the safety and welfare of the individual. For example, an individual's primary caregiver may help the individual with ADLs, but the caregiver is burdened and unable to continue providing the current level of care. In this case, the individual would have unmet needs for ADL assistance and caregiver support. There may be other unmet needs according to the individual's particular situation.

13.16.6 Completion of the assessment

All individuals completing parts of the full assessment should record their names, the agency/provider for whom they work, the provider number (for all Medicaid-certified providers), and the sections completed.

It is optional to record the name and code of the case manager assigned the case. This information can be used to track the case manager's caseload and other management activities.

13.17 Appendix A: Formal service definitions

- **Adult Day Services:** Daytime supervision and care of frail, disabled, and institutionally at-risk adults at specified congregate settings. Services include nursing, personal care, recreation, socialization, counseling, meals, and rehabilitation.

- **Adult Protective Services (APS):** Investigation of reports of abuse, neglect, or exploitation and of reports of adults who are at risk of abuse, neglect, or exploitation. Services include intake/referral, assessment of needs, counseling, emergency assistance, home or social support, medical care, legal, placement assistance, and financial assistance. According to the Code of Virginia, any person working with adults is mandated to report suspicion of abuse, neglect, or exploitation of adults. If, during the course of the assessment, the assessor suspects abuse, neglect, or exploitation, he or she must immediately report it to the local department of social services or to the APS 24-hour, toll-free hotline at 1-888-83ADULT.

- **Case Management:** Coordination of multiple home- and community-based services. Core functions include screening, assessment, development of a care plan, monitoring, and reassessment. Includes case management for mental health, mental retardation, substance abuse, vocational rehabilitation, and other special populations.

- **Chore/Companion/Homemaker Services:** Provision of housekeeping, companionship and,/or assistance with activities of daily living or instrumental activities of daily living to individuals who, because of their functional level, are unable to perform these tasks themselves.

- **Congregate Meals/Senior Center:** The provision of nutritionally balanced meals that meet one-third of the current Recommended Dietary Allowance and/or other services designed to reduce isolation and loneliness for individuals 60 years of age and older, and for the spouses, regardless of age. The provision of meals must occur at designated nutrition sites which also provide a climate/atmosphere for socialization and opportunities to alleviate isolation/loneliness. If the congregate meal is provided as part of formal adult day care, code as "Adult Day Care."

- **Consumer-Directed Personal Attendant Services:** Provision of non-medically oriented services which focus on assistance with activities of daily living. Individuals receiving this service must have no cognitive impairments and are responsible for hiring, training, supervising, and firing their personal care attendants.

- **Financial Management/Financial Counseling**: Provision of direct guidance and assistance to persons and their caregivers in the areas of consumer protection, personal financial matters, and tax preparation.

- **Friendly Visitor/Telephone Reassurance:** Provision of social contact on a one-to-one basis. The visit may occur either in the home or in other settings. Telephone reassurance is the making of prearranged, regular telephone calls to homebound elderly who may need guidance, a friendly voice, and security.

- **Habilitation/Supported Employment:** Habilitation programs provide planned combinations of individualized activities, supports, training, supervision, and transportation to people with mental retardation. The goal is to improve their conditioning or maintain an optimal level of functioning as well as to ameliorate the individual's disabilities or deficits by reducing the degree of impairment or dependency.

- **Supported Employment** is paid work in real businesses in the community where individuals with disabilities work side by side with non-disabled co-workers. A unique feature of supported employment is the involvement of a job coach or employment specialist who is responsible for providing individualized supports to assist the new worker with gaining and maintaining employment.

- **Home-Delivered Meals:** Provision of nutritionally balanced meals that meet one-third of the current Recommended Daily Allowance. The meals must be delivered and received at the homes of the individuals.

- **Home Health/Rehabilitation:** Provision of intermittent skilled nursing care under appropriate medical supervision to acutely or chronically ill homebound individuals. Various rehabilitative therapies (such as physical, occupational, and speech therapies) and home health aides providing personal care services are included.

- **Home Repairs/Weatherization:** Provision of home repairs, home maintenance, and/or the installation of materials in low-income family homes to reduce heating costs. Services are provided which will correct safety hazards or provide a healthier environment.

- **Housing:** Assistance to individuals and families in acquiring and/or maintaining safe, healthful, affordable housing and obtaining necessary household furnishings.

- **Legal:** Legal advice and representation by an attorney including counseling or other appropriate assistance by a paralegal or law student under the supervision of an attorney. Includes counseling or representation by a non-lawyer, where

permitted by law, to older individuals with economic or social needs. May also include preventive measures such as community education.

- **Mental Health:** Individual, group and family outpatient counseling, specialized diagnostic and evaluation services, 24-hour emergency services, extended day support, case management (code as "case management"), inpatient/residential services, and prevention/early intervention services.

- **Mental Retardation (Intellectual Disability):** Services to individuals with intellectual disability including emergency services, case management, residential support, day support, outpatient, prevention and early intervention services, inpatient services, and sheltered workshops.

- **Personal Care:** The provision of non-medically oriented services which focus on assistance with activities of daily living.

- **Respite:** Care and services in the home, or in the community, provided on a temporary, short-term, intermittent, or emergency basis to support a caregiver in caring for an individual with functional limitations. Services may include companion, homemaker, personal care, adult day health care, and temporary institutional (out-of-home) care.

- **Substance Abuse:** Information and referral, education, diagnosis and evaluation, individual, group and family counseling, recommendations for other treatments including residential, detoxification, halfway housing, methadone maintenance, outpatient and day services.

- **Transportation:** Group transportation to congregate meals, socialization and recreation activities, shopping, and other services available in the community. Individual transportation to needed services that promote continued independent living.

- **Vocational Rehabilitation/Job Counseling:** Assistance for persons who may have mental or physical disabilities but with a reasonable expectation that services will benefit the person in terms of employability. Services include counseling, evaluation of work capacities and limitations, employment training, medical services, case management services, and job placement.

13.18 Appendix B: Diagnoses

Definitions included here provide a brief overview of diagnoses categorized on the Uniform Assessment Instrument. Assessors are encouraged to consult medical professionals or reference books for additional information.

- **Alcoholism/Substance Abuse:** Includes alcohol, prescription, illegal and over-the-counter drug abuse.

- **Blood-Related Conditions:** Include erythremia, leukemia, lymphoma, splenic disorders, anemias, and hepatitis.

- **Cancer:** Not a single disease, but a group of disorders where normal body cells are transformed into malignant ones. If an individual reports cancer as a diagnosis, it is important to ask what type and ascertain the location of the tumor. Treatments include radiation and chemotherapy, and there may be side effects such as weight loss, poor appetite, skin irritation, diarrhea, weakness, fatigue, and pain. The assessor may want to ask a significant other about the individual's prognosis.

- **Cardiovascular**

    - **Circulation Conditions:** include disturbances in the circulatory system, such as peripheral vascular disease (PVD). These problems may be evident by edema (swelling) of the extremities, ulcers, gangrene, discoloration, absence of pulse in the extremity and severe pain. This is also the code to give someone who is taking medication for high cholesterol.

    - **Heart Conditions:** include atherosclerosis (fatty deposits in the arteries), arteriosclerosis, cardiovascular disease, coronary artery disease, congestive heart failure, and heart attack.

    - **High Blood Pressure (Hypertension or HBP)** is persistent elevation of arterial blood pressure.

    - **Other Cardiovascular Conditions**

- **Dementia**

    - **Alzheimer's Disease** is a progressive neurological problem of unknown etiology. Alzheimer's is characterized by loss of memory, confusion, agitation, loss of motor coordination, decline in the ability to perform routine tasks, personality changes, loss of language skills, and eventual death. Patients often exhibit emotional instability and problems such as wandering, depression, belligerence, and incontinence.

- **Non-Alzheimer's diseases** include organic brain syndrome (OBS), chronic brain syndrome, and senility.

- **Developmental Disabilities and Related Conditions**

  - **Mental Retardation (Intellectual Disability)** is characterized by below average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Significantly below average is considered to be an IQ of 70 or below.

  - **Autism** is a developmental disability which appears in childhood and results from a lack of organization in functioning of the brain. Symptoms include self-absorption, inaccessibility, aloneness, inability to relate, highly repetitive play, rage reactions when interrupted, predilection for rhythmical movements, and language disturbances.

  - **Cerebral Palsy** is a development disability caused by damage to the brain in utero or during birth, resulting in various types of paralysis and lack of motor coordination, particularly for muscles used in speech.

  - **Epilepsy/Seizure Disorder** results from a sudden loss of consciousness accompanied sometimes by muscular contractions or spasms.

  - **Friedreich's Ataxia** is an inherited degenerative disease with sclerosis of the spinal cord. Accompanied by ataxia, speech impairment, lateral curvature of the spinal column, and peculiar swaying and irregular movements, with paralysis of the muscles, especially of the lower extremities. Onset in childhood or adolescence.

  - **Multiple Sclerosis** is characterized by inflammation and subsequent hardening of myelin in many areas of the spinal cord and brain. It is a progressive disease of the nervous system with onset usually in young adulthood, eventually resulting in complete loss of motor control.

  - **Muscular Dystrophy** is a progressive muscle disease which causes weakness and atrophy of the muscles, respiratory difficulty, and heart failure. Muscular Dystrophy is often seen with mild retardation.

  - **Spina Bifida** is a congenital defect in which the walls of the spinal canal undergo incomplete formation causing gross deformity and paralysis in the lumbar portion of the body. Hydrocephalus, or increased accumulation of cerebrospinal fluid within the ventricles of the brain, is common.

- **Digestive, Liver, and Gall Bladder**

- **Intestinal problems** may include a wide range of digestive tract conditions such as peptic and duodenal ulcers, colitis, diverticulitis, hiatal hernia, or gall bladder disease. There are a variety of symptoms including indigestion, heartburn, nausea, belching, bloating, vomiting, diarrhea, weight loss, constipation, and pain. Other conditions in this category include cirrhosis and chronic liver disease.

- **Endocrine/Glandular**

  - **Diabetes** results form in insufficiency of insulin production by the pancreas and is characterized by the body's inability to utilize glucose (sugar). Diabetes is American's third leading cause of death and the leading cause of new cases of blindness. It also causes infections or poor healing of the legs and other complications. Depending on the type of diabetes, duration and severity, a special diet, oral medication, and/or insulin injections may be required.

  - **Other** includes hyperthyroidism and hypothyroidism.

- **Eye Disorders:** Include cataracts (age-related changes in the transparency of the lens), glaucoma (elevation of pressure of fluid within the eye causing damage to the optic nerve), blindness, conjunctivitis, and corneal ulcers.

- **Immune System:** Include lupus, Acquired Immune Deficiency Syndrome (AIDS), and HIV-positive individuals.

- **Muscular/Skeletal**

  - **Arthritis** is an inflammatory condition involving the joints which ranges in severity from occasional mild pain to constant pain that can cause crippling. Types of arthritis include rheumatoid and osteoarthritis; location may include hands, neck, back, hips, legs, or joints.

  - **Osteoporosis** is a bone-thinning process with loss of normal bone density, mass, and strength. Osteoporosis is a major cause of fractures of the spine, hip, wrists, and other bones. It occurs in older men and women, but is most common in females with a family history of osteoporosis and who are fair-skinned, thin, and small-framed. Symptoms include loss of height, dowager's hump, and fractures.

  - **Other** includes degenerative joint disease, bursitis, and tendinitis.

- **Neurological**

- **Brain Trauma/Injury** includes brain tumors which are lesions of the brain that cause varied symptoms including headaches, lack of motor coordination, seizures, or tremors. Also includes brain damage due to an accident or incident which significantly affects intellectual or adaptive functioning.

- **Spinal Cord Injury** is permanent damage to the spinal cord resulting in paralysis (loss of sensation and movement) to all or some limbs and the trunk of the body.

- **Stroke (Cerebral Vascular Accident or CVA)** is an acute episode that exhibits loss of consciousness, confusion, slurred, garbled speech or inability to speak, loss of mobility, and paralysis due to loss of oxygen to the brain. A stroke may leave permanent effects such as inability to speak or comprehend speech (aphasia), memory loss, confusion, paralysis, and contractures (shortening and tightening of muscles).

- **Other Neurological Conditions** include Parkinson's Disease, a progressive neuromuscular disorder characterized by tremors, shuffling gait and muscle weakness, polio, and tardive dyskinesia.

- **Psychiatric**

  - **Anxiety Disorders** are characterized by patterns of anxiety and avoidance behavior. While anxiety is a normal part of existence, these disorders cause impairment in social and occupational functioning.

  - **Bipolar Disorder** includes mixed, manic, depressed, and seasonal. Manic Disorder is characterized by a distinct period of abnormally and persistently elevated, expansive, or irritable mood.

  - **Major Depression** includes single episode/recurrent, chronic, melancholic, or seasonal depression disorder not otherwise specified. Major depression is characterized by depressed mood most of the day or nearly everyday, markedly diminished interest or pleasure in most or almost all activities and significant weight loss or gain.

  - **Personality Disorder** includes paranoid, schizoid, schizotypal, histrionic, narcissistic, antisocial, borderline, avoidant, dependent, obsessive-compulsive, and passive-aggressive. Characteristics include enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are inflexible and maladaptive and cause either significant functional impairment or subjective distress.

- **Schizophrenia** includes disorganized, catatonic, and paranoid types and is characterized by patterns of delusions which are false beliefs, hallucinations, incoherence or marked lessening of association, flat or grossly inappropriate affect, and disturbances in psychomotor behavior.
- **Other Psychiatric Conditions**

- **Respiratory Conditions**
  - **Black lung** (Pneumoconiosis) is a chronic, disabling lung disease which results from accumulation of coal dust in the lung tissue.
  - **COPD** is chronic obstructive pulmonary disease.
  - **Pneumonia** is characterized by fluid in the lungs.
  - **Other** includes TB, bronchitis, emphysema, asthma, and allergies.
- **Urinary/Reproductive Problems**
  - **Renal Failure** may be acute or chronic.
  - **Other Urinary/Reproductive Problems** include inflammation of the bladder, infection in the kidneys or other parts of the urinary tract, urinary tract infections, urinary retention, urinary incontinence, and disorders of the male genital organs and female genital tract (i.e., irregular menstrual cycles).
- **All Other Problems** includes anything not coded above.

13.19 Appendix C: Indicators of adult abuse, neglect or exploitation

NEGLECT: Failure by a caregiver to provide an older or incapacitated adult with the necessities of life or failure of an older or incapacitated adult to provide necessities for himself or herself.

Inadequate Hygiene Odorous/not bathed/dirty hair/body Uncut hair/unshaven Overgrown toe/finger nails Not receiving mouth care **Nutrition** Dehydrated/malnourished Constantly hungry Not fed/inadequate meals **Skin** Abrasions/lesions Pressure sores/untreated sores Insect bites Dry, scaly/rash **Physical Care** Inadequate/inappropriate/dirty clothing/shoes Inadequate supervision Lying in feces/urine/old food **Behavior of Victim** Begs for food/steals food Eats meals alone in room Picks at sores Scratches self with nails/instruments **Social Isolation** Victim feels rejected Victim is left alone No opportunity to be with others No planned activities No cognitive stimulation	**Medical Care of Victim** Not receiving needed medical care No walking aids when needed Special diet not allowed No false teeth when needed/decayed teeth No glasses or broken glasses No hearing aid or broken hearing aid Untreated mental health problems **Behavior of Abuser** Withholds food or medication Does not assist with toileting Does not assist with eating when needed Call bell out of reach/does not answer call Uses multiple medical facilities Ignores/does not talk to victim Does not allow victim to see others alone Refuses to hire needed assistance Inadequate supervision **Condition of Home** Home in disrepair Extremely dirty/garbage piled up Severe pest/rodent infestation Animal waste or smell/offensive odors Inadequate heat/no fuel Electricity cut off Inadequate/contaminated water supply No refrigerator/stove Homeless

PHYSICAL ABUSE: The infliction of physical pain or injury to the older person or the incapacitated adult.

Injuries Cuts Bites	**Violent Actions** Pushed, shoved Grabbed, shaken

Punctures Abrasions Lacerations Bleeding Sprains/Dislocations Bone fracture Bruises Burns Scratches **Injuries are. . .** Repeated Frequent Unusually placed Multiple In various stages of healing Bilateral, upper arms Clustered In shape of an object	Choked Slapped Punched, hit Kicked, beaten Cut Shot Handled roughly Force fed Scratched Poked **Medical Evidence** Skeletal injuries Retinal hemorrhages/detachment Unset bones Duodenal/jejuna injuries Ruptured inferior vena cava Peritonitis Internal injuries

UNREASONABLE CONFINEMENT: Use of physical or chemical restraints for reasons other than the adult's safety or well-being or without medical orders.

Physical Restraints	**Chemical Restraint**
Handcuffed Tied to furniture Gagged Locked in room Not checked periodically Not permitted to leave house Phone out of reach Not permitted to use phone	Over medicated Too much alcohol Inappropriate medication

EMOTIONAL ABUSE: Pain or distress which results from verbal or behavioral activity directed at the older or incapacitated adult.

Behavior of Victim	**Actions of Abuser**
Depression Self-destructive Intense fear or sadness Tearful without apparent reason Overreacts to sound of abuser's voice	Uses harsh tone of voice Swears at adult Talks of person's death Talks of person being a burden Makes derogatory remarks Threatens adult with one or more of the following: Violence, institutionalization, guardianship, Abandonment, isolation, eviction Uses insults Name calling Prohibits visitors

	Overly critical

SEXUAL ABUSE: Touching, fondling, or any sexual activities with an older or incapacitated person when the older or incapacitated person is unable to understand or give consent or is forced to engage in sexual behavior.

Behavior of Victim	**Actions or Behavior of Abuser**
Nightmares, sleep disturbances	Discussion of sexual activity
Mistrust of others	Sexual interest in victim's body
Intense fear reaction to one or more people	Sexual joke/comments
Regressive or aggressive behaviors	Sexual harassment
Self-destructive behaviors	Voyeurism
	Exhibitionism
Medical Evidence	Forcing victim to view pornography
Presence of semen	Forcing victim to perform oral sex
Presence of sexually transmitted disease	Forcing victim to engage in sexual activity
Genital or urinary irritation, injury	Forcing victim to fondle or touch abuser
Prolapsed uterus	
Frequent, unexplained physical illnesses	
Phobic behavior	
Depression	

FINANCIAL EXPLOITATION: the illegal use of an incapacitated adult's resources for another's profit or advantage

