maximus

Connecticut LTC Level of Care Determination Form

To be maintained in the individual's medical record.

I. Demographics

A. Individual

First Name:_____Middle Initial:_____Last Name:_____

Mailing Address:_____City:_____State:_____Zip:_____Phone:_____

Social Security #:_____-_____-_____Date of Birth:_____/_____/_____

Marital Status: ☐ M ☐ S ☐ W ☐ D

Gender: ☐ Male ☐ Female

Payment Method: ☐ Medicaid Active ☐ Medicaid Eligible ☐ Medicaid Pending ☐ Medicare/Medicaid Eligible
☐ Medicare ☐ Medicare and Medicaid ☐ Self Pay/Insurance
Medicare#_____ Medicaid #_____

B. Conservator/Legal Guardian - Does the individual have a Conservator/Legal Guardian? ☐ **Yes** ☐ **No**

☐ Check here if same as Individual (if not, specify below)

Name: _____

Street:_____ City: _____State:_____ Zip: _____

Primary Physician's Name:_____

Street:_____ City: _____State:_____ Zip: _____

Phone:_____Fax: _____

C. Typical Living Situation: ☐ NF ☐ Hospital ☐ Homeless ☐ Home with family ☐ Home alone
☐ Group Home ☐ Other (Specify): _____

D. Current Location

☐ Medical Facility ☐ Psychiatric Facility ☐ NF ☐ Hospital ED ☐ Community ☐ Other_____

Facility Name:_____Admit Date: _____

Location Address: ☐ Check here if location address is same as the individual mailing address.

Street:_____City:_____State:_____Zip: _____

E. Admitting Information

Admitting Facility: _____ Admission Date:_____

Street_____City_____State_____Zip: _____

Client First/Middle Name: _____ Last Name: _____

II. Application Type

LOC Type: ☐ Chronic and Convalescent Nursing Home

☐ Rest Home with Nursing Supervision

Screen Type: ☐ Applicant

☐ Resident applying for LTC Medicaid

☐ Resident/Medical improvement

☐ Resident/Prior ST Decision

Expected length of stay:

☐ Long Term

☐ Short Term Estimated at (# of days) : ❍<30 ❍30-60 ❍60-90 ❍90-120 ❍120-180

Mark the box below if you are requesting a Retrospective Review of LOC eligibility for this person. You must give specific rationale why you are requesting a Retrospective Review. **Retrospective Reviews will not be accepted for untimely completion of paperwork**. **Your request will only be approved for the time for which paperwork was completed.**

Nursing Home Retrospective:

☐ I am requesting a post hoc review of this individual's NF LOC status for the period between these dates:

Begin: _____ End: _____ **OR**

☐ This request is for approval for continuing care in the NF (mark expected length of stay above.

The reason this Retrospective Review is needed is:

_____

Medical Diagnostics

Admitting Diagnosis:

Medical History:

III. Medical Information:

Type of NF setting sought:

1.A. ☐No ☐Yes (**Chronic and Convalescent Nursing Home**/CCNH) The individual has uncontrolled, unstable, and/or chronic conditions requiring continuous skilled nursing services and/or nursing supervision on a daily basis or has chronic conditions requiring substantial assistance with personal care on a daily basis.

1.B. ☐No ☐Yes (**Rest Home with Nursing Supervision**/RHNH) The individual has controlled and/or stable chronic conditions requiring skilled nursing services, nursing supervision, or assistance with personal care on a daily basis.

If yes to either #1.A. or 1.B***, complete the following:***

Check any of the following conditions that are present and that will require continuing nursing services in the NF:

☐ Total knee/Total hip replacement post op care

☐ Diabetes Mellitus with sliding scale insulin needs

☐ IV therapy (3 x per day or more and /or continuous)

☐None of the above

If yes to either 1.A. or 1.B. ***complete the following:***

Client First/Middle Name: _____ Last Name: _____

If your descriptions do not clearly indicate NF medical needs, Ascend nurses are required to ask for clarification.

