DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Medicaid Services
F-00366 (12/2017)

WISCONSIN ADULT LONG TERM CARE (LTC) FUNCTIONAL SCREEN

BASIC INFORMATION

Basic Screen Information

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

Basic Applicant Information

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

Applicant's Contact Information

Address		
City	State	Zip Code
Telephone – Home ( ) -	Telephone – Work ( ) -	Telephone – Cell ( ) -
County/Tribe 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 (Check only one box)

- ☐ 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 (Check only one box)

- ☐ Self
- ☐ Guardian or other legal representative
- ☐ Family Member
- ☐ Spouse/Significant Other
- ☐ Parent
- ☐ Other—Specify: _____
- ☐ 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

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

Notes:

HCB WAIVER GROUP

For Home and Community Based Waiver counties only

☐ CIP 1A ☐ CIP 1B ☐ COP W & CIP II ☐ 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 (Check only one box)

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 (Check only one box)

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
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- ☐ 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? (Check only one box)

- ☐ 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

Diagnoses: Select a diagnosis here if (1) it is provided by a health care provider, or (2) you see it written in a medical record (including hospital discharge forms, nursing home admission forms, etc.), or (3) if person or informant can state the diagnosis exactly – except for intellectual disability, psychiatric, behavioral, and dementia diagnoses which must be confirmed by a health care provider or medical records.

Refer to Diagnoses Cue Sheet for coding when diagnosis does not appear below. When selecting "Other" in any section below, a diagnosis must be entered in the text box provided.

☐ **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, depending on IQ
  List Diagnoses _____
- ☐ 10 Unspecified Diagnoses that may meet state or federal definitions of DD, depending on 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 Traumatic 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	
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 (Activities of Daily Living)		Help Needed (check only one)	Who Will Help in Next Eight Weeks? (check all that apply)
BATHING	The ability to shower, bathe, or take sponge baths for the purpose of maintaining adequate hygiene. This also includes the ability to get in and out of the tub, turn faucets on and off, regulate water temperature, wash, and dry fully. ☐ **Uses Grab Bar(s)** ☐ **Uses Shower Chair** ☐ **Uses Tub Bench** ☐ **Uses Mechanical Lift**	☐ 0 ☐ 1 ☐ 2	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**		
DRESSING	The ability to safely dress and undress as necessary. The task of Dressing consists of the following components: Dressing/undressing the top half of body (includes putting on undergarments), dressing/undressing the bottom half of body (includes putting on undergarments), getting shoes and socks on and off, putting on or removing prostheses, orthotic devices, anti-embolism hose (TED hose), compression products or devices (stockings, bandages, pumps), and/or pressure relieving devices, and choosing the appropriate clothing to maintain health and safety for the environment and setting.	☐ 0 ☐ 1 ☐ 2	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**		
EATING	The ability to eat and drink using routine or adaptive utensils. This also includes the ability to chew and swallow food. **Note**: If person is fed via tube feedings or intravenous, check box 0 if they can do themselves, or box 1 or 2 if they require another person to assist.	☐ 0 ☐ 1 ☐ 2	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**		
MOBILITY IN HOME	The ability to move between locations in the individual's living environment—defined as kitchen, living room, bathroom, and sleeping area. *This excludes basements, attics, yards, and any equipment used outside the home*. ☐ **Uses Cane in Home** ☐ **Uses Wheelchair or Scooter in Home** ☐ **Has Prosthesis** ☐ **Uses Quad-Cane in Home** ☐ **Uses Crutches in Home** ☐ **Uses Walker in Home**	☐ 0 ☐ 1 ☐ 2	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**		

