SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM
I. IDENTIFYING/DEMOGRAPHIC INFORMATION

(For CLTC Use Only)
Application Date: **Intake Worker:**

Client Choice

1. Elderly Disabled	4. Children Services	20. Pre-Admission Screening	23. HMO/Nursing Home	99. Other/Unknown
2. Ventilator Waiver	5. SC Choice	21. Non-Medicaid PASARR	40. TEFRA	
3. HIV/AIDS Waiver	6. HASCI Waiver	22. Nursing Home Conversion	41. OSS RCF	

CLIENT INFORMATION

Name: ______________________

Permanent Address: ______________________

City: __________ State: ______ Zip: ________ County: __________ Rural/Urban: __________

Mailing Address: ______________________

City: __________ State: ______ Zip: ________ County: __________ Rural/Urban: __________

Phone 1: __________ Phone 2: __________ Phone 3: __________

Location: __________ Location: __________ Location: __________

Functional Touch Tone Phone: ________ Toll Free Access: ________

Date of Birth: __________ **Social Security Number:** __________

Medicare Number: __________ **Medicaid Number:** __________

PRESENT LOCATION

Address: ______________________

City: __________ State: ______ Zip: ________ Phone: __________

Directions to Client's Location:

Comments:

RESPONSIBLE PARTY

Name: ______________________

Address: ______________________

City: __________ State: ______ Zip: ________

Home Phone: __________ Work Phone: __________ Ext: ______ Cell Phone: __________

Relationship to Client:

1. Spouse	4. Parent	7. Grandparent	10. Friend	99. Other
2. Child/Child's Spouse	5. Aunt/Uncle	8. Grandchild	11. Neighbor	
3. Sibling	6. Cousin	9. Niece/Nephew	12. Self	

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I. IDENTIFYING/DEMOGRAPHIC INFORMATION

CLTC Client #: ______________________ Client Name: ______________________

DEMOGRAPHIC DATA
(Circle Appropriate Categories)

Marital Status:	**Race:**	**Sex:**	**Education:**	**Speakers English:** **Read / Writes English:**
1. Married	White	Female	0. Less than third grade	
2. Widowed	Black	Male	1. Third through eight grade	
3. Divorced/Separated	Asian		2. Some high school	
4. Single	Hispanic		3. High school graduate	
	Indian		4. Some college	
	Native Hawaiian/ Pacific Islander		5. College graduate	
	Other			

Primary Language (please circle) 1

1. English	2. Spanish	3. French	4. German	5. Russian	6. Vietnamese
7. Japanese	8. Korean	9. Chinese	10. Italian	11. Greek	99. Other______________

REFERRAL INFORMATION

Reason for Referral: (circle functional dependencies)

Locomotion	Dressing	Toilet Use	Incontinence
Transfer	Eating	Bathing	

Does client know referral is being made? (Y/N)

If no, why not?

REFERRAL SOURCE (please circle)

1. DSS	6. Hospital	11. Other	6. Self
2. DHEC	7. NH	12. Family/Friend	17. DHHS Eligibility
3. DMH	8. MD	13. Home Health	99. Other
4. DDSN	9. CLTC	14. RCF	
5. COA	10. HIV CBO	15. HMO	

Referring Person: ______________________

Address: ______________________

City: ______________ State: ________ Zip: ______________

Phone: ______________________

Referral Location:

1. Nursing Home 2. Hospital 3. Community 4. RCF 9. Other

RESOURCE INFORMATION
Complete this section for waiver, CPDN, and CPCA cases only

Private Health Insurance: (Y/N)

Policy Name: ______________________

Policy Number: ______________________

Private Long Term Care Insurance: (Y/N)

Policy Name: ______________________

Policy Number: ______________________

VA Benefits? (Y/N) **Hospice Client? (Y/N)** **Hospice Prior Authorization Code:** ______________

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CLTC Client #: ______________________ Client Name: ______________________

HOUSING INFORMATION
(Complete this section for Waiver, CPDN, and Child PCA cases only)

Number of living in household (including client)

Living Arrangements:

