COP FUNCTIONAL SCREEN

Use of form: Personally identifiable information collected on this form is confidential and used for the purposes of identification and in determining eligibility of COP, CIP II / COP–W and diverted CIP 1A / 1B applicants. Annual completion of this form is necessary to meet the requirements of Wisconsin Statutes, s. 46.27(6r)(b)(1).

Instructions: Complete at initial eligibility determination for COP; CIP II / COP–W; and diverted CIP IA / IB applicants. Complete every twelve months for eligibility redetermination for COP–W and CIP II.

Name – Applicant	Name – Person Conducting Screen
Birthdate – Applicant (mm/dd/yyyy)	Check one below. ☐ Social worker ☐ Nurse ☐ Case Manager ☐ Other (COP only)*
Name – County Agency	*Must be redone by a Social Worker, Nurse or Care Manager (as defined in the MA Waiver Manual) if CIP II / COP–W is applied for at a later date.
Date of Screening (mm/dd/yyyy)	

Guides for Use of Screen

1. Begin with Level 1 for all persons, including persons with Alzheimer's or Chronic Mental Illness and go through every level sequentially until eligibility has been determined as persons with these diagnoses may be eligible in Level 1 or 2.
2. Persons found eligible only at Level 3 are eligible for COP, but are not eligible for the Medicaid Community Waivers.
3. When completing the functional screen for children, evaluate conditions based on age appropriateness of behaviors / capacities.
4. For MA Waivers, CIP II and COP–W, the Functional Screen information is substantiated by information provided by the authorized professionals completing the Medicaid Waiver Program Health Report (F-20810).

Screen Summary

Upon completion, check the highest eligibility level. Enter corresponding number of HSRS Module (Field 9).

Screen Level	HSRS Number
Level I	☐ 1. Severe Medical
Level II	☐ 2. Substantial Medical and Social
	☐ 3. Substantial Medical and Social with Developmental Disabilities
Level III	☐ 4. Special Eligibility – Alzheimer's Disease or Related Disorder
	☐ 5. Special Eligibility – Chronic Mental Illness
	☐ 6. I.A. 1.67 Referral
Level IV	☐ 7. Not Eligible for Services

LEVEL I SEVERE MEDICAL CONDITIONS

Refer to FUNCTIONAL SCREEN DEFINITIONS AND DESCRIPTIONS in the COP Guidelines or the MA Waivers Manual for meaning of terms used here.

A. SEVERE MEDICAL CONDITION

THE PERSON HAS A LONG-TERM OR IRREVERSIBLE ILLNESS OR DISABILITY AND: **(Both No. 1 and No. 2 are required. If either 1 or 2 cannot be checked, PROCEED TO LEVEL II.)**

☐ 1. The person has a complex or unstable medical condition (see definitions). Provide a **description** of the complexity or the instability of the medical condition(s). Explain items checked in section 2. (For COP–W / CIP II, ensure information is verifiable by documentation provided on the F-20810.)

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☐ 2. At least one of the following applies:

- ☐ a. Medically prescribed treatment is needed for any of the following conditions **at least five days per week**:
  - ☐ 1) Decubitus ulcers
  - ☐ 2) Comotose condition
  - ☐ 3) Frequent severe pain
  - ☐ 4) Terminal illness due to a severe medical condition
- ☐ b. Person requires the following prescribed medical equipment or service **at least three days per week**:
  - ☐ 1) Oxygen
  - ☐ 2) Ventilator / respirator
  - ☐ 3) Suction equipment
  - ☐ 4) Tube feeding
  - ☐ 5) Hickman catheter or I.V.
  - ☐ 6) Dialysis equipment
  - ☐ 7) Total parenteral nutrition (TPN)
  - ☐ 8) Urinary catheter
- ☐ c. Person must follow special routines or prescribed treatments **at least five days per week**:
  - ☐ 1) Ostomy care (e.g., ileostomy, colostomy, tracheostomy, gastrostomy)

    OR
  - 2) Special rehabilitation for significant improvement or prevention of a condition: (Check one)
    - ☐ a) Receiving physical therapy (see definitions)
    - ☐ b) Receiving occupational therapy (see definitions)
- ☐ d. Administration of prescribed medicine (excluding vitamins) by intravenous, intramuscular or subcutaneous injection is required more than one time per week.
- ☐ e. Ongoing medical observation and assessment of a changing **physical** condition is required by a physician at least once every 30 days. The physician determines the type of contact (in person or by phone contact) to maintain optimum treatment.
- ☐ f. Person is unable to safely manage alone an uncontrolled seizure disorder.

THE PERSON IS COP AND MA WAIVER ELIGIBLE IF THE PERSON HAS A **LONG-TERM OR IRREVERSIBLE** ILLNESS OR DISABILITY, AND NO. 1 and, at minimum, one item in No. 2 are checked. THERE IS NO NEED TO PROCEED FURTHER. IF NOT, PROCEED TO LEVEL II.

LEVEL II SUBSTANTIAL MEDICAL AND SOCIAL / BEHAVIORAL NEEDS

THE PERSON HAS A LONG-TERM OR IRREVERSIBLE ILLNESS OR DISABILITY AND: (A OR B required)

A. MEDICAL (Two required – check all that apply.) The focus of this section is on unstable or stable medical and psychiatric conditions requiring long-term maintenance and prevention.

☐ 1. In the last 12 months, the person has experienced a significant deterioration in the overall condition of health (physical and / or mental) resulting in new treatments, interventions or an increase in services. **Describe** the deterioration of the person's functional status.

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☐ 2. The physician requires daily monitoring of the kind and amounts of fluids and solids intake and / or output.

☐ 3. At least three days per week the person is required to take six or more different medications that are prescribed by a physician.

☐ 4. The person requires one of the following: (Check one)

- ☐ a. Supervision or assistance at least three times per week to ensure that medication is taken correctly and / or that side effects are observed.
- ☐ b. Supervision or assistance because the person refuses to take medication necessary to treat an illness.

☐ 5. The person requires supervision and assistance at least weekly to ensure that special laboratory tests are administered.

☐ 6. The person is incontinent of bowel and / or bladder OR uses a device, such as a urinary collection device (leg bag, night drainage bag, disposable diaper, bed pan).

☐ 7. The person requires turning or repositioning every 2–4 hours to prevent skin breakdown as ordered by his / her physician.

☐ 8. The person requires range of motion exercises on a daily basis or receives physical therapy / occupational therapy three times a week, as ordered by his / her physician.

☐ 9. To maintain a stable health condition, the person requires direct assistance from others at least five days per week for health care needs (see definitions.)

☐ 10. At least three days per week the person requires assistance from others for bowel evacuation.

☐ 11. The person is medically fragile (see definitions) due to both advanced age (85 +) and inability to independently manage his / her medical condition.

OR

B. DEVELOPMENTAL DISABILITY (Check one)

☐ 1. The person has a diagnosis of developmental disability (see definition) AND mental retardation AND needs active treatment (any age). (NOTE: The person is not eligible for CIP II / COP–W.)

☐ 2. The person has a diagnosis of developmental disability with no mental retardation AND does not need active treatment (see definitions). (FOR CIP II / COP–W, the Bureau or its designee will determine NAT.)

☐ 3. The person has a diagnosis of developmental disability with or without mental retardation and is 65 + years of age AND does not need active treatment (see definitions). (FOR CIP II / COP–W, the Bureau or its designee will determine will determine NAT.)

IF BOXES ARE CHECKED FOR AT LEAST TWO CONDITIONS IN THE MEDICAL SECTION OR THE PERSON IS DEVELOPMENTALLY DISABLED, PROCEED TO THE NEXT SECTION OF LEVEL II. IF NEITHER CONDITION ABOVE (MEDICAL OR DEVELOPMENTAL DISABILITY) IS MET, THE APPLICANT IS NOT ELIGIBLE FOR THE MEDICAID HOME AND COMMUNITY BASED SERVICES WAIVERS. PROCEED TO LEVEL III FOR POSSIBLE COP ELIGIBILITY.

