

Last Name:

First Name:

To be completed by a knowledgeable caregiver. Note: this form and its instructions are entirely based upon the MS Division of Medicaid (PAS) Application for Long Term Care. Refer to instructions from the PAS for any areas requiring clarification.

Points	Weight	Points	Max Points	CRITERIA
				ADL/IADL: SCALE: (0 POINTS) INDEPENDENT: independently completes activity safely; (1 POINT) SUPERVISION: Completes activity safely with cueing, set-up or standby assist or limited occasional physical hands-on assistance; (2 POINTS) PHYSICAL ASSISTANCE: Can participate but requires physical/hands on assistance to complete safely; (3 POINTS) TOTAL DEPENDENCY: Completely dependent on others to complete activity safely.
	7.0		21.0	1. Mobility/Ambulation: How well can the individual purposefully move within his/her residence/living environment?
	.5		1.5	2. Community Mobility: How well can the individual move around neighborhood or community? This includes accessing buildings, stores, restaurants and using (including enter/exit) any mode of transportation (such as walking, wheelchair, cars, buses, taxis, etc.).
	7		21.0	3. Transferring: How much human assistance is needed on a consistent basis for safe transfer, including bed/chair to wheelchair, walker or standing; onto and off toilet; into and out of bath/shower?
	5.0		15.0	4. Eating: How well is the individual able to eat/drink safely, including chew and swallow? If tube or IV fed, circle 0 if individual can feed self independently, or circle 1, 2, or 3 if another person is required to assist. <u>Excludes meal prep.</u>
	1.0		3.0	5. Meal Prep: How well is the individual able to safely obtain and prepare routine meals? (Includes ability to independently open containers & use appliances). If tube or IV fed, circle 0 if individual can prep tube/IV feeding independently, or circle 1,2, or 3 if another person is required to assist
	5.0		15.0	6. Toileting: How well can the individual use toilet, commode, bedpan or urinal safely? This includes flushing, cleansing of self, changing of protective garment, adjusting clothing, washing hands, managing an ostomy or catheter. <u>Excludes transfer and continence</u> (Note – limited hands-on assistance includes emptying bedpans.)
	5.0		15.0	7. Bathing: How well is the individual able to bathe, shower or take sponge baths safely for the purpose of maintaining adequate hygiene and skin integrity? Includes washing hair. <u>Excludes transfer</u> (Note – limited hands-on assistance includes helping with hard to reach areas, such as the back.)
	5.0		15.0	8. Dressing: How well is the individual able to safely dress and undress as necessary, regardless of clothing type? This includes ability to put on prostheses, braces, anti-embolism hose and choice of appropriate clothes for the weather and for personal comfort. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit. (Note: if individual can dress independently, but normally requires 30 minutes or longer doing so, score as “Supervisory” (1).)
	5.0		15.0	9. Personal Hygiene: How well is the individual able to perform personal hygiene/grooming activities safely, including but not limited to combing hair, shaving, oral care? <u>Exclude nail care and washing hair.</u>
	5.0		15.0	10. Med Management: How well is the individual able to safely manage and administer pills, liquids, inhalers, nebulizers, eye drops, ear drops, self-administered injectables, IV medications, medication pumps? <u>Excludes insulin and monthly injections, such as B-12 shots.</u>
				Does the individual use insulin? How well is the individual able to safely manage and administer insulin? If individual does not use insulin, select N/A for all items. Consider the past 30 days. Score based on functionality achieved with assistive device(s), if used. <input type="checkbox"/> N <input type="checkbox"/> Y (if yes, answer 11 a-c; if no, proceed to 12)
	Capped .5		1.0	11a. Can individual administer finger sticks and understand Accu-Chek® (glucose testing) results? <input type="checkbox"/> N (1 point) <input type="checkbox"/> Y (0 points) <input type="checkbox"/> N/A 11b. If on a fixed dose, can individual self-inject insulin with a pre-filled syringe? <input type="checkbox"/> N (1 point) <input type="checkbox"/> Y (0 points) <input type="checkbox"/> N/A