11. Alone, in home or apartment
12. Alone, in rented room(s)
13. Alone, in boarding home
14. Alone, in nursing home
15. Alone, in hospital
16. Alone, in other location
21. With spouse, in home or apt.
22. With spouse, in rented room(s)
29. With spouse, in other location
31. With others, in home or apt.
32. With others, in rented room9s)
39. With others, in other location

Type of Dwelling:

1. Single Family Home
2. Duplex
3. Apartment Building
4. Mobile Home
5. Residential Care Facility
6. Nursing Home
7. Hospital
8. Rented Room(s)
99. Other

0Ownership: 0

1. Client owns
2. Client rents
3. Family member owns
4. Family member rents
99. Other

PHYSICIAN INFORMATION

Primary Physician: ______________________

Address: ______________________

City: ____________ State: ________ Zip: ____________

Phone: ____________ Fax: ____________

Office Contact: ______________________

Secondary Physician: ______________________

Address: ______________________

City: ____________ State: ________ Zip: ____________

Phone: ____________ Fax: ____________

Office Contact: ______________________

Specialty: ______________________

Signature of Person Completing Section I: ______________________ **Date:** ____________

(For CLTC use only)

Assigned to Waiting List? (Y/N) CLTC Number Assigned: ______________________

Referral Type:

1. New Application
2. Re-Application
3. Transfer

Referral Mode:

1. Assessment
2. Phone/Walk-in
3. 1231
4. Written
9. Other

Intake Criteria Met:

1. Under 18 (E/D Waiver)
2. Not in Geographic Area
3. No mental/Physical Impairment
4. Other – Inappropriate at Intake
5. Not Diagnosed AIDS/ARC
6. Not Ventilator Dependent
7. Under 21 (Vent Waiver)

Financial Eligibility Verified? (Y/N) Eligibility Category: ______________________

NC/CM Assigned: ______________________ Date Assigned: ______________________

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SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM
II. MEDICAL INFORMATION

CLTC Client # ______________________ Client Name: ______________________

A. DIAGNOSES/ CONDITIONS	Indicate only those diagnoses or conditions present that have a relationship to current ADL status, cognitive, behavioral status, medical treatments, or risk of death. Code: 1 = current/new; 2 = discontinued. (Do not list old/inactive diagnoses or conditions.)										
	A	B	C	D	E		A	B	C	D	E
HEART/CIRCULATION						**PULMONARY**					
a. Arteriosclerotic/atheroscotic heart disease						ee. Emphysema/Asthma/COPD					
b. Cardiac dysrhythmia						ff. Pneumonia					
c. Congestive heart failure						gg. Cystic fibrosis					
d. Hypertension						hh. Tuberculosis					
e. Hypotension											
f. Peripheral vascular disease											
g. Myocardial infarction						**SKIN CONDITION**					
h. Other cardiovascular disease						ii. Decubiti					
						jj. Specify stage					
SENSORY						**OTHER**					
i. Cataracts						kk. Allergies (specify) ____________					
j. Glaucoma						ll. Anemia					
NEUROLOGICAL						mm. Arthritis					
k. Alzheimer's						nn. Diabetes mellitus					
l. Dementia other than Alzheimer's						oo. Hyperthyroidism					
m. Aphasia						pp. Hypothyroidism					
n. Cerebrovascular accident (stroke)						qq. Cancer (specify) ___________					
o. Frequent TIA's						rr. Osteoporosis					
p. Multiple sclerosis						ss. Septicemia					
q. Cerebral palsy						tt. Urinary tract infection/last 30 days					
r. Muscular dystrophy						uu. Seizure disorder					
s. Head injury						vv. Missing limb (specify) _______					
t. Parkinson's disease						ww. Fracture (specify) ___________					
u. Spinal cord injury						xx. Paraplegia					
v. Mental retardation						yy. Quadriplegia					
w. Autism						zz. Renal failure					
PSYCHIATRIC/MOOD						aaa. Other (specify diagnosis)					
x. Anxiety disorder						____________________________					
y. Depression						____________________________					
z. Schizophrenia											
aa. Paranoia											
bb. Manic depressive (bipolar disease)											
cc. Suicidal risk											
dd. Psychosis											

SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM
II. MEDICAL INFORMATION

CLTC Client # ______________________ Client Name: ______________________

		A	B	C	D	E
HIV/AIDS (Diagnoses/ Conditions continued)	bbb. AIDS					
	ccc. HIV+ (list specific conditions below)					
	______________________					
	______________________					
	______________________					
	CD4 Level (enter current level)					
B. STABILITY OF CONDITION (check applicable)	a. Condition/disease unstable.					
	b. Client experiencing an acute episode or a flare-up of a recurrent/chronic problem.					
	c. None of the above c. NONE OF THE ABOVE (stable)					

C. ABNORMAL DATA	**Lab Data** (i.e. blood sugar, drug levels; date each entry)	**Vital Signs** (Date each entry)

D. TREATMENTS AND THERAPIES (indicate frequencies for all that apply using frequency codes below; place a check in u. if client receives no treatments or therapies.)		A	B	C	D	E	COMMENTS
	a. Speech therapy						
	b. Occupational therapy						
	c. Physical therapy						
	d. Ventilator/Respirator						
	e. Sterile dressings						
	f. Lesion irrigation						
	g. Decubitus care						
	h. Ostomy care						
	i. Special catheter care						
	j. Chemotherapy						
	k. Radiation						
	l. Dialysis						
	m. Suctioning						
	n. Trach care						
	o. Parenteral IV						
	p. Transfusions						
	q. Oxygen						
	r. Respiratory therapy						
	s. Feeding tube						
	t. Other (specify in comment section)						
	u. None of the above						

SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM
II. MEDICAL INFORMATION

CLTC Client # ____________________ Client Name: ____________________

E. NUTRITION		A	B	C	D	E	COMMENTS
(check all that apply)	a. Complains about the taste of many foods						
	b. Insufficient fluid; dehydrated						
	c. Did NOT consume all/almost all liquids provided in last 3 days						
	d. Regular complaint of hunger						
	e. Leaves 25%+ of food uneaten at meals						
	f. Wasting						
	g. Weight Loss/Gain						
	h. Mechanically altered diet						
	i. Syringe (oral feeding)						
	j. Dietary supplement between meals						
	k. Plate guard, stabilized built-up utensil, etc.						
	l. No added salt						
	m. Low sodium						
	n. Diabetic (specify cals)						
	o. Low fat						
	p. No concentrated sugars						
	q. Regular diet and approach						
	r. Swallowing problem						
	s. Other (specify in comment section)						
	t. None of the above						

SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM
II. MEDICAL INFORMATION

CLTC Client # ______________________ Client Name: ______________________

NUTRITIONAL SCREENING

(check all that apply)

*MUST BE COMPLETED ON ALL CCM CASES; OPTIONAL FOR PRE-ADMISSION CASES.

	A	B	C	D	E	COMMENTS
1. I have an illness or condition that made me change the Kind and/or amount of food I eat. (2 points)						
2. I eat fewer than two (2) meals per day. (3 points)						
3. I eat few fruits per day. I eat few vegetables per day. I eat few milk products per day. (2 points)						
4. I have three (3) or more drinks of beer, liquor, or wine almost every day. (2 points)						
5. I have teeth or mouth problems that make it hard for me to eat. (2 points)						
6. I don't always have enough money to buy the food I need. (4 points)						
7. I eat alone most of the time. (1 point)						
8. I take three (3) or more different prescribed or over-the-counter drugs a day. (1 point)						
9. a) Without wanting to, I have lost ten (10) pounds within the last six (6) months. b) Without wanting to, I have gained ten (10) pounds within the last six (6) months. (2 points)						
10. I am not always physically able to shop. I am not always physically able to cook. I am not always physically able to feed myself. (2 points)						
TOTAL NUTRITIONAL SCORE =						

F. SKIN

(check all that apply)

	A	B	C	D	E	COMMENTS
a. Abrasions, bruises						
b. Burns (second or third degree)						
c. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)						
d. Rashes (e.g, inpetigo, eczema, drug rash, heat rash, herpes zoster)						
e. Skin desensitized to pain or pressure						
f. Skin tears or cuts (other than surgery)						
g. Surgical Wounds						
h. NONE OF ABOVE						

G. HEIGHT AND WEIGHT

Height ______ ft ______ in.

Weight (code in lbs. below)

A	B	C	D	E

	Date	Initials	Source
A			
B			
C			
D			
E			

Source codes

A = Medical record

B = Physician

C = Family

D = Client

E = Other

SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM
III. FUNCTIONAL INFORMATION

CLTC Client # ______________________ Client Name: ______________________

H. MEDICATIONS

1. List medication name and dosage.

2. RA (route of administration)

1= By mouth (PO)	3=Intramuscular (IM)	5=Subcutaneous (SubQ)	7=Topical	9=Enteral tube
2= Sublingual (SL)	4=Intravenous (IV)	6=Rectally	8=Inhalation	10=Other

3. FREQ (frequency): Use the appropriate code to show the number of times the medication was given.

PR= (PRN) as necessary 1H= (qh) every hour 2H= (q2h) every 2 hours 3H= (q3h) every 3 hours 4H= (q4h) every 4 hours	6H= (q6h) every 6 hours 8H= (q8h) every 8 hours C= continuous 1D= (qd or hs) once daily 2D= (BID) two times daily	3D= (TID) three times daily 4D= (QID) four times daily 1W= (QWeek) once weekly 2W= twice weekly 3W= three times weekly	QO= (QOD) every other day 4W= four times weekly 5W= five times weekly 6W= six times weekly 1M= (Qmonth) once monthly	2M= twice monthly

4. D/C Date medication discontinued.

1.Medication name and dosage	2. RA	3. FREQ	4.D/C	1. Medication name and dosage	2. RA	3. FREQ	4.D/C

	A	B	C	D	E	
Do any meds require frequent monitoring or adjustment? Code: 0 = No; 1 = Yes						Describe if yes:

Signature Person Completing Section H: ______________________ Date:

SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM
III. FUNCTIONAL INFORMATION

CLTC Client # ______________________ Client Name: ______________________

I. ACTIVITIES OF DAILY LIVING CODING INSTRUCTIONS	ADL SELF-PERFORMANCE--(Code for client's PERFORMANCE during last 7 days--Not including setup) **0. INDEPENDENT** - No help or oversight - OR - Help/oversight provided only 1 or 2 times during last 7 days **1. SUPERVISION** - Oversight encouragement or cuing provided 3+ times during last 7 days - OR - Supervision plus physical assistance provided only 1 or 2 times during last 7 days. **2. LIMITED ASSISTANCE** - Client highly involved in activity, received physical help in guided maneuvering of limbs, or other nonweight bearing assistance 50% or more of the time -OR- More assistance < 50% of the time during last 7 days **3. EXTENSIVE ASSISTANCE** - While client performed part of activity, over last 7 day period, help of following type(s) provided 50% or more of the time: --Weight-bearing support --Full caregiver performance during part (but not all) of last 7 days **4. TOTAL DEPENDENCE** - Full caregiver performance of activity during entire 7 days. DEFINITIONS **A. TRANSFER** - How the client moves between surfaces - to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet) **B. LOCOMOTION** - How the client moves between locations in his/her room and living area. If in a wheelchair, self-sufficiency once in chair. **C. DRESSING** - How the client puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis. **D. EATING** - How the client eats and drinks (regardless of skill). **E. TOILET USE** - How the client uses the toilet (or commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

	A	B	C	D	E	COMMENTS
A. TRANSFER						
B. LOCOMOTION						
C. DRESSING						
D. EATING						[ ] Unable to prepare meals
E. TOILET USE						

BATHING--How client takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair. Code for most dependent in self-performance and support. Bathing Self-Performance codes appear below.)

0. Independent--No help provided
1. Supervision--Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence

	A	B	C	D	E	COMMENTS
F. BATHING						

CONTINENCE SELF-CONTROL CATEGORIES (Code for client performance over 14 days)

0. CONTINENT - Complete control
1. USUALLY CONTINENT - BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. OCCASIONALLY INCONTINENT - BLADDER, 2+ times a week but not daily; BOWEL, once a week
3. FREQUENTLY INCONTINENT - BLADDER, tended to be incontinent daily, but some control present; BOWEL, 2-3 times a week
4. INCONTINENT - Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time; or an indwelling catheter/ostomy that controls bladder/bowel

		A	B	C	D	E	COMMENTS
J. BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed						[ ] Self-care
K. BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed						[ ] Self-care

SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM
III. FUNCTIONAL INFORMATION

CLTC Client # ______________________ Client Name: ______________________

L. MODES OF TRANSFER		A	B	C	D	E	
(check all that apply)	1. Bedfast all or most of time						
	2. Bed rail used						
	3. Lifted Manually						
	4. Lifted mechanically						
	5. Transfer aid (e.g., slide board, trapeze, cane, walker, brace)						
M. MODES OF LOCOMOTION		A	B	C	D	E	
(check all that apply)	1. Cane/Walker/Crutch						
	2. Wheels self						
	3. Other person wheels						
	4. Wheelchair primary mode of locomotion						
N. APPLIANCES AND PROGRAMS		A	B	C	D	E	COMMENTS
(check all that apply)	1. Any scheduled toileting plan						
	2. Bladder retaining program						
	3. External (condom) catheter						
	4. Indwelling catheter						
	5. Intermittent catheter						
	6. Pads/briefs used						
	7. Ostomy present						
	8. Require bowel program						
O. COMMUNICATION		A	B	C	D	E	COMMENTS
HEARING (code appropriatelu)	(With hearing appliance, is used) 0. Hears adequately—normal talk, TV, phone 1. Minimal difficulty when not in quiet setting 2. Hears in special situations only00speaker has to adjust tonal quality and speak distinctly 3. Highly impaired/absence of useful hearing						
MAKING SELF UNDERSTOOD (code appropriately)	(Express information content—however able) 0. Understood 1. Usually Understood—difficulty finding words of finishing thought 2. Sometimes Understood—ability is limited to making concrete requests 3. Rarely/Never Understood						
ABILITY TO UNDERSTAND OTHERS (code appropriately)	(Understanding verbal information content—however able) 0. Understands 1. Usually Understands—may miss some part/intent of message 2. Sometimes Understands—responds adequately to simple direct communications 3. Rarely/Never Understands						

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SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM
III. FUNCTIONAL INFORMATION

CLTC Client # ______________________ Client Name: ______________________

		A	B	C	D	E	COMMENTS
SPEECH CLARITY	0.Clear speech – distinct, intelligible 1. Unclear speech – slurred, mumbled words 2. No speech – absence of spoken words						
		A	B	C	D	E	COMMENTS
MODES OF EXPRESSION	A. Speech						
	B. Writing messages to express or clarify needs						
	C. American sign Language or Braille						
	D. Signs/gestures/sounds						
	E. Communication board						
	F. Other						
	G. NONE OF ABOVE						
		A	B	C	D	E	COMMENTS
P. VISION (code appropriately)	(Ability to see in adequate light and with glasses if used) 0. Adequate—sees fine detail, including regular print in newspapers/books 1. Impaired—sees large print, but not regular print in newspapers/books 2. Highly Impaired—limited vision; not able to see newspaper headlines; appears to follow objects with eyes 3. Severely Impaired—no vision or appears to see only light, colors, or shapes						
Q. COGNITIVE PATTERS	**IV. PSYCHOBEHAVIORAL INFORMATION**	A	B	C	D	E	COMMENTS
COMOTOSE (code appropriately)	(No discernible consciousness) 0. No 1. Yes (Stop section IV here)						
MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory Problem (moderate/severe) 2. Unable to Rate						
	b. Long-term memory OK—seems/appears to recall past 0. Memory OK 1. Memory Problem (moderate/severe) 2. Unable to Rate						

SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM
IV. PSYCHOBEHAVIORAL INFORMATION

CLTC Client # ______________________ Client Name: ______________________

		A	B	C	D	E	COMMENTS
COGNITIVE SKILLS FOR DAILY DECISION-MAKING (judgment) (code appropriately)	(Made decisions regarding tasks of daily life) 0. Independent--decisions consistent/reasonable 1. Modified Independence--some difficulty in new situations only 2. Moderately Impaired--decisions poor, close supervision required 3. Severely Impaired--never/rarely made decisions						
R. MOOD & BEHAVIOR PATTERNS	(Code for behavior in last 7 days) 0. Behavior not exhibited in last 7 days. 1. Behavior of this type occurred less than daily. 2. Behavior of this type occurred daily or more frequently						
SAD OR ANXIOUS MOOD		A	B	C	D	E	COMMENTS
	a. VERBAL EXPRESSIONS OF DISTRESS BY CLIENT (sadness, senses that nothing matters, hopelessness, worthlessness, unrealistic fears, vocal expressions of anxiety or grief)						
	b. DEMONSTRATED (OBSERVABLE) SIGNS OF MENTAL DISTRESS (Tearfulness, emotional, groaning, sighing, breathlessness)						
	c. Motor agitation such as pacing, handwringing or picking						
	d. Failure to eat or take medications, withdrawal from selfcare or leisure activities						
	e. Persistent concern with health						
	f. Recurrent thoughts of death--e.g., believes he/she about to die, have a heart attack						
	g. Suicidal/homicidal thoughts/actions						
	h. NONE OF ABOVE						
PROBLEM BEHAVIOR		A	B	C	D	E	COMMENTS
	a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety.)						
	b. VERBALLY ABUSIVE (others were threatened, screamed at, cursed at.)						
	c. PHYSICALLY ABUSIVE (others were hit, shoved,						
	d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disruptive sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings.)						

SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM
IV. PSYCHOBEHAVIORAL INFORMATION

CLTC Client # ______________________ Client Name: ______________________

	Code 1 = Correct 2 = Incorrect	A	B	C	D	E	COMMENTS
S. MENTAL STATUS QUESTIONNAIRE	What is the name of this place?						
	Where is it located?						
	What month is it now?						
	What year is it now?						
	How old are you?						
	What month were you born in?						
	Who is the president of the U.S.?						
	Who was the president before him?						
	TOTAL MSQ SCORE (# of incorrect answers)						
T. COMMENTS (date all comments)							

______________________ DATE ______________________
SIGNATURE OF NURSE/SOCIAL WORKER/PHYSICIAN

	DATE	INITIALS
B		
C		
D		
E		

ASSESSMENT TYPE CODES

2= Non CCM Reevaluation

3= CCM Reevaluation

5= Other

6= Recertification

For CLTC use only

LOC	ASSESS TYPE	DATE	TEAM INITIALS

SOUTH CAROLINA LONG TERM CARE ASSESSMENT FORM
IV. PSYCHOBEHAVIORAL INFORMATION

CLTC Client #______________________ Client Name:______________________

U. CLIENT OUTCOMES

Date Entered Program: _____/_____/______ Date of Termination: _____/_____/_____

CLTC PROGRAM
1. Elderly/Disabled Waiver
2. Ventilator Waiver
3. HIV/AIDS Waiver
4. Children's PCA
37. Elderly Disabled and Optional State Supplementation
38. HIV and Optional State Supplementation

Current Client Status:

TERMINATION REASON
7. Entered Nursing Home (Complete Sec. V)
8. Died
9. Moved Out of State
10. Referred to New Area # ____________
11. Declined Participation
12. Financially Ineligible
13. Medically Ineligible
14. Entered DMH/DDSN Program
15. Term. & Referred-Medicare
16. Cert.& Closed (complete Sec.V)
17. Inappropriate After Intake
18. Entered Admin.Days
19. Terminated/Other/Unknown
20. Entered RCF
21. Non-Medicaid PASARR
31. Referred to HASCI Waiver
32. Entered MR/RD Waiver
33. Entered TEFRA
34. Closed CCM - Full Calendar Month

V. NURSING HOME CERTIFICATION

Certified level of care **S**killed **I**ntermediate Time limited **Y**es **N**o
Effective date ______/_____/_____
Expiration date ______/_____/_____ Name of Facility:______________________

W. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Code for each task: 1= Independent 2= Some assistance 3= Dependent

	A	B	C	D	E	COMMENTS
1. Medications						
2. Telephone/communications						
3. Meal preparation						
4. Financial management						
5. Housework/chores/laundry						
6. Shopping/errands						
7. Transportation/escort						

X. RESIDENCE

Code for each question: 1= Yes 2= No

1. Safe access to all necessary areas						
2. Essential repairs/replacements						
3. In-home safety items						
4. Security (ie locks on windows & doors)						
5. Adequate Plumbing						
6. Adequate Electricity						
7. Adequate cooling and heating						
8. Working refrigerator						
9. Working stove						
10. Access to laundry						
11. Animal/Pest control						

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