LEVEL II SUBSTANTIAL MEDICAL AND SOCIAL / BEHAVIORAL NEEDS (continued)

C. INFORMAL SUPPORTS (One required, plus "D")

☐ 1. The person has no friends or relatives who are able or willing to provide needed assistance, support, and personal or chore services.

☐ 2. Friends or relatives who have been providing needed assistance are not able or willing to continue to provide help.

☐ 3. Friends or relatives who have been providing assistance are no longer able or willing to increase the amount of help needed to meet changing conditions.

IF AT LEAST ONE BOX IN SECTION C. ABOVE IS CHECKED, PROCEED TO LEVEL II, PART D. – INSTRUMENTAL ACTIVITIES OF DAILY LIVING. IF NOT, THE APPLICANT IS NOT ELIGIBLE FOR THE MEDICAID HOME AND COMMUNITY BASED SERVICES WAIVERS. PROCEED TO LEVEL III FOR POSSIBLE COP ELIGIBILITY.

D. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (Two required)

☐ 1. The person is unable to carry out, on a consistent basis, the following tasks due to a serious physical, or mental health problem:

- ☐ a. Meet their nutritional needs on a daily basis.
- ☐ b. Light work around the house.
- ☐ c. Shop for groceries.
- ☐ d. Travel in a van, taxi, bus or car without assistance or special equipment.
- ☐ e. Take medicines without supervision or reminder.
- ☐ f. Answer the telephone or call the telephone operator without special equipment on a daily basis.
- ☐ g. Take care of grooming (adequate physical appearance).
- ☐ h. Financial management for basic necessities (e.g., food, clothing, shelter).

IF AT LEAST TWO BOXES UNDER D. INSTRUMENTAL ACTIVITIES OF DAILY LIVING ARE CHECKED, THEN CONTINUE TO SECTION E. OR F. IF NOT, THE APPLICANT IS NOT ELIGIBLE FOR THE MEDICAID HOME AND COMMUNITY BASED SERVICES WAIVERS. PROCEED TO LEVEL III FOR POSSIBLE COP ELIGIBILITY.

E. PHYSICAL ACTIVITIES OF DAILY LIVING (Two required)

☐ 1. The person is unable to do the following without the direct assistance of another person; or under the supervision of another person; or without the use of assistive devices / equipment (see definitions); or without daily prompting; or cannot complete the task within a reasonable time frame. (Check all that apply)

- ☐ a. The person is unable to feed him / herself.
- ☐ b. The person is unable to transfer from a bed or chair.
- ☐ c. The person is unable to change clothes (from street clothes to night clothes and vice versa).
- ☐ d. The person is unable to bathe (get in and out of the tub or shower, setting the water temperature, wash, rinse, drain the tub, and towel off).
- ☐ e. The person is unable to use the toilet.
- ☐ f. The person is able to use the toilet but is unable to clean him / herself after toileting.
- ☐ g. The person is unable to ambulate (see definitions).

OR

F. BEHAVIORAL CONDITIONS (Numbers 1 and 2 required)

☐ 1. The person requires daily supervision or ongoing assertive case management to ensure his or her safety or the safety of others.

☐ 2. The person has been experiencing at least one of the following behaviors or conditions:

- ☐ a. Wanders aimlessly or leaves the house and cannot find the way home.
- ☐ b. Confuses days and nights to the degree / extent that it significantly disrupts the living arrangement.
- ☐ c. Is combative and / or exhibits behavior that significantly disrupts.
- ☐ d. Is isolated from others or avoids social situations almost entirely
- ☐ e. Is abusive or dangerous to self, others, property.

LEVEL II SUBSTANTIAL MEDICAL AND SOCIAL / BEHAVIORAL NEEDS (continued)

- ☐ f. Is unable to make decisions affecting his / her health, safety or welfare.
- ☐ g. Hears voices, sees things, believes in things that are not real.
- ☐ h. Has, but denies, a mental illness or emotional problems.
- ☐ i. Has exhibited behaviors during the past year that were so severe that assistance or intervention from the human services crises intervention and / or judicial system was needed.
- ☐ j. Misuses or abuses drugs or alcohol to the extent that human service intervention occurred or was attempted in the past year, or is currently warranted.

THE PERSON IS ELIGIBLE IF THE PERSON HAS A **LONG-TERM OR IRREVERSIBLE** ILLNESS OR DISABILITY, MEETS ALL LEVEL II REQUIREMENTS OF THE PREVIOUS PAGES, AND AT LEAST TWO BOXES ARE CHECKED FOR D., INSTRUMENTAL ACTIVITIES OF DAILY LIVING, AND AT LEAST TWO BOXES ARE CHECKED FOR E., PHYSICAL ACTIVITIES OF DAILY LIVING, OR TWO FOR F., BEHAVIORAL CONDITIONS.

IF ALL OF THE ABOVE ARE NOT MET, THE APPLICANT IS NOT ELIGIBLE FOR THE MEDICAID HOME AND COMMUNITY BASED SERVICES WAIVERS. PROCEED TO LEVEL III FOR POSSIBLE COP ELIGIBILITY.

LEVEL III SUPERVISION AND CARE

THIS SECTION TO BE COMPLETED ONLY AFTER PERSON HAS BEEN REVIEWED AND FOUND INELIGIBLE ON LEVEL I AND LEVEL II.

A. ALZHEIMER'S AND RELATED DISEASES (Both required)

☐ 1. The person has a physician's written and dated statement that the person has Alzheimer's and / or another qualifying irreversible dementia (see definitions).

☐ 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 needs, but not regular nursing care.

IF BOXES ARE CHECKED FOR BOTH OF THE ABOVE TWO CONDITIONS, THEN THE PERSON IS ELIGIBLE FOR COP SERVICE FUNDS.

OR

B. CHRONIC MENTAL ILLNESS (Both required)

☐ 1. The person has a diagnosis of a chronic mental illness (see definitions).

AND

☐ 2. The person:

☐ a. Requires and receives ongoing psychiatric observation and assessment of a changing, unstable mental condition (see definitions) by a psychiatrist at least once every 30 days. The psychiatrist determines the type of contact (in person or by phone) to maintain optimum treatment;

OR

☐ b. Is a current resident of an IMD or is eligible for services in an IMD. Eligibility for an IMD must be documented by a "Request for Title XIX Care Level Determination" and "Minimum Data Set" (MDS) rated at an ICF 2 level or higher (F-62256 and F-62256A).

OR

☐ c. Has been hospitalized in a psychiatric hospital or psychiatric unit in a general hospital at least three times in the last 12 months **or** has been hospitalized in a psychiatric hospital or psychiatric unit in a general hospital for 180 days or more in the last 12 months.

IF BOXES ARE CHECKED FOR ITEM 1 AND ONE OF THE CIRCUMSTANCES IN ITEM 2, THE PERSON IS ELIGIBLE FOR COP SERVICE FUNDS.

OR

C. INTERDIVISIONAL AGREEMENT 1.67

☐ 1. The person resided in a nursing home and was referred through interdivisional Agreement 1.67 in accordance with s. 46.27(6r)(b)(3) or the person received CIP II / COP–W services and was terminated because of the level of care reduction in accordance with the Waiver Manual, Chapter II.

IF THE CRITERIA IN EITHER LEVEL I, II OR III ARE MET, THE PERSON IS ELIGIBLE FOR COP FUNDED SERVICES. ENTER APPLICABLE CODE IN THE HSRS ON THE F-22018, FIELD NO. 9.