1.C: **Related Skilled Nursing Service:** List separately the nursing services the individual will need in an NF. Indicate the frequency/ intensity of the service. For example the frequency or intensity of: wound care, IV infusions, tube feedings, required monitoring of changes in lab values, vitals, fluctuations in medical presentations. These are the required nursing services which qualify the individual for NF under the Connecticut Level of Care rules list in either 1.A or 1.B.	**1.D. Medical Diagnosis:** List the diagnoses requiring each nursing service listed. These are the medical diagnoses/history which requires the nursing services listed in 1.C. You must indicate the acuity/chronicity and stability of each diagnosis.

2.A. ☐No ☐Yes The physician has ordered at least one (or a combination) of the **rehabilitative services** listed below

2.B. ☐No ☐Yes The individual presents with restorative potential (**If yes** complete the table below)

	Start Date	**Frequency (# of days/week)**	**Duration**
☐ Speech Therapy			
☐ Physical Therapy			
☐ Occupational Therapy			
☐ Respiratory Therapy			

3. Medication Supports (Choose all that apply.)

Supports Needed	**Medication Supports Needed to be physically capable of adhering to physician ordered medication regimen. Rate compliance issues separately under item #9 of this section (*Behaviors*).**
☐	None and/or does not apply
☐	Set ups
☐	Verbal or gestural assistance (reminding, instructing, coaching, pointing)
☐	Physical assistance with some or all of the physical steps of taking medications, and adherence cannot be ensured with verbal and gestural support alone**.**
☐	Injections
☐	Other (Specify):
If support needs were selected, describe the reason for the needed support and either complete Section IV.1 or fax a copy of the medication list (e.g., MAR or MD orders)	

Client First/Middle Name: _____ Last Name: _____

IV. Medication Needs: Optional

1. Provide the following information for each physician ordered medication (**This section is optional & should be provided if medication information is a factor in supporting or clarifying the individual's need for NF level of care and, if so, a medication list (such as a MAR or MD orders) may be faxed in lieu of completing this table**).

☐ Check here if you are faxing the MAR or Medication list

Medication	Diagnosis	Dosage	Route/Frequency

V. Functional Capabilities Needs Assessment

1. Activities of Daily Living (ADL)

Choose the single best answer for each ADL. **The ADL ratings are not to reflect supports needed because of behavioral compliance issues that are secondary to mental health conditions.**		
0 – Independent or supervision < daily		Requires no assistance or supervision. If assistive devices are used, needs no monitoring, assistance, or supervision to use those devices.
1 – Supervision daily		Capable of completing most parts of the activity independently but needs some supervision or assistance (e.g., cues/prompts, etc).
2 – Hands on		Capable of completing some parts of the activity but needs continual supervision or assistance (e.g., assistance with weight bearing tasks, extensive physical assistance).
3 – Total Dependence		Requires total assistance with the activity.
	Bathing	Abilities to get into and out of the bathing area, adjust the water temperature, and cleanse the body and hair.
	Dressing	Abilities to select weather appropriate clothing and put on and adjust clothing.
	Eating/ feeding	Abilities to use utensils, set up food tray, eat appropriate amount, and eat at appropriate pace; feeding by nasogastric, gastrostomy, jejunostomy, or parenteral route. Does not include supervision of obesity or weight reduction.
	Toileting	Abilities to transfer to/from the toilet, adjust clothing, and attend to hygiene, and/or ostomy or catheter care.
	Mobility	Ambulation and use of wheelchair, cane, walker, crutch, or other mobility aid.
	Transfer	Movement from surface to surface (e.g., chair to wheelchair or bed to chair).
	Continence	Includes supports needed to either: assist the individual to control one's body to empty the bladder and/or bowel appropriately, or, to appropriately change incontinence pads/briefs, cleanse the changing pads, and dispose of soiled articles.

For each ADL rated 1, 2, or 3, describe assistance needed, including frequency and reason for support needs (including physical and cognitive). If applicable, include details about tube feedings, IV fluids, fluid monitoring, catheter or ostomy care, mobility aids, transfer aids, and incontinence care: _____

2. Meal Preparation (Choose the single best answer.)

☐ Requires no assistance or supervision.
☐ Capable of preparing meals with minimal assistance (e.g., set-up of ingredients, oversight, or cueing).
☐ Requires continual supervision or physical assistance with multiple components of meal preparation.
☐ Requires total physical assistance with meal preparation.

Cognitive Data

3. Orientation

Choose the single best answer for each type of orientation.	**Self** (awareness of own name)
0 – Fully oriented and needs no prompting or cueing.	**Place** (awareness of current location)
1 – Occasionally disoriented & needs prompting or cueing.	**Time** (awareness of current date & time)
2 – Disoriented all or most of the time.	**Situation** (awareness of current situation)

4. Memory (choose one)

☐ Able to remember past and present events with no cueing or prompting.
☐ Needs cueing or prompting to remember past and/or present events.
☐ Unable to remember past and present events such that daily supervision is needed to prevent harm

5. Judgment (choose one)

☐ Solves problems and makes decisions with no assistance.
☐ Solves problems & makes decisions with minimal assistance (e.g., prompts or cues may be required).
☐ Unable to solve problems well and make appropriate decisions such that daily supervision is needed to prevent harm

6. Communication (choose one)

☐ Communicates information in intelligibly & understands information conveyed without assistance.
☐ Needs assistance to communicate information and/or understand information conveyed.
☐ Inability to communicate information in an intelligible manner and/or understand information conveyed

(*choose all that apply*)

Communication Method: ☐ Verbal ☐ Sign language ☐ Writing ☐ Gestures ☐ Other:

7. Vision: (choose all that apply)

☐ No problems indicated
☐ Cataracts ☐ Glaucoma ☐ Blind
☐ Orientation/mobility problems due to vision
☐ Other (specify):

8. Behaviors Due To Corroborated Dementia: (choose all that apply)

☐ No problems indicated ☐ Verbally aggressive toward others ☐ Wanders/runs away
☐ Self-injurious ☐ Physically aggressive toward others
☐ Unsafe or unhealthy habits such as throwing or smearing food or excrement, disrobing in inappropriate situations, screaming, making inappropriate sexual advances.
☐ Threats to Health/Safety: Inability to follow a medication or dietary regimen without supervision; creating a fire hazard; exhibiting poor judgment which is potentially harmful to self or others.

Describe frequency and severity of behaviors: _____

_____

_____

Describe needs related to behaviors, including type of required intervention: _____

_____

Client First/Middle Name: _____ Last Name: _____

VI. Additional Comments

Additional Notes/Comments (Use this area for any important information you think was not adequately addressed in the above sections.) _____

_____

_____

VII. Practitioner Certification

Certification that the client meets the nursing facility level of care criteria described in Section 19-13- D(8)(t)(d)(1) of the Public Health Code must be provided by a physician, APRN, or physician assistant. This certification must be signed and dated by the practitioner; telephone and voice orders are not acceptable.

Signature: _____ Credentials: _____ Date: _____

VIII. Attestation/Referral Source Information

By entering my name and credentials, I attest that I am the person who completed this form. I understand that CT DSS considers knowingly submitting inaccurate, incomplete, or misleading LOC information to be Medicaid fraud, and I have completed this form to the best of my knowledge.

Person completing form: _____ Facility: _____

Facility Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

IX. Special Instructions

*This form may be completed at www.assessmentpro.com or faxed to Maximus at **877.431.9568**. The physician's attestation must be faxed once the screen is complete to 1-877-431-9568.* **Mailed forms may be sent to: Maximus • Attn: Connecticut Division • 2555 Meridian Blvd Suite #350 Franklin, TN 37067 • Phone: 877-431-1388 • Fax: 877-431-9568 • *For assistance with completing this form or accessing WEBSTARS™, call Ascend toll free at 1.877.431.1388 and ask to speak with a CT LTC nurse reviewer.***