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				11c. If on a sliding scale, can individual draw up the correct amount and inject insulin? <input type="checkbox"/> N (1 point) <input type="checkbox"/> Y (0 points) <input type="checkbox"/> N/A
				Continence: (Consider the past 30 days; score based on functionality achieved with assistive devices, if used. Includes catheter and ostomy) Scale: (0 Points) Complete Voluntary Control; (1 Point) Incontinent Episodes Less than weekly; (2 Points) Incontinent episodes once per week; (3 Points) Incontinent episodes Two or more times per week
	5.0		15.0	12. BLADDER CONTINENCE – How well is the individual able to voluntarily control the discharge of body waste from the bladder?
	5.0		15.0	13. BOWEL CONTINENCE – How well is the individual able to voluntarily control the discharge of body waste from the bowel?
	Capped 1.0		10.0	14. UNDERLYING CAUSES OF ADL/IADL LIMITATIONS – Check all Physical Impairments and Supervision Needs that apply below. (Each option results in one point; maximum = 10) # selected:

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		Physical Impairments					
<input type="checkbox"/>	Amputation	<input type="checkbox"/>	Balance Problems	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	Physiological Defect
<input type="checkbox"/>	Catheter	<input type="checkbox"/>	Bladder incontinence	<input type="checkbox"/>	Tube feeding	<input type="checkbox"/>	Sensory Impairment – Hearing
<input type="checkbox"/>	Choking	<input type="checkbox"/>	Bowel incontinence	<input type="checkbox"/>	Poor Dentition	<input type="checkbox"/>	Sensory Impairment – Vision
<input type="checkbox"/>	Pain	<input type="checkbox"/>	Decreased Endurance	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	Fine or gross motor impairment
<input type="checkbox"/>	Oxygen use	<input type="checkbox"/>	Neurological Impairment	<input type="checkbox"/>	Ostomy	<input type="checkbox"/>	Swallowing Problems
<input type="checkbox"/>	Obesity	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Muscle Tone	<input type="checkbox"/>	Limited Range of motion
<input type="checkbox"/>	Fractures	<input type="checkbox"/>	Lack of assistive devices	<input type="checkbox"/>	History of falls	<input type="checkbox"/>	
Supervision Needs/Mental Health (Check all that apply. Each option results in one point)							
<input type="checkbox"/>	Behavioral Issues	<input type="checkbox"/>	Lack of motivation/apathy	<input type="checkbox"/>	Memory impairment	<input type="checkbox"/>	Cognitive Impairment
<input type="checkbox"/>	Other (describe)						
		II. Vision: The ability to see in adequate light and with glasses, if used.					
	1.0		4.0	15. Vision Rating: 0= ADEQUATE – Sees fine detail, including regular print in newspapers/books; 1= MILDLY IMPAIRED – Sees large print, but not regular print in newspapers/books; 2= MODERATELY IMPAIRED – Limited vision; not able to see newspaper headlines, but can identify objects; 3= HIGHLY IMPAIRED – Object identification in question, but eyes appear to follow objects; 4= SEVERELY IMPAIRED – No vision OR sees only light, colors and shapes; eyes do not appear to			

			follow objects; UNK=Unable to determine appropriate score
III. Orientation: Report the total number of No responses for a-k (0-11)			
			16. Orientation Ratings
			Q.1 Person; At time of screen:
			Does the individual know his/her First name? <input type="checkbox"/> N (1 Pt) <input type="checkbox"/> Y (0 pts) <input type="checkbox"/> Unable to determine
			Does the individual know his/her Last name? <input type="checkbox"/> N (1 Pt) <input type="checkbox"/> Y (0 pts) <input type="checkbox"/> Unable to determine
			Does the individual know caregiver's name? <input type="checkbox"/> N (1 Pt) <input type="checkbox"/> Y (0 pts) <input type="checkbox"/> Unable to determine
			Q.2 Place; At time of screen, does individual know his/her:
			Immediate environment? <input type="checkbox"/> N (1 Pt) <input type="checkbox"/> Y (0 pts) <input type="checkbox"/> Unable to determine
3.0		33.0	Place of residence? <input type="checkbox"/> N (1 Pt) <input type="checkbox"/> Y (0 pts) <input type="checkbox"/> Unable to determine
			City? <input type="checkbox"/> N (1 Pt) <input type="checkbox"/> Y (0 pts) <input type="checkbox"/> Unable to determine
			State? <input type="checkbox"/> N (1 Pt) <input type="checkbox"/> Y (0 pts) <input type="checkbox"/> Unable to determine
			Q.3 Time; At time of screen, does individual know his/her:
			Day? <input type="checkbox"/> N (1 Pt) <input type="checkbox"/> Y (0 pts) <input type="checkbox"/> Unable to determine
			Month? <input type="checkbox"/> N (1 Pt) <input type="checkbox"/> Y (0 pts) <input type="checkbox"/> Unable to determine
			Year? <input type="checkbox"/> N (1 Pt) <input type="checkbox"/> Y (0 pts) <input type="checkbox"/> Unable to determine
			Time of Day? <input type="checkbox"/> N (1 Pt) <input type="checkbox"/> Y (0 pts) <input type="checkbox"/> Unable to determine
IV. Behaviors: Consider behaviors during the past 90 days that required some level of intervention; Mark 'H' if > 90 days but within the past 2 years); Consider the most common level of intervention required; "Easily altered" refers to redirection verbally without difficulty; "Not easily altered" refers to redirection verbally with difficulty or need for physical or chemical restraints (to the extent allowed by law)			
			A. Verbally Aggressive (threatening/Screaming/cursing) Assign points Score Based on Frequency:
			(0) Has not occurred in 90 days; (2) Frequent & requiring intervention ≥ 1 X/week and < 1X/day;
			(1) Occasional (within 90 days)& requiring intervention ≤ 1 X/week; (3) Constant & requiring intervention daily
			(H) historically occurred (>90 days ago) AND <2 years ago
3.0		9.0	B. Verbally Aggressive: Check applicable behaviors (If score > 0, select all that apply)
			<input type="checkbox"/> Falsely accuses others of stealing <input type="checkbox"/> Spitting at others <input type="checkbox"/> Screaming/cursing at others
			<input type="checkbox"/> Verbal threats <input type="checkbox"/> Other (please specify):
			C. Verbally Aggressive (intensity): If Frequency is > 0, what intensity of intervention is required? Behavior is:
3.0		3.0	<input type="checkbox"/> (0 Pts) easily altered <input type="checkbox"/> (1 Pt) not easily altered
			A. Physically Aggressive (Hitting/shoving/scratching/sexual abuse) Assign points Score Based on Frequency:
			(0) Has not occurred in 90 days; (2) Frequent & requiring intervention ≥ 1 X/week and < 1X/day;
			(1) Occasional (within 90 days) & requiring intervention ≤ 1 X/week; (3) Constant & requiring intervention daily
			(H) historically occurred (>90 days ago) AND <2 years ago

			<p>b. Physically Aggressive: Check applicable behaviors (If score > 0, select all that apply)</p> <p><input type="checkbox"/> Combative regarding personal care <input type="checkbox"/> Hits/shoves/scratches others <input type="checkbox"/> Sexually abusive</p> <p><input type="checkbox"/> Throws items at others <input type="checkbox"/> Intimidating/threatening physical harm</p> <p><input type="checkbox"/> Other (please specify):</p>
3.0		3.0	<p>C. Physically Aggressive (intensity): If Frequency is > 0, what intensity of intervention is required? Behavior is:</p> <p><input type="checkbox"/> (0 Pts) easily altered <input type="checkbox"/> (1 Pt) not easily altered</p>

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			<p>A. Wandering/Elopement (movement with no rational purpose, seemingly oblivious to needs or safety) Assign points Score Based on Frequency:</p> <p>(0) Has not occurred in 90 days; (2) Frequent & requiring intervention ≥ 1 X/week and < 1X/day;</p> <p>(1) Occasional (within 90 days) & requiring intervention ≤ 1 X/week; (3) Constant & requiring intervention daily</p> <p>(H) historically occurred (>90 days ago) AND <2 years ago</p>
3.0		9.0	<p>B. Wandering/Elopement: Check applicable behaviors (If score > 0, select all that apply)</p> <p><input type="checkbox"/> Leaves home and becomes lost <input type="checkbox"/> Wanders - seeking exit <input type="checkbox"/> Wanders - not seeking exit</p> <p><input type="checkbox"/> Other (please specify):</p>
3.0		3.0	<p>C. Wandering/Elopement (intensity): If Frequency is > 0, what intensity of intervention is required? Behavior is:</p> <p><input type="checkbox"/> (0 Pts) easily altered <input type="checkbox"/> (1 Pt) not easily altered</p>
			<p>A. Inappropriate/Unsafe (includes socially inappropriate, unsafe, and disruptive behaviors. Excludes aggression) Assign points Score Based on Frequency:</p> <p>(0) Has not occurred in 90 days; (2) Frequent & requiring intervention ≥ 1 X/week and < 1X/day;</p> <p>(1) Occasional (within 90 days) & requiring intervention ≤ 1 X/week; (3) Constant & requiring intervention daily</p> <p>(H) historically occurred (>90 days ago) AND <2 years ago</p>
3.0		9.0	<p>B. Inappropriate/Unsafe: Check applicable behaviors (If score > 0, select all that apply)</p> <p><input type="checkbox"/> Breaks objects <input type="checkbox"/> Hiding items <input type="checkbox"/> Hoarding <input type="checkbox"/> Inappropriate noises</p> <p><input type="checkbox"/> Inappropriate talk/action <input type="checkbox"/> Inappropriate toileting/menses <input type="checkbox"/> Puts inappropriate non-food items in mouth</p> <p><input type="checkbox"/> Repetitive movements <input type="checkbox"/> Rummaging/takes belongings <input type="checkbox"/> unsafe cooking <input type="checkbox"/> Unsafe smoking</p> <p><input type="checkbox"/> Other (please specify):</p>
3.0		3.0	<p>C. Inappropriate/Unsafe (intensity): If Frequency is > 0, what intensity of intervention is required? Behavior is:</p> <p><input type="checkbox"/> (0 Pts) easily altered <input type="checkbox"/> (1 Pt) not easily altered</p>
			<p>A. Self-Injurious (Repeat behaviors that cause self-harm. Can include suicidality) Assign points Score Based on Frequency:</p> <p>(0) Has not occurred in 90 days; (2) Frequent & requiring intervention >1 X/week and < 1X/day;</p> <p>(1) Occasional (within 90 days) & requiring intervention <1 X/week; (3) Constant & requiring intervention daily</p> <p>(H) historically occurred (>90 days ago) AND <2 years ago</p>
3.0		9.0	

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Use the space below to provide any additional pertinent information:

Provide copies of any consultations or evaluations that support and/or substantiate the mental health, physical and/or behavioral change(s) noted on this form. Select attachments included:

MD Notes Nursing Notes MAR Sheet(s) Hospital Records Medical Consultation(s) Psychiatric Evaluation(s)

Other (List):

Date form was submitted to Maximus:

I attest that the information provided herein is a true and accurate representation of the individual's medical status and needs

Completed by:

Signature: _____

Printed Name & credentials:

Facility:

Phone:

Assessor:

Date: