

DEMOGRAPHICS			
Provide the following:	First Name Middle Initial Last Name	Mailing Address City State	Zip Code County Phone
Is this the individual's state of residence?	<input type="checkbox"/> No <Specify state of residence> <input type="checkbox"/> Yes		
Type of identification:	<input type="checkbox"/> Social security number <Provide>		
Provide the following:	Date of Birth Marital Status	Gender Race	
Current Location:	<input type="checkbox"/> Community Setting/Home <input type="checkbox"/> Medical Facility Medical Unit <input type="checkbox"/> Medical Facility ER/ED Medical <input type="checkbox"/> Facility Psychiatric Unit	<input type="checkbox"/> Psychiatric Facility <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Other <Specify>	
Provide the following:	Current Location Address City State	Zip Code Phone Fax	Contact Name Date of Admission Admitting Facility
What is the individual's method of payment for nursing facility care?	<input type="checkbox"/> Self-Pay <input type="checkbox"/> Private Pay <input type="checkbox"/> Medicare <Provide Medicare ID> <input type="checkbox"/> Medicaid <Provide Medicaid ID, MCO> <input type="checkbox"/> Medicaid Pending <Provide Medicaid ID, MCO>		
What has been his/her "typical" living situation over the past year?	<input type="checkbox"/> Home alone <input type="checkbox"/> Home with natural supports/family <input type="checkbox"/> Home with paid supports Assisted living <input type="checkbox"/> Nursing home <input type="checkbox"/> Homeless	<input type="checkbox"/> Group home <input type="checkbox"/> Psychiatric facility <input type="checkbox"/> Jail/prison <input type="checkbox"/> ICF/IID (Intermediate Care Facility) <input type="checkbox"/> Other <Specify>	
GUARDIAN/INTERPRETER (Applies only to persons with known or suspected MI and/or ID/RC)			
Does the individual have a legal guardian?	<input type="checkbox"/> No <input type="checkbox"/> Yes <Provide Guardian name, address, phone>		
IF YES: Verify guardian status:	<input type="checkbox"/> Upload or fax verification of guardian status <input type="checkbox"/> Attestation		
Does the individual have a primary physician?	<input type="checkbox"/> No <input type="checkbox"/> Yes <Required: primary physician name, address, fax, and phone>		
What is the individual's primary language/means of communication?	<input type="checkbox"/> English <input type="checkbox"/> American Sign Language <input type="checkbox"/> Arabic/Hindu <input type="checkbox"/> Armenian <input type="checkbox"/> Chinese <input type="checkbox"/> Dutch <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Greek <input type="checkbox"/> Hindi <input type="checkbox"/> Italian <input type="checkbox"/>	<input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Polish <input type="checkbox"/> Portuguese <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Yiddish <input type="checkbox"/> Other <Specify>	
IF SELECTION OTHER THAN ENGLISH: Is an interpreter needed?	<input type="checkbox"/> No <input type="checkbox"/> Yes <Note how interpreter service should be obtained>		
MENTAL HEALTH DIAGNOSES			
Check any or all of the following mental health conditions that are diagnosed or suspected for this individual now or in the past: <Indicate current or suspected>	<input type="checkbox"/> No mental health diagnosis is known or suspected <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizoaffective Disorder <input type="checkbox"/> Major Depression <input type="checkbox"/> Psychotic/Delusional Disorder <input type="checkbox"/> Bipolar Disorder (manic depression) <input type="checkbox"/> Paranoid Disorder <input type="checkbox"/>	<input type="checkbox"/> Personality Disorder <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Trauma/Stress Related Disorder <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Depression(mild or situational) <input type="checkbox"/> Other mental health diagnosis <Specify—do not include dementia>	
SUBSTANCE-RELATED DIAGNOSES			

