DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Medicaid Services
F-00366 (08/2023)

WISCONSIN ADULT LONG TERM CARE FUNCTIONAL SCREEN (LTCFS)

BASIC INFORMATION

Basic Screen Information

Name – Screening Agency

Referral Date	Screen Type (Check only one box) ☐ 01 Initial Screen ☐ 02 Rescreen
Name – Screener	Screener ID

Applicant Information

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

Address

City	State	Zip Code
Telephone – Home ( ) -	Telephone – Work ( ) -	Telephone – Cell ( ) -
County of Residence	County/Tribe of Responsibility	

Directions: _____

Notes:

SCREEN INFORMATION

Source of 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)
- ☐ FDD/ICF-IID
- ☐ State Center
- ☐ Home Health Agency
- ☐ Community Agency
- ☐ Other—Specify: _____
- ☐ 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

- ☐ Advocates4U
- ☐ Connections
- ☐ First Person Care Consultants
- ☐ Midstate Independent Living Choices (MILC)
- ☐ Progressive Community Services (PCS)
- ☐ TMG

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
☐ Other

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
☐ Ex-Spouse	☐ Power of Attorney	☐ Other Informal Caregiver/Support:
☐ Guardian of Person	☐ Sibling	_____

Name (First)	(Middle Initial)	(Last)

Address

City	State	Zip Code

Home Phone	Work Phone	Cell Phone
( ) -	( ) -	( ) -

Best time to contact and/or comments:

Contact Information 2

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

Name (First)	(Middle Initial)	(Last)

Address

City	State	Zip Code

Home Phone	Work Phone	Cell Phone
( ) -	( ) -	( ) -

Best time to contact and/or comments:

Contact Information 3

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

Name (First)	(Middle Initial)	(Last)

Address

City	State	Zip Code

Home Phone	Work Phone	Cell Phone
( ) -	( ) -	( ) -

Best time to contact and/or comments:

Notes:

LIVING SITUATION

Current Residence

Own Home or Apartment
- ☐ Alone
- ☐ With Spouse/Partner/Family
- ☐ With Non-Relatives/Roommates
- ☐ With Live-in Paid Caregiver(s)

Someone Else's Home or Apartment
- ☐ Family
- ☐ Non-relative
- ☐ Certified Adult Family Home (1-2 Bed AFH) or other paid caregiver's home
- ☐ Home or Apartment for which lease is held by support services provider

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

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
- ☐ FDD/ICF-IID
- ☐ DD Center/State Institution for Developmental Disabilities
- ☐ Mental Health Institute/State Psychiatric Institution
- ☐ Other IMD
- ☐ Child Caring Institution
- ☐ Hospice Care Facility

☐ **No Permanent Residence**

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

Prefers to Live
- ☐ Stay at current residence
- ☐ Move to their own home or apartment
- ☐ Move to someone else's home or apartment
- ☐ Move to an apartment with onsite services
- ☐ Move to a group residential care setting
- ☐ Move to a health care facility or institution
- ☐ No permanent residence
- ☐ Unsure, or unable to determine person's preference for living arrangement

Guardian/Family's Preference for this Individual
- ☐ Not applicable
- ☐ Stay at current residence
- ☐ Move to their own home or apartment
- ☐ Move to someone else's home or apartment
- ☐ Move to an apartment with onsite services
- ☐ Move to a group residential care setting
- ☐ Move to a health care facility or institution
- ☐ No consensus among multiple parties
- ☐ No response or no preference from guardian or family

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
  List diagnoses _____
- ☐ 10 Unspecified Diagnoses, that may meet state or federal definitions of DD
  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 _____
- ☐ 8 Memory Loss by Provider
- ☐ 9 Memory Loss by Memory Screening
  List Date and Results _____

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 partial or complete hands-on assistance.	**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** ☐ **No Equipment** ☐ **Uses Adaptive Equipment**	☐ 0 ☐ 1 ☐ 2	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**		
DRESSING		☐ 0 ☐ 1 ☐ 2	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**		
EATING		☐ 0 ☐ 1 ☐ 2	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**		
MOBILITY IN HOME	**Adaptive Equipment Options** ☐ **No Equipment** ☐ **Uses Cane, Crutches, or Walker in Home** ☐ **Uses Wheelchair or Scooter in Home** ☐ **Has Prosthesis**	☐ 0 ☐ 1 ☐ 2	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**		
TOILETING	**Adaptive Equipment Options** ☐ **No Equipment** ☐ **Uses Grab Bar, Commode, or Other Adaptive Equipment** ☐ **Uses Urinary Catheter** ☐ **Has Ostomy** ☐ **Receives Regular Bowel Program**	☐ 0 ☐ 1 ☐ 2	☐ U ☐ PF ☐ PP ☐ N
	INCONTINENCE: *Do not include stress incontinence* ☐ **Does not have incontinence or has incontinence less often than weekly** ☐ **Has incontinence less than daily but at least once per week** ☐ **Has incontinence daily**		
Primary Diagnosis:	**Secondary Diagnosis:**		