ADLs (Activities of Daily Living)		Help Needed (check only one)	Who Will Help in Next Eight Weeks? (check all that apply)
TOILETING	The ability to use the toilet, commode, bedpan, or urinal. This includes transferring on/off the toilet, cleansing of self, changing of pads, managing an ostomy or catheter, and adjusting clothes. ☐ **Uses Grab Bar(s)** ☐ **Uses 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* (small amount of urine leaking during sneezing, coughing, or other exertion) ☐ **Does not have incontinence** ☐ **Has incontinence less than daily but at least once per week** ☐ **Has incontinence daily**		
Primary Diagnosis:	**Secondary Diagnosis:**		
TRANSFERRING	The physical ability to move between surfaces: from bed/chair to wheelchair, walker, or standing position. The ability to get in and out of bed or usual sleeping place. The ability to use assistive devices for transfers. *Excludes toileting transfers.* ☐ **Uses Grab Bar(s)** ☐ **Uses Transfer Board** ☐ **Uses Trapeze** ☐ **Uses Mechanical Lift** (not a lift chair)	☐ 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

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)

IADL	Level of Help Needed	Who Will Help in Next Eight Weeks? (check all that apply)
MEAL PREPARATION	☐ 0 Independent ☐ 1 Needs help from another person weekly or less often (For example, grocery shopping) ☐ 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	☐ NA—Has no medications ☐ 0 Independent (with or without assistive devices) ☐ 1 Needs some 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 and can make decisions regarding each medication. ☐ 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 ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**	
MONEY MANAGEMENT	☐ 0 Independent ☐ 1 Can only complete small transactions ☐ 2 Needs help from another person with all transactions	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**	
LAUNDRY and/or CHORES	☐ 0 Independent ☐ 1 Needs help from another person weekly or less often ☐ 2 Needs help more than once a week	☐ U ☐ PF ☐ PP ☐ N
Primary Diagnosis:	**Secondary Diagnosis:**	
TELEPHONE	**1. Ability to Use Phone** ☐ 1a Independent—has cognitive and physical abilities to make calls and answer calls (with assistive devices currently used by this person) ☐ 1b Lacks cognitive or physical abilities to use phone independently **2. Access to Phone** ☐ 2a Currently has working telephone or access to one ☐ 2b Has no phone and no access to a phone	☐ U ☐ PF ☐ PP ☐ N
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**. Includes no driver's license due to medical problems (For example, seizures, poor vision). ☐ 3 **Person does not drive due to other reasons**	☐ U ☐ PF ☐ PP ☐ 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

This section concerns the need for assistance to perform employment-specific activities – that is, job duties. Since the need for help with ADLs and other IADLs (e.g., transportation, personal care) is captured in other sections, this section essentially concerns supports necessary for successful performance of work tasks.

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)

☐ 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 Employed, Where?

☐ 1 Paid work where the environment and the work tasks are designed for people with disabilities (e.g., sheltered workshop)

☐ 2 Paid work in other group situation for people with disabilities (e.g., work crew/enclave)

☐ 3 Paid work outside the home (situations other than those described in B1 and B2)

☐ 4 Paid work at home

C. Need for Assistance to Work

Mandatory for ages 18-64; otherwise optional

☐ 0 Independent (with assistive devices if uses them)

☐ 1 Needs help weekly or less (For example, 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

Primary Diagnosis: **Secondary Diagnosis:**

Educational Information (check only **one** box for each question)

***Is the individual currently participating in an educational program?**

☐ No ☐ Yes

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

☐ No ☐ Yes

Primary Diagnosis: **Secondary Diagnosis:**

Guardianship (check only **one** box for each question)

***Does this individual have a guardianship?**

☐ No ☐ Yes

Is the guardianship due to intellectual disability?

☐ No ☐ Yes

Diagnoses with Onset before Age 22 (check only **one** box)

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

☐ No ☐ Yes

Expected Diagnosis Duration and Disability Determination (check only **one** box for each question)

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

☐ No ☐ Yes

*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?