<p>Does the individual have a substance related disorder (abuse or dependency)? <i><Indicate last known use: Less than 7 days, 7-14 days, 15-30 days, 31 days – 3 months, 4-6 months, 7-12 months, more than 12 months, unknown></i></p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes—if yes indicate: Alcohol</p> <p><input type="checkbox"/> Cannabis</p> <p><input type="checkbox"/> Phencyclidine</p> <p><input type="checkbox"/> Hallucinogens</p> <p><input type="checkbox"/> Inhalants</p>	<p><input type="checkbox"/> Opioids</p> <p><input type="checkbox"/> Phencyclidine</p> <p><input type="checkbox"/> Sedatives/Anxiolytics/ Hypnotics</p> <p><input type="checkbox"/> Amphetamines</p> <p><input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> Other <i><Specify></i></p>		
<p>Is the request for nursing home care in any way associated with or resulting from the substance related disorder (including any withdrawal related symptoms)?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>			
<p>DEMENTIA/NEUROCOGNITIVE DISORDERS</p>				
<p>Does the individual have a diagnosis of dementia/neurocognitive disorder?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <i><If yes, complete rest of section questions></i></p>			
<p>Are the deficits due to dementia/ neurocognitive disorder so severe that the individual cannot live in the community because of those deficits?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>			
<p>Due to the dementia/neurocognitive disorder, does the individual present with:</p>	<table border="0"> <tr> <td style="vertical-align: top;"> <p>1. Significant difficulty communicating?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>2. Significant difficulty ambulating and/or completing routine motor tasks?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>3. Significant difficulty recognizing familiar people or familiar objects?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> </td> <td style="vertical-align: top;"> <p>4. Significant short-term memory impairments?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>5. Significant long-term memory impairments?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> </td> </tr> </table>		<p>1. Significant difficulty communicating?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>2. Significant difficulty ambulating and/or completing routine motor tasks?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>3. Significant difficulty recognizing familiar people or familiar objects?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>4. Significant short-term memory impairments?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>5. Significant long-term memory impairments?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>
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<p>Is corroborative testing or other information available to verify the presence or progression of the dementia?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes—if yes indicate:</p> <p><input type="checkbox"/> Dementia work up</p> <p><input type="checkbox"/> Comprehensive Mental Status</p> <p><input type="checkbox"/> Exam Other <i><Specify></i></p>			
<p>INTERPERSONAL BEHAVIORS</p>				
<p>Check any or all of the following interpersonal behaviors or symptoms experienced by this individual recently or in the past: <i><Indicate when last experienced: Current or within the past 30 days, within the past 2-6 months, within the past 7-12 months, within the past 13-24 months, within the past 25 months – 5 years, greater than five years></i></p>	<p><input type="checkbox"/> There are no known mental health behaviors which affect interpersonal interactions</p> <p><input type="checkbox"/> Serious difficulty interacting with others</p> <p><input type="checkbox"/> Altercations, evictions, or unstable employment</p> <p><input type="checkbox"/> Excessive isolation from or avoidance of others (such as would occur with a person with severe anxiety, paranoia, depression, or fear of strangers)</p>			
<p>CONCENTRATION/TASK COMPLETION</p>				
<p>Check whether any or all of the following task- or concentration-related behaviors or symptoms have occurred for this individual recently or in the past: <i><indicate when last experienced: Current or within the past 30 days, within the past 2-6 months, within the past 7-12 months, within the past 13-24 months, within the past 25 months – 5 years, greater than five years></i></p>	<table border="0"> <tr> <td style="vertical-align: top;"> <p><input type="checkbox"/> There are no known mental health symptoms affecting the individual's ability to think through or complete tasks which s/he should be physically capable of completing</p> <p><input type="checkbox"/> Serious difficulty thinking through or completing tasks that s/he should be capable of completing</p> </td> <td style="vertical-align: top;"> <p><input type="checkbox"/> Requires assistance thinking through or completing tasks which s/he should be capable of thinking through or completing</p> <p><input type="checkbox"/> Substantial errors thinking through or completing tasks</p> </td> </tr> </table>		<p><input type="checkbox"/> There are no known mental health symptoms affecting the individual's ability to think through or complete tasks which s/he should be physically capable of completing</p> <p><input type="checkbox"/> Serious difficulty thinking through or completing tasks that s/he should be capable of completing</p>	<p><input type="checkbox"/> Requires assistance thinking through or completing tasks which s/he should be capable of thinking through or completing</p> <p><input type="checkbox"/> Substantial errors thinking through or completing tasks</p>
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<p>MENTAL HEALTH SYMPTOMS</p>				

<p>Check whether any of the following behaviors or symptoms have occurred for this individual recently or in the past: <indicate when last experienced: Current or within the past 30 days, within the past 2-6 months, within the past 7-12 months, within the past 13-24 months, within the past 25 months – 5 years, greater than five years></p>	<input type="checkbox"/> None or No Symptoms experienced <input type="checkbox"/> Self-injurious or self-mutilation <input type="checkbox"/> Suicidal talk <input type="checkbox"/> History of suicide attempt or gestures <input type="checkbox"/> Physical violence <input type="checkbox"/> Physical threats (with potential for harm) <input type="checkbox"/> Physical threats (no potential for harm) <input type="checkbox"/> Severe appetite disturbance	<input type="checkbox"/> Hallucinations or delusions <input type="checkbox"/> Serious loss of interest in things <input type="checkbox"/> Excessive tearfulness <input type="checkbox"/> Excessive irritability <input type="checkbox"/> Other major mental health symptoms (this may include recent symptoms that have emerged or worsened as a result of recent life changes as well as any ongoing symptoms. Describe symptoms.)
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BEHAVIORAL HEALTH SYMPTOMS

<p>Has the individual received any of the following mental health services now or in the past? <indicate when last received: Current or within the past 30 days, within the past 2-6 months, within the past 7-12 months, within the past 13-24 months, within the past 25 months – 5 years, greater than five years></p>	<input type="checkbox"/> No <input type="checkbox"/> Inpatient psychiatric hospitalization <input type="checkbox"/> Partial hospitalization services <input type="checkbox"/> Residential treatment services <input type="checkbox"/> Mental health crisis services <input type="checkbox"/> Other intensive services <Specify>
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BEHAVIORAL HEALTH IMPACT

<p>Has there been legal intervention due to mental health symptoms?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes <indicate when last occurred>
<p>Has the individual ever had to move to another setting because of mental health symptoms?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes <indicate when last occurred>
<p>Has the individual ever attempted suicide?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes <indicate when last occurred>
<p>Has the individual ever been homeless?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes <indicate when last occurred>
<p>Are there other examples where the individual's life has been seriously affected because of mental health symptoms?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes <Describe and indicate when last occurred>
<p>Are the individual's behaviors/symptoms stable (meaning that there is no evidence of dangerousness/risk to self or others)?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes

PSYCHOTROPIC MEDICATIONS

<p>Has the individual been prescribed psychoactive (mental health) medications now or within the past 6 months?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes (list below)	
<p>Do not list medications given for medical diagnoses.</p>	<p>Select from dropdown medication list. Include dosage mg/day and corresponding diagnosis.</p>	

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

<p>Does the individual have a diagnosis of an intellectual disability?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>Does the individual have presenting evidence of Intellectual Disability (ID) that has not been diagnosed?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>Is there evidence of a cognitive or developmental impairment that occurred prior to age 18?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>Has the individual ever received services from an agency that serves people with Intellectual Disability (ID)?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes <Provide Facility/Agency name and phone if known>

<p>Does the individual have a diagnosis which affects intellectual or adaptive functioning?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes <specify> <input type="checkbox"/> Autism <input type="checkbox"/> Epilepsy <input type="checkbox"/> Blindness <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Closed Head <input type="checkbox"/> Injury Deaf <input type="checkbox"/> Other <Specify>
<p>Did this condition develop prior to age 22?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>Are there substantial functional limitations NOT due to the medical condition, dementia or mental illness?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Mobility <input type="checkbox"/> Self-Care <input type="checkbox"/> Self-Direction <input type="checkbox"/> Learning <input type="checkbox"/> Understanding/use of language <input type="checkbox"/> Capacity for living independently

CATEGORICAL DECISIONS (Applies only to persons with known or suspected MI and/or ID/RC)

To be eligible for short term exemption or categorical decision, the individual must be psychiatrically and behaviorally stable
When authorization is provided for a short term categorical or exemption, the NF must submit a new level I to Ascend.

<p>Does the admission meet criteria for Hospital Convalescence?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes, meets all criteria for 30 day Exempted Hospital Discharge <input type="checkbox"/> Yes, meets all criteria for 60 day Categorical Decision <ul style="list-style-type: none"> • Admission to NF directly from hospital after receiving acute medical care • AND need for NF is required for the condition treated in the hospital; <specify> • AND the attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services (exempted hospital discharge) OR The Attending physician has certified prior to NF admission the individual will require less than 60 calendar days of NF services (60 day categorical decision)
<p>Does the individual meet one of the following criteria for Respite admission for up to 30 calendar days?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes, meets the following criteria: <ul style="list-style-type: none"> • The individual requires respite care for up to 30 calendar days to provide relief to the family and/or caregiver • The individual will be returning to the community at the conclusion of the respite stay
<p>Does the individual meet one of the following criteria for categorical NF approval as a result of terminal state or severe illness?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes, meets the following criteria: <ul style="list-style-type: none"> <input type="checkbox"/> Terminal Illness: Prognosis of life expectancy of ≤ 6 months, along with nursing care of supervision needs associated with the condition <input type="checkbox"/> Severe Illness: Coma, ventilator dependent, brain-stem functioning, progressed ALS, Progressed Huntington's, etc., so severe that the individual would be unable to participate in a program of specialized care associated with his/her MI and/or ID/RC. (documentation of the individual's medical status must accompany this screen.)
<p>Does the individual have co-occurring dementia and Intellectual Disability/Developmental Disability?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes —if yes, is the dementia progressed to the extent that the individual could not benefit from ID/DIDD services? <input type="checkbox"/> No <input type="checkbox"/> Yes

SUBMITTER ATTESTATION/SIGNATURE

Gives opportunity to provide any additional contacts to reach if questions arise and/or additional phone numbers. Text box available for additional notes/comments.

- By checking this box, I attest that I have reviewed all information contained herein and that I take responsibility for the completeness and accuracy of information reported throughout this submission. I also attest this information was provided by a health care professional working in a clinical capacity for this facility. The health care professional who provided this submission information meets the required clinical qualifications.**

I understand that the state of Tennessee considers knowingly submitting inaccurate, incomplete or misleading Level I information to be Medicaid fraud, and I have completed this form to be the best of my knowledge.

Please enter the name of the Clinical Professional who is signing off on the clinical information:

<Provides a field for submitter phone number and a text box for additional notes/comments>

PROPRIETARY