	ADLs	Help Needed	Who Will Help in Next Eight Weeks?
TRANSFERRING	**Adaptive Equipment Options** ☐ **No Equipment** ☐ **Uses Grab Bar(s), Bed Bar, or Bed Railing** ☐ **Uses Transfer Board or Pole** ☐ **Uses Trapeze** ☐ **Uses Mechanical Lift or Power Stander**	☐ 0 ☐ 1 ☐ 2	☐ U ☐ PF ☐ PP ☐ 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 ☐ 1: Needs help weekly or less often ☐ 2: Needs help 2-7 times a week ☐ 3: Needs help with every meal	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**	
MEDICATION ADMINISTRATION and MEDICATION MANAGEMENT	☐ N/A: Has no medications ☐ 0: Independent ☐ 1: Needs help 1-2 days per week or less often. ☐ 2a: Needs help at least once a day 3-7 days per week—CAN direct the task ☐ 2b: Needs help at least once a day 3-7 days per week—CANNOT direct the task	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**	
MONEY MANAGEMENT	☐ 0: Independent ☐ 1: Can only complete small transactions (Needs help to complete some components of Money Management) ☐ 2: Needs help with all transactions	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**	
LAUNDRY and/or CHORES	☐ 0: Independent ☐ 1: Needs help weekly or less often ☐ 2: Needs help more than once a week	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**	
TELEPHONE USE	**1. Ability to Use Phone** ☐ 1a: Independent—has cognitive and physical abilities to use a phone ☐ 1b: Lacks cognitive or physical abilities to use phone independently **2. Access to Phone** ☐ 2a: Currently has working phone or access to one ☐ 2b: Has no phone and no access to a phone	
Primary Diagnosis:	**Secondary Diagnosis:**	
TRANSPORTATION	☐ 1a: Person drives **regular** vehicle ☐ 1b: Person drives **adapted** vehicle ☐ 1c: Person drives **regular** vehicle but there are serious safety concerns ☐ 1d: Person drives **adapted** vehicle but there are serious safety concerns ☐ 2: **Person cannot drive due to physical, psychiatric, or cognitive impairment**. ☐ 3: **Person does not drive due to other reasons**	
Primary Diagnosis:	**Secondary Diagnosis:**	

Notes:

ADDITIONAL SUPPORTS

Overnight Care or Overnight Supervision Information

Does the 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 person
☐ 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:**

I/DD Diagnoses with Onset before Age 22

Was the onset of at least one of the A1-A10 diagnosis(es) 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							
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) orAssistance with Pre-Selected or Set-Up Medications							
Primary Diagnosis:	Secondary Diagnosis:						
Medication Management—Set-up and/or Monitoring Medications (for Effects, Side Effects, Adjustments, Pain Management)—and/or Blood Levels							
Primary Diagnosis:	Secondary Diagnosis:						
Ostomy-Related Skilled Services							
Primary Diagnosis:	Secondary Diagnosis:						
Positioning in Bed or Chair Every 2-3 Hours							
Primary Diagnosis:	Secondary Diagnosis:						
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, IVs or Ulcer - Stage 2, 3, or 4)							
Primary Diagnosis:	Secondary Diagnosis:						
Ventilator-Related Interventions							
Primary Diagnosis:	Secondary Diagnosis:						
Requires Nursing Assessment and Interventions							
Primary Diagnosis:	Secondary Diagnosis:						
Other—Specify:							

Skilled Therapy—PT, OT, SLP (Any One or Combination at Any Location) ☐ 1-4 sessions/week ☐ 5+ sessions/week

Primary Diagnosis: Secondary Diagnosis:

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
- ☐ 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
- ☐ 2: Unable to remember things over several days or weeks
- ☐ 3: Long-Term Memory Loss
- ☐ 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
- ☐ 1: No current diagnosis. Person may be at risk of recurrence or evidence suggests current problem
- ☐ 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 FDD/ICF-IID) if they do not receive needed assistance or person is currently residing in a nursing home or FDD/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 within the next 4 months

Notes:

SCREEN TIME

Screen Time Information

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

Time to Complete Screen	Hours	Minutes
Face-to-Face Contact with 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 an IQ greater than 75.
   ☐ N/A ☐ 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: