**DEPARTMENT OF HEALTH SERVICES** **STATE OF WISCONSIN**
Division of Medicaid Services
F-00366 (12/2019)

# WISCONSIN ADULT LONG-TERM CARE (LTC) FUNCTIONAL SCREEN

## BASIC INFORMATION

### Basic Screen Information

| Name – Screening Agency | |
|---|---|
| Name – Screener | Screener ID |
| Date of Referral (mm/dd/yyyy) | Screen Type (Check only one box)<br>☐ 01 Initial Screen<br>☐ 02 Rescreen |

### Basic Applicant Information

| Title | Name – Applicant (First) | (Middle) | (Last) |
|---|---|---|---|
| Gender<br>☐ Male<br>☐ Female | Date of Birth (mm/dd/yyyy) | | Social Security Number (###-##-####) |

### Applicant's Contact Information

| Address | | |
|---|---|---|
| City | State | Zip Code |
| Telephone – Home<br>(  )  - | Telephone – Work<br>(  )  - | Telephone – Cell<br>(  )  - |
| County of Residence | County/Tribe of Responsibility | |

Directions: _____

**Notes**:

## TRANSFER INFORMATION

To be completed after eligibility determination and enrollment counseling and after applicant enrolls in a program.

| Date of Referral to Service Agency (mm/dd/yyyy) | Name – Service Agency |
|---|---|

## SCREEN INFORMATION

**Referral Source**

- ☐ Self
- ☐ Family/Significant Other
- ☐ Friend/Neighbor/Advocate
- ☐ Physician/Clinic
- ☐ Hospital Discharge Staff
- ☐ Nursing Home
- ☐ CBRF (Group Home)
- ☐ AFH (Adult Family Home)
- ☐ RCAC (Residential Care Apartment Complex)
- ☐ ICF-IID/FDD
- ☐ State Center
- ☐ Home Health Agency
- ☐ Community Agency
- ☐ Other—Specify: _____
- ☐ Rescreen
- ☐ Guardian or other legal representative

**Primary Source for Screen Information**

- ☐ Self
- ☐ Guardian or other legal representative
- ☐ Family Member
- ☐ Spouse/Significant Other
- ☐ Parent
- ☐ Child
- ☐ Advocate
- ☐ Case Manager
- ☐ Hospital Staff
- ☐ Nursing Home Staff
- ☐ ICF-IID/Center Staff
- ☐ Residential Care Staff
- ☐ Home Health, Personal Care, or Supportive Home Care Staff
- ☐ Other—Specify: _____ Indicate name(s): _____

**Location Where Screen Interview was Conducted**

- ☐ Person's Current Residence
- ☐ Temporary Residence (non-institutional)
- ☐ Nursing Home
- ☐ Other—Specify: _____
- ☐ Hospital
- ☐ Agency Office/Resource Center

**HCB Waiver Group Information**

- ☐ IRIS

**Notes**:

## DEMOGRAPHICS

**Medical Insurance** (Check all boxes that apply)

☐ Medicare Policy Number: _____

☐ Part A Effective Date (mm/dd/yyyy): _____

☐ Part B Effective Date (mm/dd/yyyy): _____

☐ Medicare Managed Care

☐ Medicaid

☐ Private Insurance [includes employer-sponsored (job benefit) insurance]

☐ Private Long-Term Care Insurance

☐ VA Benefits–Policy #: _____

☐ Railroad Retirement–Policy #: _____

☐ Other insurance

☐ No medical insurance at this time

**Ethnicity—Is Applicant Hispanic or Latino?**

☐ Yes ☐ No

**Race** (Check all boxes that apply)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

**If an interpreter is required, select language below**

| | | |
|---|---|---|
| ☐ American Sign Language | ☐ Hmong | ☐ Other—Specify: |
| ☐ Spanish | ☐ Russian | _____ |
| ☐ Vietnamese | ☐ A Native American Language | |

**Contact Information 1**

| | | |
|---|---|---|
| ☐ Adult Child | ☐ Parent/Step-Parent | ☐ Spouse |
| ☐ Former-Spouse | ☐ Power of Attorney | ☐ Other Informal Caregiver/Support: |
| ☐ Guardian of Person | ☐ Sibling | _____ |

| Name (First) | (Middle Initial) | (Last) |
|---|---|---|
| | | |

Address

| City | State | Zip Code |
|---|---|---|
| | | |

| Telephone – Home | Telephone – Work | Cell Phone |
|---|---|---|
| (  )  - | (  )  - | (  )  - |

Best time to contact and/or comments:

**Contact Information 2**

☐ Adult Child ☐ Parent/Step-Parent ☐ Spouse
☐ Former-Spouse ☐ Power of Attorney ☐ Other Informal Caregiver/Support: _____
☐ Guardian of Person ☐ Sibling

| Name (First) | (Middle Initial) | (Last) |
|---|---|---|
| | | |

Address

| City | State | Zip Code |
|---|---|---|
| | | |

| Telephone – Home | Telephone – Work | Cell Phone |
|---|---|---|
| (  )  - | (  )  - | (  )  - |

Best time to contact and/or comments:

**Contact Information 3**

☐ Adult Child ☐ Parent/Step-Parent ☐ Spouse
☐ Former-Spouse ☐ Power of Attorney ☐ Other Informal Caregiver/Support: _____
☐ Guardian of Person ☐ Sibling

| Name (First) | (Middle Initial) | (Last) |
|---|---|---|
| | | |

Address

| City | State | Zip Code |
|---|---|---|
| | | |

| Telephone – Home | Telephone – Work | Cell Phone |
|---|---|---|
| (  )  - | (  )  - | (  )  - |

Best time to contact and/or comments:

**Notes**:

## LIVING SITUATION

**Current Residence**

**Own Home or Apartment**
- ☐ Alone (includes person living alone who receives in-home services)
- ☐ With spouse/partner/family
- ☐ With non-relatives/roommates (includes dorm, convent or other communal setting)
- ☐ With live-in paid caregiver(s) (includes service in exchange for room and board)

**Someone Else's Home or Apartment**
- ☐ Family
- ☐ Non-relative
- ☐ 1-2 bed Adult Family Home (certified) or other paid caregiver's home
- ☐ Home/apartment for which lease is held by support services provider

**Apartment with Services**
- ☐ Residential Care Apartment Complex
- ☐ Independent Apartment CBRF (Community-Based Residential Facility)

**Group Residential Care Setting**
- ☐ Licensed Adult Family Home (3-4 bed AFH)
- ☐ CBRF 1-20 beds
- ☐ CBRF more than 20 beds
- ☐ Children's Group Home

**Health Care Facility/Institution**
- ☐ Nursing Home (includes rehabilitation facility if licensed as a nursing home)
- ☐ ICF-IID/FDD
- ☐ DD Center/State institution for developmental disabilities
- ☐ Mental Health Institute/State psychiatric institution
- ☐ Other IMD
- ☐ Child Caring Institution
- ☐ Hospice Care Facility

☐ **No Permanent Residence** (For example, is in homeless shelter, etc.)

☐ **Other (includes jail)—Specify:** _____

**Prefers to Live**

**Own Home or Apartment**
- ☐ Alone (includes person living alone who receives in-home services)
- ☐ With spouse/partner/family
- ☐ With non-relatives/roommates (includes dorm, convent or other communal setting)
- ☐ With live-in paid caregiver(s) (includes service in exchange for room and board)

**Someone Else's Home or Apartment**
- ☐ Family
- ☐ Non-relative
- ☐ 1-2 bed Adult Family Home (certified) or other paid caregiver's home
- ☐ Home/apartment for which lease is held by support services provider

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- ☐ ICF-IID/FDD
- ☐ DD Center/State institution for developmental disabilities
- ☐ Mental Health Institute/State psychiatric institution
- ☐ Other IMD
- ☐ Child Caring Institution
- ☐ Hospice Care Facility

☐ **No Permanent Residence** (For example, is in homeless shelter, etc)

☐ **Unable to determine person's preference for living arrangement**

**What is the guardian's/family's preference for living arrangements for this individual?**
- ☐ Not applicable
- ☐ Stay at current residence
- ☐ Move to own home/apartment (includes living with spouse/family, roommates, 1-2 bed AFH)
- ☐ Move to an apartment with onsite services (RCAC, independent apartment CBRF)
- ☐ Move to a group residential care setting (CBRF, licensed 3-4 bed AFH)
- ☐ Move to a nursing home or other health care facility (ICF-IID, State Center, IMD)
- ☐ Unsure, or unable to determine
- ☐ No consensus among multiple parties

**Notes**:

## DIAGNOSES

☐ **No current diagnoses** **IQ:** Score _____ ☐ Unknown

### A. DEVELOPMENTAL DISABILITY

- ☐ 1 Intellectual Disability
- ☐ 2 Autism
- ☐ 3 Brain Injury with onset BEFORE age 22
- ☐ 4 Cerebral Palsy
- ☐ 5 Prader-Willi Syndrome
- ☐ 6 Seizure Disorder with onset BEFORE age 22
- ☐ 7 Other Congenital Disorders similar to intellectual Disability
  List Diagnoses _____
- ☐ 8 Down Syndrome
- ☐ 9 Other Congenital Disorders, that may meet state or federal definitions of DD, record IQ
  List Diagnoses _____
- ☐ 10 Unspecified Diagnoses, that may meet state or federal definitions of DD, record IQ
  List Diagnoses _____

### B. ENDOCRINE/METABOLIC

- ☐ 1 Diabetes Mellitus
- ☐ 2 Hypothyroidism/Hyperthyroidism
- ☐ 3 Dehydration/Fluid and Electrolyte Imbalances
- ☐ 4 Liver Disease (hepatic failure, cirrhosis)
- ☐ 5 Other Disorders of Digestive System (mouth, esophagus, stomach, intestines, gall bladder, pancreas)
  List diagnoses _____
- ☐ 6 Other Disorders of the Metabolic System (For example, B-12 deficiency, high cholesterol, Hyperlipidemia)
  List diagnoses _____
- ☐ 7 Other Disorders of the Hormonal System (For example, adrenal insufficiency or Addison's Disease)
  List diagnoses _____
- ☐ 8 Obesity
- ☐ 9 Malnutrition
- ☐ 10 Eating Disorders

### C. HEART/CIRCULATION

- ☐ 1 Anemia/Coagulation Defects/Other Blood Diseases
- ☐ 2 Angina/Coronary Artery Disease/Myocardial Infarction (MI)
- ☐ 3 Disorders of Heart Rate or Rhythm
- ☐ 4 Congestive Heart Failure (CHF)
- ☐ 5 Disorders of Blood Vessels or Lymphatic System
- ☐ 6 Hypertension
- ☐ 7 Hypotension (low blood pressure)
- ☐ 8 Other Heart/Circulatory Conditions (including valve disorders)
  List diagnoses _____

### D. MUSCULOSKELETAL/NEUROMUSCULAR

- ☐ 1 Amputation
- ☐ 2 Arthritis (For example, osteoarthritis, rheumatoid arthritis)
- ☐ 3 Hip Fracture/Replacement
- ☐ 4 Other Fracture/Joint Disorders/Scoliosis/Kyphosis
  List diagnoses _____
- ☐ 5 Osteoporosis/Other Bone Disease
- ☐ 6 Contractures/Connective Tissue Disorders
- ☐ 7 Multiple Sclerosis/ALS
- ☐ 8 Muscular Dystrophy
- ☐ 9 Spinal Cord Injury
- ☐ 10 Paralysis Other than Spinal Cord Injury
- ☐ 11 Spina Bifida
- ☐ 12 Other Chronic Pain Or Fatigue [For example, fibromyalgia, migraines, headaches, back pain (including disks), chronic fatigue syndrome]
  List diagnoses _____
- ☐ 13 Other Musculoskeletal, Neuromuscular, or Peripheral Nerve Disorders
  List diagnoses _____

### E. BRAIN/CENTRAL NERVOUS SYSTEM

- ☐ 1 Alzheimer's Disease
- ☐ 2 Other Irreversible Dementia
  List diagnoses _____
- ☐ 3 Cerebral Vascular Accident (CVA, stroke) with onset at age 22 or AFTER
- ☐ 4 Brain Injury at age 22 or AFTER
- ☐ 5 Seizure Disorder with onset at age 22 or AFTER
- ☐ 6 Other brain disorders with onset at age 22 or AFTER
  List diagnoses _____
- ☐ 7 Other Neurological Disorders
  List diagnoses _____

### F. RESPIRATORY

- ☐ 1 Chronic Obstructive Pulmonary Disease (COPD)/Emphysema/Chronic Bronchitis
- ☐ 2 Pneumonia/Acute Bronchitis/Influenza
- ☐ 3 Tracheostomy
- ☐ 4 Ventilator Dependent
- ☐ 5 Other Respiratory Condition
  List diagnoses _____
- ☐ 6 Asthma

## DIAGNOSES (Continued)

### G. DISORDERS OF GENITOURINARY/REPRODUCTIVE SYSTEM

- ☐ 1 Renal Failure, other Kidney Disease
- ☐ 2 Urinary Tract Infection, current or recently recurrent
- ☐ 3 Other Disorders of GU System (For example, bladder or urethra)
  List diagnoses _____
- ☐ 4 Disorders of Reproductive System

### H. DOCUMENTED MENTAL ILLNESS

- ☐ 1 Anxiety Disorder (For example, phobias, post-traumatic stress disorder, obsessive-compulsive disorder)
- ☐ 2 Bipolar/Manic-Depressive
- ☐ 3 Depression
- ☐ 4 Schizophrenia
- ☐ 5 Other Mental Illness Diagnosis (For example, personality disorder)
  List diagnoses _____

### I. SENSORY

- ☐ 1 Blind
- ☐ 2 Visual Impairment (For example, cataracts, retinopathy, glaucoma, macular degeneration)
- ☐ 3 Deaf
- ☐ 4 Other Sensory Disorders
  List diagnoses _____

### J. INFECTIONS/IMMUNE SYSTEM

- ☐ 1 Allergies
- ☐ 2 Cancer in Past 5 Years
- ☐ 3 Diseases of Skin
- ☐ 4 HIV - Positive
- ☐ 5 AIDS Diagnosed
- ☐ 6 Other Infectious Disease
  List diagnoses _____
- ☐ 7 Auto-Immune Disease (other than rheumatism)

### K. OTHER

- ☐ 1 Substance Use Issue
- ☐ 2 Behavioral Diagnoses (not found in part H above)
- ☐ 3 Terminal Illness (prognosis < or = 12 months)
- ☐ 4 Wound/Burn/Bedsore/Pressure Ulcer
- ☐ 5 Other
  List diagnoses _____
- ☐ 6 Additional Diagnoses
  List diagnoses _____

**Notes**:

## ADLS (ACTIVITIES OF DAILY LIVING)

| Coding for Level of Help Needed to Complete Task Safely | Coding for Who Will Help in Next Eight (8) Weeks (check all that apply) |
|---|---|
| **0:** Person is **independent** in completing the activity safely. | **U:** Current **UNPAID** caregiver will continue |
| **1:** Help is needed to complete task safely but **helper DOES NOT have to be physically present throughout the task**. "Help" can be supervision, cueing, or hands-on assistance. | **PF:** Current **PUBLICLY FUNDED** paid caregiver will continue |
| **2:** Help is needed to complete task safely and **helper DOES need to be present throughout task**. "Help" can be supervision, cueing, and/or hands-on assistance (partial or complete). | **PP:** Current **PRIVATELY PAID** caregiver will continue |
| | **N:** **Need** to find new or additional caregiver(s) |

| ADLs | | Help Needed | Who Will Help in Next Eight Weeks? |
|---|---|---|---|
| **BATHING** | **Adaptive Equipment Options**<br>☐ **No Equipment**<br>☐ **Uses Grab Bar(s)**<br>☐ **Uses Shower Chair**<br>☐ **Uses Tub Bench**<br>☐ **Uses Mechanical Lift** | ☐ 0<br>☐ 1<br>☐ 2 | ☐ U<br>☐ PF<br>☐ PP<br>☐ N |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | |
| **DRESSING** | | ☐ 0<br>☐ 1<br>☐ 2 | ☐ U<br>☐ PF<br>☐ PP<br>☐ N |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | |
| **EATING** | | ☐ 0<br>☐ 1<br>☐ 2 | ☐ U<br>☐ PF<br>☐ PP<br>☐ N |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | |
| **MOBILITY IN HOME** | **Adaptive Equipment Options**<br>☐ **No Equipment**<br>☐ **Uses Cane in Home**<br>☐ **Uses Wheelchair or Scooter in Home**<br>☐ **Has Prosthesis**<br>☐ **Uses Quad-Cane in Home**<br>☐ **Uses Crutches in Home**<br>☐ **Uses Walker in Home** | ☐ 0<br>☐ 1<br>☐ 2 | ☐ U<br>☐ PF<br>☐ PP<br>☐ N |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | |
| **TOILETING** | **Adaptive Equipment Options**<br>☐ **No Equipment**<br>☐ **Uses Grab Bar(s)**<br>☐ **Uses Commode or Other Adaptive Equipment**<br>☐ **Uses Urinary Catheter**<br>☐ **Has Ostomy**<br>☐ **Receives Regular Bowel Program** | ☐ 0<br>☐ 1<br>☐ 2 | ☐ U<br>☐ PF<br>☐ PP<br>☐ N |
| | **INCONTINENCE**: *Do not include stress incontinence*<br>☐ **Does not have incontinence**<br>☐ **Has incontinence less than daily but at least once per week**<br>☐ **Has incontinence daily** | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | |

| | ADLs | Help Needed | Who Will Help in Next Eight Weeks? |
|---|---|---|---|
| **TRANSFERRING** | **Adaptive Equipment Options**<br>☐ **No Equipment**<br>☐ **Uses Grab Bar(s), Bed Bar, or Bed Railing**<br>☐ **Uses Transfer Board or Pole**<br>☐ **Uses Trapeze**<br>☐ **Uses Mechanical Lift or Power Stander** | ☐ 0<br>☐ 1<br>☐ 2 | ☐ U<br>☐ PF<br>☐ PP<br>☐ N |

**Primary Diagnosis:** **Secondary Diagnosis:**

**Notes**:

## IADLS (INSTRUMENTAL ACTIVITIES OF DAILY LIVING)

**KEY: Coding for Who Will Help in Next Eight (8) Weeks –See ADLs**

| IADL | Level of Help Needed | Who Will Help in Next Eight Weeks? |
|---|---|---|
| **MEAL PREPARATION** | ☐ 0: Independent<br>☐ 1: Needs help from another person weekly or less often<br>☐ 2: Needs help 2-7 times a week<br>☐ 3: Needs help with every meal | ☐ U<br>☐ PF<br>☐ PP<br>☐ N |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | |
| **MEDICATION ADMINISTRATION and MEDICATION MANAGEMENT** | ☐ NA: Has no medications<br>☐ 0: Independent (with or without assistive devices)<br>☐ 1: Needs help 1-2 days per week or less often. Includes having someone set-up medications, pre-filled syringes, or the administration of medication.<br>☐ 2a: Needs help at least once a day 3-7 days per week—CAN direct the task and can make decisions regarding each medication.<br>☐ 2b: Needs help at least once a day 3-7 days per week—CANNOT direct the task; is cognitively unable to follow through without another person to administer each medication. | ☐ U<br>☐ PF<br>☐ PP<br>☐ N |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | |
| **MONEY MANAGEMENT** | ☐ 0: Independent<br>☐ 1: Can only complete small transactions (Needs help from another person to complete some components of Money Management)<br>☐ 2: Needs help from another person with all transactions | ☐ U<br>☐ PF<br>☐ PP<br>☐ N |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | |
| **LAUNDRY and/or CHORES** | ☐ 0: Independent<br>☐ 1: Needs help from another person weekly or less often<br>☐ 2: Needs help more than once a week | ☐ U<br>☐ PF<br>☐ PP<br>☐ N |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | |
| **TELEPHONE USE** | **1. Ability to Use Phone**<br>☐ 1a: Independent—has cognitive and physical abilities to use a phone<br>☐ 1b: Lacks cognitive or physical abilities to use phone independently<br>**2. Access to Phone**<br>☐ 2a: Currently has working phone or access to one<br>☐ 2b: Has no phone and no access to a phone | ☐ U<br>☐ PF<br>☐ PP<br>☐ N |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | |
| **TRANSPORTATION** | ☐ 1a: Person drives **regular** vehicle<br>☐ 1b: Person drives **adapted** vehicle<br>☐ 1c: Person drives **regular** vehicle but there are serious safety concerns<br>☐ 1d: Person drives **adapted** vehicle but there are serious safety concerns<br>☐ 2: **Person cannot drive due to physical, psychiatric, or cognitive impairment**.<br>☐ 3: **Person does not drive due to other reasons** | ☐ U<br>☐ PF<br>☐ PP<br>☐ N |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | |

**Notes**:

## ADDITIONAL SUPPORTS

**Overnight Care or Overnight Supervision Information**

Does person require overnight care or overnight supervision?

☐ 0: No
☐ 1: Yes; caregiver can get at least six hours of uninterrupted sleep per night
☐ 2: Yes; caregiver cannot get at least six hours of uninterrupted sleep per night

**Primary Diagnosis:** **Secondary Diagnosis:**

**Employment Information**

**A. Current Employment Status**

☐ 1: Retired (Does not include people under 65 who stopped working for health or disability reasons)
☐ 2: Not working (No paid work)
Is the individual interested in employment? ☐ Yes or ☐ No
☐ 3: Working full-time (Paid work averaging 30 or more hours per week)
☐ 4: Working part-time (Paid work averaging fewer than 30 hours per week)

**B. If Paid Work, Where? (Check all that apply)**

☐ 1: Facility-Based Setting
Is the individual interested in working in the community? ☐ Yes or ☐ No
☐ 2: Group-Supported employment in the community (two or more) or individual employment in the community, with or without employment services, paid at a subminimum wage
☐ 3: Individual employment in the community, with or without employment services, paid at a competitive wage (minimum wage or higher)
☐ 4: At home or self-employed

**C. Need for Assistance to Work**

☐ 0: Independent (with assistive devices if uses them)
☐ 1: Needs help weekly or less (e.g., if a problem arises)
☐ 2: Needs help every day but does not need the continuous presence of another
☐ 3: Needs the continuous presence of another person
☐ 4: Not applicable (please explain)

**Primary Diagnosis:** **Secondary Diagnosis:**

**Educational Information**

Is the individual currently participating in an educational program?

☐ Yes ☐ No

Does the individual need assistance from another person to participate in an educational program?

☐ Yes ☐ No

**Primary Diagnosis:** **Secondary Diagnosis:**

**Guardianship**

Does this individual have a guardianship?

☐ Yes ☐ No

**Primary Diagnosis:** **Secondary Diagnosis:**

**Diagnoses with Onset before Age 22**

Was the onset of the condition that caused the diagnosis (A1-A10) before the age of 22?

☐ Yes ☐ No

**Expected Diagnosis Duration and Disability Determination**

Are the needs that are caused by the individual's primary and secondary diagnosis(es) expected to last more than 90 days?

☐ Yes ☐ No

Are the needs that are caused by the individual's primary and secondary diagnosis(es) expected to last more than 12 months OR does the individual have a terminal illness?