☐ No ☐ Yes

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

☐ No ☐ Yes ☐ 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 Each of the following four criteria MUST be present: • A current health instability that • requires skilled nursing assessment and interventions, AND • involves CHANGES in the medical treatment or nursing care plan, AND • 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)

COMMUNICATION AND COGNITION

Communication (check only **one** box)
Includes the ability to express oneself in one's own language, including non-English languages and American Sign Language (ASL) or other generally recognized non-verbal communication. This includes the use of assistive technology.

- ☐ 0 Can fully communicate with no impairment or only minor impairment (For example, 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 (At least one box must be checked. Check all applicable boxes, however, if box "0" is checked, do not check boxes 1, 2, 3, or 4)

- ☐ 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 (check only **one** box)

- ☐ 0 **Independent**—Person can make decisions that are generally consistent with his/her **own** lifestyle, values, and goals (not necessarily with professionals' values and goals)
- ☐ 1 Person can make safe decisions in **familiar/routine situations**, but needs some help with decision-making when faced with new tasks or 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 (check only **one** box)

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

Notes:

BEHAVIORAL HEALTH

Wandering
Defined as a person with cognitive impairments leaving residence/immediate area without informing others. *Person may still exhibit wandering behavior even if elopement is impossible due to, for example, facility security systems.*

- ☐ 0 Does not wander
- ☐ 1 Daytime wandering but sleeps nights
- ☐ 2 Wanders at night, or day and night

Self-Injurious Behaviors
Behaviors that cause or could cause injury to one's own body. *Examples include physical self-abuse (hitting, biting, head-banging, etc.), pica (eating inedible objects), and water intoxication (polydipsia).*

- ☐ 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
Behavior that causes others significant pain, substantial distress, or is at a point that law enforcement would typically be called to intervene.

- ☐ 0 No offensive or violent behaviors demonstrated
- ☐ 1 Some offensive or violent behaviors require occasional interventions **weekly or less**
- ☐ 2 Offensive or violent behaviors require interventions 2-6 times per week **OR** 1-2 times per day
- ☐ 3 Offensive or violent behaviors 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: (Check only one of the three boxes below)

- ☐ 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

At least one box must be checked. Check all applicable boxes, however, if box "0" is checked, do not check boxes 1, 2, 3, or 4.

- ☐ 0 No risk factors or evidence of abuse or neglect 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 (This can include an in-person interview, or observation if person cannot participate in the interview.)		
Collateral Contacts (Either in person or indirect contact with any other people, including the person's guardian, family, advocates, providers, etc.)		
Paper Work (Includes review of medical documents, etc.)		
Travel Time		
Total Time to Complete Screen		

COP LEVEL 3 AND NO ACTIVE TREATMENT (NAT)

COP Level 3 (for Home and Community-Based Waiver counties only)

Part A—Alzheimer's and related diseases

1. The person has a physician's written and dated statement that the person has Alzheimer's and/or another qualifying irreversible dementia.
   ☐ NA ☐ Yes ☐ No
2. The person needs personal assistance, supervision and protection, and periodic medical services and consultation with a registered nurse, or periodic observation and consultation for physical, emotional, social, or restorative need, but not regular nursing care.
   ☐ NA ☐ Yes ☐ No

Part B—Interdivisional Agreement 1.67

1. The person resided in a nursing home or received CIP II/COP-W services and was referred through an Interdivisional Agreement 1.67 in accordance with s. 46.27(6r)(b)(3).
   ☐ NA ☐ Yes ☐ No

No Active Treatment (Section must be completed for any individual who has an A1-A10 diagnosis[es] selected on the Diagnoses Table.)

Part A—Criteria that can be documented prior to enrollment:

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

Part B—Criteria that can be documented after enrollment:

1. The person has physical and mental incapacitation due to advanced age such that his/her needs are similar to those of geriatric nursing home residents.
   ☐ NA ☐ Yes ☐ No
2. The person is age 65 or older and would no longer benefit from active treatment.
   ☐ NA ☐ Yes ☐ No
3. The person has severe chronic medical needs that require skilled nursing level of care.
   ☐ NA ☐ Yes ☐ No