Indicators
Bank activity is erratic, unusual or uncharacteristic
Bank activity is inconsistent with adult's abilities (e.g. the ATM card is used when the person is unable to use it)
Recent new acquaintances, especially those that take up residence with the adult
Sudden changes to property titles, wills or other documents, particularly if the person is confused and/or the documents favor a new acquaintance
Power of attorney is executed by a confused person
Lack of amenities when the person can afford them
Missing property or documents
Suspicious activity on credit card accounts
Forged or suspicious signatures on documents
Failure to receive services that have been paid for
Eviction or utilities disconnected
Adult is not cared for when arrangements for care have been made
Mail has been redirected

13.20 Appendix D: Medical and long-term care terminology and abbreviations

a before	BUN blood urea nitrogen
aa of each	
a (n) absence of	c with
abn abnormal	C Centigrade
ac before meals	CA cancer
acou, acu hear	cal calorie
ad up to	carcin (o) cancer
aden (o) gland	caps capsule
ADL activities of daily living	cardio (o) heart
ad lib as desired	CBC complete blood count
adm admission, admitted	cc cubic centimeter
aer (o) air	CCU coronary care unit
AF auricular fibrillation	CD communicable disease
AF atrial fibrillation	ceph head
AFB acid fast bacillus	cerebr (o) brain
AK above knee	cervic neck
alg pain	CF cystic fibrosis
ALS amyotrophic lateral sclerosis	CHD congenital heart disease
AM morning, before noon	CHF congestive heart failure
AMA against medical advice	Chol (e) bile, referring to gall bladder
amb ambulatory	Chondro (o) cartilage
andr (o) man	Circum around, about
angi (o) vessel	cm centimeter
ankyl (o) crooked, curved	CNP certified nurse practitioner
ante before	CNS central nervous system
anter (i) front, forward against artery	contra against, counter body
arthro joint	COPD chronic obstructive pulmonary disease
articul joint	cost (o) rib
ather (o) fatty hearing	c/o complains of
aur (i) ear	CP cerebral palsy
auto (o) self	crani(o) skull
ASCVD arteriosclerotic cardiovascular disease	CRF chronic renal failure
ASHD arteriosclerotic heart disease	Cry (o) cold
as tol as tolerated	C&S culture & sensitivity
	Cut skin
BC/BS Blue Cross/Blue Shield	CV clinic visit
BC birth control	CVA cerebrovascular accident (stroke)
BE barium enema	CXR chest X-ray
bid twice each day	Cyan(o) blue
bil bilateral	Cyst (o) bladder
bi, bis twice, double, two	Cyt (o) cell
BK amp below knee amputation	
BM bowel movement	d day
BMR basal metabolic rate	dactyl (o) finger or toe
BP blood pressure	d/c discharge
BR bathroom	D/C discontinue
Brachy short	Dent tooth
Brady slow	Derm (ato)skin
BRP bathroom privileges	Dipl(o) double

bucc (o) cheek
DNA deoxyribonucleic acie
DNKA did not keep appointment
DOA dead on arrival
DOB date of birth
Dors back
dsg dressing
dx diagnosis
dys faulty, bad, abnormal

ECG, EKG electrocardiogram
Ectomy excision (removal by cutting)
ED emergency department
EEG electro-encephalogram
EENT eye, ears, nose, and throat
EMG electromyelogram
Emia blood
Encephal (o) brain
End (o) inside
ENT ear, nose, and throat
Enter(o) inside
epi epidemiology, outer, superficial, upon
ER emergency room
et and
ETOH alcohol
ESRD end-stage renal disease
Eu normal
ext. external, exterior
extra outside

F Fahrenheit
f female
F & C foam and condoms
fa father
FAS fetal alcohol syndrome
FBS fasting blood sugar
feb pertaining to fever (febrile)
F.H. family history
Fib. fibrillation
fl fluid
F/N/V/D fever, nausea, vomiting, diarrhea
Foley type of urinary catheter
f/u or F/U follow-up
FUO fever of unknown origin
fx fracture

G gravid
Gastr (o) stomach
Gen become, originate
GI gastrointestinal
Gloss (o) tongue
Glyc (o) sweet, glucose
disp dispense
gtt drops
gram, graph write, record
GU genito-urinary
GYN gynecology, woman

HBP high blood pressure
hct hematocrit
Hep hepatitis
HEENT head, ears, eyes, nose, throat
Hem (ato) blood
Hemi half
Hepat (o) liver
hgb hemoglobin
hist (o) tissue
HIV human immunodeficiency virus
H & P history and physical
HOH hard of hearing
H or hr hour
hs bedtime, hour of sleep
ht height
HV home visit
hx history
hydr (o) water
hyper excessive, high
hypo deficient, low
hyster (o) uterus

iatr (o) doctor
I & R information & referral
IBS irritable bowel syndrome
ID identification
ID intellectual disability
IDDM insulin dependent diabetes mellitus
IG immunoglobulin
IM intramuscular
infra beneath
inf. infection
inj. Injection
inter among, between
intra inside
IPPB intermittent positive pressure breathing
IV intravenous
IVP intravenous pyelogram
It is inflammation

K potassium
Kg kilogram
KUB kidney, ureter, bladder

L liter
L or l left
Lact(o) milk

Gm gram	lap. Laparoscopy
gr grain	Lapar (o) flank, abdomen
lat. lateral	NPO nothing by mouth
Latero side	N/S normal saline
Leuk(o) white	Nutria nourish
Lingu (o) tongue	N/V nausea and vomiting
Lip(o) fat	
LLL left lower lobe	OC oral contraceptive
LLQ left lower quadrant	Ocul(o) eye
LMP last menstrual period	o.d. right eye
LOM loss of motion	odyn(o) pain
LOQ left outer quadrant	oint ointment
LP lumbar puncture	OM otitis media
LPN licensed practical nurse	Oma tumor
LS lumbo-sacral	Onc(o) tumor
LSE last sexual encounter	OOB out of bed
LUL left upper lobe	Oophor(o) ovaries
LUQ left upper quadrant	OP outpatient
Lys (is) dissolve	Opth opthamology
	Ophthalm(o) eye
Mal bad, abnormal	Opia vision
Malac soft	Opsy examination
Mammo breast	Orchi(o) testes
mcg microgram	o.s. left eye
meds medications	os mouth
megal(o) large	osis condition
melan(o) black	osse(o) bone
mening(o) membranes	osteaio bone
mg milligram	OT occupational therapy
MH mental health	OTC over-the-counter
MI myocardial infarction (heart	Ot(o) ear
attack)	o.u. both eyes
ml milliliter	OV office visit
mm millimeter	oz ounce
MMR measles, mumps, rubella	
MOM milk of magnesia	p after
MR mental retardation	P pulse
MRI magnetic resonance imaging	PA posterior-anterior
MS multiple sclerosis	Para parity (# of births)
MVP mitral valve prolapse	Path. Pathology
My(o) muscle	Patho disease
Myco fungus	pc after meals
Myel(o) marrow	PE physical exam
	Ped(o) child
Na sodium	Penia deficient, deficiency
NAD no acute distress	Peps, pept digest
Nas (o) nose	per by, through
N/C no complaints	PERLA pupils equal, react to light &
Necr(o) death	Accommodation
neg negative	peri around
nephro kidneys	Ph acid or base (hydrogen ion concentration)
neuro neurology, nreves	Phag(o) eat, destroy
N/G nasogastric	Pharmaco drug

noct. nocturnal NP nurse practitioner	Pharyngo(o) throat Phelb(o) vein

PHN public health nurse Phob(ia) fear PID pelvic inflammatory disease Plasty repair Pleg(ia) paralysis PM afternoon PMH past medical history Pnea breathing Pneum(ato) breath, air Pneumon(o) lung po by mouth (per os) pod(o) foot poie make, produce poly much, many post after poster(i) back, behind post-op post-operative POT plan of treatment pp post prandial pre-op pre-operative presby elder PRN whenever necessary proct(o) anus Prog prognosis Pseudo false Psycho mind pt patient PT physical therapy PTA prior to admission pulm pulmonary pulmono lung pyel(o) pelvis, kidney pyr(o) fever, fire q every qd every day qhs at bedtime qh every hour qid four times daily qns quantity not sufficient qod every other day qam every morning qs quantity sufficient R or r right	RD registered dietician Ren(o) kidneys resp respiratory rhag break, burst RHD rheumatic heart disease Rhe flow Rhin(o) nose RF rheumatic fever RLL right lower lobe RLQ right lower quadrant Rh Rh factor RN registered nurse R/O rule out R.O.M. range of motion RPT registered physical therapist RTC return to clinic RUQ right upper quadrant RV return visit Rx prescription, treatment or therapy s without S & S signs and symptoms Scler (o) hard Scope instrument Scopy examination SES socioeconomic status sed rate sedimentation rate Sig or S write on labels SL sublingual SLE systemic lupus erythematosus sl sublingual (under the tongue) SOB short of breath sol solution somat(o) body spondyl(o) vertebra Sq squamous sq subcutaneous ss one-half SSE soap suds enema ST speech therapy stat at once, immediately STD sexually transmitted disease Steat(o) fat Sten(o) narrow, compressed Steth(o) chest Stom mouth, opening sub subcutaneous (under the skin)

R respiration RA rheumatoid arthritis Rachi(o) spine RBC red blood cells or count SW social worker Sx symptoms T or t temperature tab tablet tachy quick, fast TB tuberculosis TC telephone call Therap treatment Thermo heat Thorac(o) chest Thromb(o) clot, lump tid three times a day TLC tender loving care TMJ temporal mandibular joint TO telephone order Tomy incision (operate by cutting) Tox(i) poison TPR temperature, pulse, respiration tsp teaspoon TURP trans-urethral resection prostate Tx treatment	supp suppository supra above surg surgery susp suspension UA urinalysis UGI upper gastrointestinal UIQ upper inner quadrant UOQ upper outer quadrant urol urology URI upper respiratory infection Uria urine UTI urinary tract infection vag vaginal vas(o) vessel VD venereal disease Ven(o) vein Vesic(o) bladder Xer(o) dry

13.21 Appendix E: City/County FIPS Codes

Counties		Cities
001 Accomack	097 King & Queen	510 Alexandria
003 Albemarle	099 King George	515 Bedford
005 Alleghany	101 King William	520 Bristol
007 Amelia	103 Lancaster	530 Buena Vista
009 Amherst	105 Lee	540 Charlottesville
011 Appomattox	107 Loudoun	550 Chesapeake
013 Arlington	109 Louisa	560 Clifton Forge
015 Augusta	111 Lunenburg	570 Colonial Heights
017 Bath	113 Madison	580 Covington
019 Bedford	115 Mathews	590 Danville
021 Bland	117 Mecklenburg	595 Emporia
023 Botetourt	119 Middlesex	600 Fairfax City
025 Brunswick	121 Montgomery	610 Falls Church
027 Buchanan	125 Nelson	620 Franklin
029 Buckingham	127 New Kent	630 Fredericksburg
031 Campbell	131 Northampton	640 Galax
033 Caroline	133 Northumberland	650 Hampton
035 Carroll	135 Nottoway	660 Harrisonburg
036 Charles City	137 Orange	670 Hopewell
037 Charlotte	139 Page	678 Lexington
041 Chesterfield	141 Patrick	680 Lynchburg
043 Clarke	143 Pittsylvania	683 Manassas
045 Craig	145 Powhatan	85 Manassas Park
047 Culpeper	147 Prince Edward	690 Martinsville
049 Cumberland	149 Prince George	700 Newport News
051 Dickenson	153 Prince William	710 Norfolk
053 Dinwiddie	157 Rappahannock	720 Norton
057 Essex	159 Richmond County	730 Petersburg
059 Fairfax	161 Roanoke County	740 Portsmouth
061 Fauquier	163 Rockbridge	750 Radford
063 Floyd	165 Rockingham	760 Richmond City
065 Fluvanna	167 Russell	770 Roanoke City
067 Franklin	169 Scott	780 South Boston
069 Frederick	171 Shenandoah	790 Staunton
071 Giles	173 Smyth	800 Suffolk
073 Gloucester	175 Southampton	810 Virginia Beach
075 Goochland	177 Spotsylvania	820 Waynesboro
077 Grayson	179 Stafford	830 Williamsburg
079 Greene	181 Surry	840 Winchester
081 Greensville	183 Sussex	
083 Halifax	185 Tazewell	
085 Hanover	187 Warren	
087 Henrico	191 Washington	
089 Henry	193 Westmoreland	
091 Highland	195 Wise	
093 Isle of Wight	197 Wythe	
095 James City	199 York	

13.22 Appendix F: Contact information

Department for Aging and Rehabilitative Services Adult Protective Services Division 8004 Franklin Farms Drive, Richmond, VA 23229	
APS Division Home Office Staff	
Paige McCleary, Director	804-662-7605
Tishaun Harris-Ugworji, Program Consultant	804-662-7531
Venus Bryant, Administrative Assistant	804-726-1904 804-662-9531 (fax)
APS Division Regional Consultants	
Central Region, Marjorie Marker	804-662-9783
Eastern Region, Carey Raleigh	757-491-3983
Northern Region, Andrea Jones	540-347-6313
Piedmont Region, Angie Mountcastle	540-204-9640
Western Region, Carol McCray	276-676-5636

VDSS Division of Licensing Programs 804-726-7154 http://www.dss.virginia.gov/facility/alf.cgi	
VDSS Division of Licensing Programs Field Offices	
Central	804-662-9743
Eastern	757-491-3990
Peninsula	757-247-8020

Northern	540-347-6345
Fairfax	703-934-1505
Piedmont	540-204-9615
Valley	540-332-2330
Western	276-676-5490

VDSS Division of Benefit Programs

http://www.dss.virginia.gov/benefit/

Department of Medical Assistance Services Division of Long-Term Care

600 East Broad Street, Richmond, VA 23219

Provider Help Desk: 800-786-0211

http://dmasva.dmas.virginia.gov/default.aspx

www.dmas-info@dmas.virginia.gov

Xerox Help Desk (for ePAS)

866-352-0496

13.23 Appendix G: Resources

Medication Information

http://www.merckmanuals.com/professional/drugnames-index/generic/a.html

http://www.merckmanuals.com/

http://www.rxlist.com/script/main/hp.asp

Geriatric Assessment

Geriatric Pocket Doc: http://centeronelderabuse.org/order_pocket_doc.asp

Preadmission Screening Supporting Documents

The "Guide for Long-term Care Services in Virginia" contains information on all DMAS long-term care services and supports as well as the list of dependencies needed to qualify for long-term care. The document is available at: http://www.dmas.virginia.gov/Content_pgs/ltc-home.aspx

PAS Technical Assistance (TA) Documents for community based teams are located on SPARK at http://spark.dss.virginia.gov/divisions/dfs/as/procedures.cgi and for hospital discharge planners/screeners at http://www.dss.virginia.gov/family/as/servtoadult.cgi. Local health department staff may obtain TA documents from the appropriate VDH staff.

Nursing Facility Level of Care Worksheet

STEP 1: Based on a completed Virginia Uniform Assessment Instrument (UAI), check how the individual scores in the following categories

ADLs	Check if Semi-Dependent (d)	Check if Dependent (D)
Bathing		
Dressing		
Toileting		
Transferring		
Eating/Feeding		
Bowel		
Bladder		

OTHER FUNCTIONS	Check if Semi-Dependent (d)	Check if Dependent (D)
Medication Administration		
Behavior Pattern & Orientation (combination variable)		
Mobility		
Joint Motion		

STEP 2: Apply the above responses to the variables below.

Number of ADL Dependencies: _____
Medication Administration: Check if Semi-dependent _____ or Dependent _____
Behavior Pattern & Orientation: Check if Semi-dependent _____ or Dependent _____

Mobility: Check if Semi-dependent _____ or Dependent _____
Joint Motion: Check if Semi-dependent _____ or Dependent _____

STEP 3: Apply the responses in Step 2 to the criteria below.

CATEGORY 1: Individuals must meet items #1 and #2 in category 1; plus either item #3 or #4.
1) Rated dependent in 2 to 4 ADLs: ___ *YES*; **PLUS**
2) Rated semi-dependent **or** dependent in behavior pattern and orientation: ___ *YES*; **PLUS**
3) Rated semi-dependent in joint motion ___ *YES*; **OR**
4) Rated dependent in medication administration: ___ *YES*.

CATEGORY 2: Individuals must meet all items in this category.
1) Rated dependent in 5 to 7 ADLs: ___ *YES;* **PLUS**
2) Rated dependent in mobility: ___ *YES.*

CATEGORY 3: Individuals must meet all items in this category.
1) Rated semi-dependent in 2-7 ADLS: ___ *YES:* **PLUS**
2) Rated dependent in mobility: ___ *YES,* **PLUS**
3) Rated dependent in behavior and orientation: ___ *YES.*

STEP 4: Individuals MUST have a medical nursing need to meet criteria for long term care services.
This means: 1) the individual's medical condition requires observation and assessment to assure evaluation of needs due to an inability for self-observation or evaluation; OR 2) the individual has complex medical conditions that may be unstable or have the potential for instability; OR 3) the individual requires at least one ongoing medical or nursing service.
The individual does have medical nursing needs: ___ *YES*

STEP 5: Determination of whether the individual meets criteria.
1. Individual meets at least one of the three categories in Step 3: ___ *YES;* AND
2. Individual has medical nursing needs as defined in Step 4: ___ *YES.*
3. Individual is seeking waiver placement and meets the definition of 'at risk" ___ *YES*

This individual meets criteria (i.e., both 1. and 2. above are answered "YES"): ___ *YES;* ___ *NO.*

13.24 Appendix H: Forms

Depending on the type of assessment (e.g. ALF or PAS) being conducted, several forms in addition to the UAI may need to be completed. For additional information about these forms, please see the DMAS PAS Provider Manual or the Public Pay ALF Assessment Manual. Many of these forms are located on the DSS public website at http://www.dss.virginia.gov/family/as/servtoadult.cgi or on the DMAS web portal under the Provider Services tab. The DMAS-95, 96 and 97 are also part of the ePAS system.

The following forms are used for PAS:

- DMAS-95 MI/MR/RC
- Medicaid Funded Long-Term Care Services Authorization Form (DMAS-96)
- DMAS-97 Individual Choice-Institutional Care or Waiver Services Form

The following forms are used for ALF assessment or reassessment:

- Medicaid Funded Long-Term Care Services Authorization Form (DMAS-96)
- Attachment to Public Pay Short Form Assessment
- Eligibility Communication Document (ECD)
- Worksheet to Determine ALF Level of Care (optional form)