☐ Yes ☐ No

Does the individual have a disability determination from the Social Security Administration?

☐ Yes ☐ No ☐ Pending

**Notes**:

## HEALTH RELATED SERVICES

Check only one box per row—Leave row blank if not applicable

| Health-Related Services | Person is Independent | Frequency of Help/Services Needed from Other Persons | | | | | |
|---|---|---|---|---|---|---|---|
| | | 1-3 times/ month | Weekly | 2-6 times/ week | 1-2 times/ day | 3-4 times/ day | 5+ times a day |
| **Behaviors** requiring interventions (wandering, SIB, offensive/violent behaviors) | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Exercises/Range of Motion** | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **IV Medications**, fluids or IV line flushes | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Medication Administration** (not IV)—includes assistance with pre-selected or set-up meds | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Medication Management**—Set-up and/or monitoring (for effects, side effects, adjustments, pain management)—AND/OR blood levels (For example, drawing blood sample for laboratory tests or “finger-sticks” for blood sugar levels.) | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Ostomy-related SKILLED Services** | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Positioning** in bed or chair every 2-3 hours | | | | | | | |
| **Oxygen and/or Respiratory Treatments**)—tracheal suctioning, C-PAP, Bi-PAP, nebulizers, IPPB treatments (does NOT include inhalers) | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Dialysis** | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **TPN** (total parenteral nutrition) | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Transfusions** | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Tracheostomy care** | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Tube Feedings** | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Ulcer – Stage 2** | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |

| HEALTH RELATED SERVICES (Continued) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Ulcer – Stage 3 or 4** | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Urinary Catheter-**related **skilled** tasks (irrigation, straight catheterizations) | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Other Wound Cares** (not catheter sites, ostomy sites, or IVs or ulcers) | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Ventilator-related interventions** | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Requires Nursing Assessment and Interventions**<br>Each of the following four criteria MUST be present:<br>• A current health instability that<br>• requires skilled nursing assessment and interventions, AND<br>• involves CHANGES in the medical treatment or nursing care plan, AND<br>• cannot be captured in any other HRS row. | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |
| **Other—Specify**: | | | | | | | |
| **Primary Diagnosis:** | **Secondary Diagnosis:** | | | | | | |

**Skilled Therapy—PT, OT, SLP** (any one or combination, any location) ☐ 1-4 sessions/week ☐ 5+ sessions/week

**Who will help with all health-related needs in next eight (8) weeks** (check **all** that apply)

- ☐ **U** Current **UNPAID** caregiver will continue
- ☐ **PP** Current **PRIVATELY PAID** caregiver will continue
- ☐ **PF** Current **PUBLICLY FUNDED** paid caregiver will continue
- ☐ **N** **Need** to find new or additional caregiver(s)

**Notes:**

## COMMUNICATION AND COGNITION

**Communication**

- ☐ 0: Can fully communicate with no impairment or only minor impairment (e.g, slow speech)
- ☐ 1: Can fully communicate with the use of assistive device
- ☐ 2: Can communicate ONLY BASIC needs to others
- ☐ 3: No effective communication

**Primary Diagnosis:** **Secondary Diagnosis:**

**Memory Loss**

- ☐ 0: No memory impairments evident during screening process
- ☐ 1: Short-Term Memory Loss (seems unable to recall things a few minutes up to 24 hours later)
- ☐ 2: Unable to remember things over several days or weeks
- ☐ 3: Long-Term Memory Loss (seems unable to recall distant past)
- ☐ 4: Memory impairments are unknown or unable to determine. Explain why:_____

**Cognition for Daily Decision Making**

- ☐ 0: Person makes decisions consistent with their own lifestyle, values, and goals
- ☐ 1: Person makes safe, familiar/routine decisions but cannot do so in new situations
- ☐ 2: Person needs help with reminding, planning, or adjusting routine, even with familiar routine
- ☐ 3: Person needs help from another person most or all of the time

**Primary Diagnosis:** **Secondary Diagnosis:**

**Physically Resistive to Care**

- ☐ 0: No
- ☐ 1: Yes, person is physically resistive to cares due to a cognitive impairment

**Notes**:

## BEHAVIORAL HEALTH

**Wandering**

- ☐ 0: Does not wander
- ☐ 1: Daytime wandering, but sleeps nights
- ☐ 2: Wanders during the night, or during both day and night

**Self-Injurious Behaviors**

- ☐ 0: No injurious behaviors demonstrated
- ☐ 1: Some self-injurious behaviors require interventions weekly or less
- ☐ 2: Self-injurious behaviors require interventions 2-6 times per week OR 1-2 times per day
- ☐ 3: Self-injurious behaviors require intensive one-on-one interventions more than twice each day

  List behavior:_____

**Offensive or Violent Behavior to Others**

- ☐ 0: No offensive or violent behaviors demonstrated
- ☐ 1: Some offensive or violent behaviors that require interventions weekly or less
- ☐ 2: Offensive or violent behaviors that require interventions 2-6 times per week OR 1-2 times per day
- ☐ 3: Offensive or violent behaviors that require intensive one-on-one interventions more than twice each day

  List behavior:_____

**Mental Health Needs**

- ☐ 0: No mental health problems or needs evident
- ☐ 1: No current diagnosis. Person may be at risk and in need of mental health services
- ☐ 2: Person has a current diagnosis of mental illness

**Substance Use Disorder**

- ☐ 0: No substance use issues or diagnosis evident at this time
- ☐ 1: No current diagnosis. Person or others indicate(s) a current substance use problem, or evidence suggests possibility of a current problem or high likelihood of recurrence without significant ongoing support or interventions. *Examples are police intervention, detox, history of withdrawal symptoms, inpatient treatment, job loss, major life changes.*
- ☐ 2: Person has a current diagnosis of substance use disorder

**Notes**:

## RISK

**Part A – Current APS or EAN Client**

- ☐ A1: Person is known to be a current client of Adult Protective Services (APS)
- ☐ A2: Person is currently being served by the lead Elder Adult/Adult at Risk (EA/AAR) agency

**Part B – Risk Evident During Screening Process**

- ☐ 0: No risk factors or evidence of abuse, neglect, or exploitation apparent at this time
- ☐ 1: The individual is currently failing or is at high risk of failing to obtain nutrition, self-care, or safety adequate to avoid significant negative health outcomes
- ☐ 2: The person is at imminent risk of institutionalization (in a nursing home or ICF-IID) if they do not receive needed assistance or person is currently residing in a nursing home or ICF-IID and needs that level of care or supervision
- ☐ 3: There are statements of, or evidence of, possible abuse, neglect, or exploitation
  - ☐ Not Applicable
  - ☐ Referring to APS and/or EA/AAR now
- ☐ 4: The person's support network appears to be adequate at this time, but may be fragile in the near future (within next 4 months)

**Notes**:

## SCREEN COMPLETION

**Date of Screen Completion** (mm/dd/yyyy): _____

| Time to Complete Screen | Hours | Minutes |
|---|---|---|
| **Face-to-face contact with the person** | | |
| **Collateral Contacts** | | |
| **Paper Work** | | |
| **Travel Time** | | |
| **Total Time to Complete Screen** | | |

## NO ACTIVE TREATMENT (NAT)

**No Active Treatment**

Part A Statements:

1. The person has a terminal illness.
   ☐ Yes ☐ No
2. The person has a documented IQ greater than 75.
   ☐ NA ☐ Yes ☐ No
3. The person is ventilator-dependent.
   ☐ Yes ☐ No

Part B Statements:

1. The person has physical and mental incapacitation, typically but not always due to advanced age, such that their needs are similar to those of geriatric nursing home residents.
   ☐ Yes ☐ No
2. The person is age 65 or older and would no longer benefit from active treatment.
   ☐ Yes ☐ No
3. The person has severe chronic medical needs that require skilled nursing care.
   ☐ Yes ☐ No

**Notes**: