

WISCONSIN ADULT LONG TERM CARE (LTC) FUNCTIONAL SCREEN

BASIC INFORMATION

Basic Screen Information

Name – Screener		Name – Screening Agency	
Date of Referral (mm/dd/yyyy)	Screen Type (Check only one box) <input type="checkbox"/> 01 Initial Screen <input type="checkbox"/> 02 Rescreen		

Basic Applicant Information

Title	Name – Applicant (First)	(Middle)	(Last)
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number (###-##-####)		Date of Birth (mm/dd/yyyy)

Applicant's Contact Information

Address		
City	State	Zip Code
Telephone – Home () -	Telephone – Work () -	Telephone – Cell () -
County / Tribe of Residence		County / Tribe of Responsibility
Directions		

Notes:

TRANSFER INFORMATION

To be completed after eligibility determination and enrollment counseling, and after applicant enrolls in a program.

Date of Referral to Service Agency (mm/dd/yyyy)	Name – Service Agency
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SCREEN INFORMATION

Referral Source (Check only one box)

- | | |
|---|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> RCAC (Residential Care Apartment Complex) |
| <input type="checkbox"/> Family / Significant Other | <input type="checkbox"/> ICF-MR / FDD |
| <input type="checkbox"/> Friend / Neighbor / Advocate | <input type="checkbox"/> State Center |
| <input type="checkbox"/> Physician / Clinic | <input type="checkbox"/> Home Health Agency |
| <input type="checkbox"/> Hospital Discharge Staff | <input type="checkbox"/> Community Agency |
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Other—Specify: _____ |
| <input type="checkbox"/> CBRF (Group Home) | <input type="checkbox"/> Rescreen |
| <input type="checkbox"/> AFH (Adult Family Home) | <input type="checkbox"/> Guardian or other legal representative |

Primary Source for Screen Information (Check only one box)

- | | | |
|---|---|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Child | <input type="checkbox"/> ICF-MR / Center Staff |
| <input type="checkbox"/> Guardian or other legal representative | <input type="checkbox"/> Advocate | <input type="checkbox"/> Residential Care Staff |
| <input type="checkbox"/> Family Member | <input type="checkbox"/> Case Manager | <input type="checkbox"/> Home Health, Personal Care, or Supportive Home Care Staff |
| <input type="checkbox"/> Spouse / Significant Other | <input type="checkbox"/> Hospital Staff | |
| <input type="checkbox"/> Parent | <input type="checkbox"/> Nursing Home Staff | |
| <input type="checkbox"/> Other—Specify: _____ | Indicate name(s): _____ | |

Location Where Screen Interview was Conducted

- | | |
|--|--|
| <input type="checkbox"/> Person's Current Residence | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Temporary Residence (non-institutional) | <input type="checkbox"/> Agency Office / Resource Center |
| <input type="checkbox"/> Nursing Home | |
| <input type="checkbox"/> Other—Specify: _____ | |

TARGET GROUP

(Check all that apply. At least one box must be checked. If "No Target Group" is checked, then no other box should be checked.)

This person has a condition related to (refer to the definitions on the last page and to the instructions):

- Frail Elder
- Physical Disability
- Developmental Disability per FEDERAL definition
- Developmental Disability per STATE definition but NOT Federal definition
- Alzheimer's disease or other irreversible dementia (onset of any age)
- A terminal condition with death expected within one year from the date of this screening
- Severe and persistent mental illness
- None of the above—No Target Group

Notes:

Is the condition related to the eligible target group expected to last more than 12 months OR does the person have a terminal illness?

Yes No

Is the condition related to the eligible target group expected to last more than 90 days?

Yes No

Does the applicant have a disability determination from the Disability Determination Bureau or the Social Security Administration?

Yes No Pending

HCB WAIVER GROUP

For Home and Community Based Waiver counties only

CIP 1A CIP 1B COP W & CIP II IRIS

Notes:

DEMOGRAPHICS

Medical Insurance (Check all boxes that apply)

- Medicare Policy Number: _____
 - Part A Effective Date (mm/dd/yyyy): _____
 - Part B Effective Date (mm/dd/yyyy): _____
 - Medicare Managed Care
- Medicaid
- Private Insurance [includes employer-sponsored (job benefit) insurance]
- Private Long Term Care Insurance
- VA Benefits—Policy #: _____
- Railroad Retirement—Policy #: _____
- Other insurance
- No medical insurance at this time

Ethnicity—Is Applicant Hispanic or Latino?

- Yes No

Race (Check all boxes that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

If an interpreter is required, select language below

- American Sign Language Hmong Other—Specify: _____
- Spanish Russian _____
- Vietnamese A Native American Language _____

Contact Information 1

- Adult Child Parent / Step-Parent Spouse
- Ex-Spouse Power of Attorney Other Informal Caregiver / Support: _____
- Guardian of Person Sibling _____

Name (First)	(Middle Initial)	(Last)
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Address _____

City	State	Zip Code
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Telephone – Home () -	Telephone – Work () -	Cell Phone () -
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Best time to contact and / or comments: _____

Contact Information 2

- | | | |
|---|---|--|
| <input type="checkbox"/> Adult Child | <input type="checkbox"/> Parent / Step-Parent | <input type="checkbox"/> Spouse |
| <input type="checkbox"/> Ex-Spouse | <input type="checkbox"/> Power of Attorney | <input type="checkbox"/> Other Informal Caregiver / Support: |
| <input type="checkbox"/> Guardian of Person | <input type="checkbox"/> Sibling | _____ |

Name (First)	(Middle Initial)	(Last)
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Address

City	State	Zip Code
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Telephone – Home () -	Telephone – Work () -	Cell Phone () -
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Best time to contact and / or comments:

Contact Information 3

- | | | |
|---|---|--|
| <input type="checkbox"/> Adult Child | <input type="checkbox"/> Parent / Step-Parent | <input type="checkbox"/> Spouse |
| <input type="checkbox"/> Ex-Spouse | <input type="checkbox"/> Power of Attorney | <input type="checkbox"/> Other Informal Caregiver / Support: |
| <input type="checkbox"/> Guardian of Person | <input type="checkbox"/> Sibling | _____ |

Name (First)	(Middle Initial)	(Last)
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Address

City	State	Zip Code
------	-------	----------

Telephone – Home () -	Telephone – Work () -	Cell Phone () -
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Best time to contact and / or comments:

Notes:

LIVING SITUATION**Current Residence** (Check only one box)**Own Home or Apartment**

- Alone (includes person living alone who receives in-home services)
- With spouse / partner / family
- With non-relatives / roommates (includes dorm, convent or other communal setting)
- With live-in paid caregiver(s) (includes service in exchange for room and board)

Someone Else's Home or Apartment

- Family
- Non-relative
- 1-2 bed Adult Family Home (certified) or other paid caregiver's home
- Home / apartment for which lease is held by support services provider

Apartment with Services

- Residential Care Apartment Complex
- Independent Apartment CBRF (Community-Based Residential Facility)

Group Residential Care Setting

- Licensed Adult Family Home (3-4 bed AFH)
- CBRF 1-20 beds
- CBRF more than 20 beds
- Children's Group Home

Health Care Facility / Institution

- Nursing Home (includes rehabilitation facility if licensed as a nursing home)
- ICF-MR / FDD
- DD Center / State institution for developmental disabilities
- Mental Health Institute / State psychiatric institution
- Other IMD
- Child Caring Institution
- Hospice Care Facility
- No Permanent Residence** (e.g., is in homeless shelter, etc.)
- Other (includes jail)—Specify:** _____

Prefers to Live (Check only one box)**Own Home or Apartment**

- Alone (includes person living alone who receives in-home services)
- With spouse / partner / family
- With non-relatives / roommates (includes dorm, convent or other communal setting)
- With live-in paid caregiver(s) (includes service in exchange for room and board)

Someone Else's Home or Apartment

- Family
- Non-relative
- 1-2 bed Adult Family Home (certified) or other paid caregiver's home
- Home / apartment for which lease is held by support services provider

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- ICF-MR / FDD
- DD Center / State institution for developmental disabilities
- Mental Health Institute / State psychiatric institution
- Other IMD
- Child Caring Institution
- Hospice Care Facility
- No Permanent Residence** (e.g., is in homeless shelter, etc.)
- Unable to determine person's preference for living arrangement**

What is the guardian's / family's preference for living arrangements for this individual? (Check only one box)

- Not applicable
- Stay at current residence
- Move to own home / apartment (includes living with spouse / family, roommates, 1-2 bed AFH)
- Move to an apartment with onsite services (RCAC, independent apartment CBRF)
- Move to a group residential care setting (CBRF, licensed 3-4 bed AFH)
- Move to a nursing home or other health care facility (ICF-MR, State Center, IMD)
- Unsure, or unable to determine
- No consensus among multiple parties

Notes:

ADLS (ACTIVITIES OF DAILY LIVING)			
Coding for Level of Help Needed to Complete Task Safely		Coding for Who Will Help in Next Eight (8) Weeks	
0	Person is independent in completing the activity safely.	U	Current UNPAID caregiver will continue
1	Help is needed to complete task safely but helper DOES NOT have to be physically present throughout the task. "Help" can be supervision, cueing, or hands-on assistance.	PF	Current PUBLICLY FUNDED paid caregiver will continue
2	Help is needed to complete task safely and helper DOES need to be present throughout task. "Help" can be supervision, cueing, and / or hands-on assistance (partial or complete).	PP	Current PRIVATELY PAID caregiver will continue
		N	Need to find new or additional caregiver(s)
ADLs (Activities of Daily Living)		Help Needed (check only one)	Who Will Help in Next Eight Weeks? (check all that apply)
BATHING	The ability to shower, bathe, or take sponge baths for the purpose of maintaining adequate hygiene. This also includes the ability to get in and out of the tub, turn faucets on and off, regulate water temperature, wash, and dry fully. <input type="checkbox"/> Uses Grab Bar(s) <input type="checkbox"/> Uses Shower Chair <input type="checkbox"/> Uses Tub Bench <input type="checkbox"/> Uses Mechanical Lift	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> U <input type="checkbox"/> PF <input type="checkbox"/> PP <input type="checkbox"/> N
DRESSING	The ability to dress and undress as necessary and choose appropriate clothing. Includes the ability to put on prostheses, braces, anti-embolism hose (e.g., "TED" stockings) with or without assistive devices, and includes fine motor coordination for buttons and zippers. Includes choice of clothing appropriate for the weather. <i>Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit.</i>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> U <input type="checkbox"/> PF <input type="checkbox"/> PP <input type="checkbox"/> N
EATING	The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew, and swallow food. Note: If person is fed via tube feedings or intravenous, check box 0 if they can do themselves, or box 1 or 2 if they require another person to assist.	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> U <input type="checkbox"/> PF <input type="checkbox"/> PP <input type="checkbox"/> N
MOBILITY IN HOME	The ability to move between locations in the individual's living environment—defined as kitchen, living room, bathroom, and sleeping area. <i>This excludes basements, attics, yards, and any equipment used outside the home.</i> <input type="checkbox"/> Uses Cane in Home <input type="checkbox"/> Uses Wheelchair or Scooter in Home <input type="checkbox"/> Has Prosthesis <input type="checkbox"/> Uses Quad-Cane in Home <input type="checkbox"/> Uses Crutches in Home <input type="checkbox"/> Uses Walker in Home	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> U <input type="checkbox"/> PF <input type="checkbox"/> PP <input type="checkbox"/> N

Notes:

ADLs (Activities of Daily Living)		Help Needed (check only one)	Who Will Help in Next Eight Weeks? (check all that apply)
TOILETING	The ability to use the toilet, commode, bedpan, or urinal. This includes transferring on/off the toilet, cleansing of self, changing of pads, managing an ostomy or catheter, and adjusting clothes. <input type="checkbox"/> Uses Grab Bar(s) <input type="checkbox"/> Uses Commode or Other Adaptive Equipment <input type="checkbox"/> Uses Urinary Catheter <input type="checkbox"/> Has Ostomy <input type="checkbox"/> Receives Regular Bowel Program	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> U <input type="checkbox"/> PF <input type="checkbox"/> PP <input type="checkbox"/> N
	INCONTINENCE: <i>Do not include stress incontinence</i> (small amount of urine leaking during sneezing, coughing, or other exertion) <input type="checkbox"/> Does not have incontinence <input type="checkbox"/> Has incontinence less than daily but at least once per week <input type="checkbox"/> Has incontinence daily		
TRANSFER-RING	The physical ability to move between surfaces: from bed/chair to wheelchair, walker or standing position. The ability to get in and out of bed or usual sleeping place. The ability to use assistive devices for transfers. <i>Excludes toileting transfers.</i> <input type="checkbox"/> Uses Grab Bar(s) <input type="checkbox"/> Uses Transfer Board <input type="checkbox"/> Uses Trapeze <input type="checkbox"/> Uses Mechanical Lift (not a lift chair)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> U <input type="checkbox"/> PF <input type="checkbox"/> PP <input type="checkbox"/> N

Notes:

IADLS (INSTRUMENTAL ACTIVITIES OF DAILY LIVING)**KEY: Coding for Who Will Help in Next Eight (8) Weeks****U** Current **UNPAID** caregiver will continue**PP** Current **PRIVATELY PAID** caregiver will continue**PF** Current **PUBLICLY FUNDED** paid caregiver will continue**N** **Need** to find new or additional caregiver(s)

IADL	Level of Help Needed	Who Will Help in Next Eight Weeks? (check all that apply)
MEAL PREPARATION	<input type="checkbox"/> 0 Independent <input type="checkbox"/> 1 Needs help from another person weekly or less often (e.g., grocery shopping) <input type="checkbox"/> 2 Needs help 2-7 times a week <input type="checkbox"/> 3 Needs help with every meal	<input type="checkbox"/> U <input type="checkbox"/> PF <input type="checkbox"/> PP <input type="checkbox"/> N
MEDICATION ADMINISTRATION and MEDICATION MANAGEMENT	<input type="checkbox"/> NA—Has no medications <input type="checkbox"/> 0 Independent (with or without assistive devices) <input type="checkbox"/> 1 Needs some help 1-2 days per week or less often. <input type="checkbox"/> 2a Needs help at least once a day 3-7 days per week—CAN direct the task and can make decisions regarding each medication. <input type="checkbox"/> 2b Needs help at least once a day 3-7 days per week—CANNOT direct the task; is cognitively unable to follow through without another person to administer each medication.	<input type="checkbox"/> U <input type="checkbox"/> PF <input type="checkbox"/> PP <input type="checkbox"/> N
MONEY MANAGEMENT	<input type="checkbox"/> 0 Independent <input type="checkbox"/> 1 Can only complete small transactions <input type="checkbox"/> 2 Needs help from another person with all transactions	<input type="checkbox"/> U <input type="checkbox"/> PF <input type="checkbox"/> PP <input type="checkbox"/> N
LAUNDRY and / or CHORES	<input type="checkbox"/> 0 Independent <input type="checkbox"/> 1 Needs help from another person weekly or less often <input type="checkbox"/> 2 Needs help more than once a week	<input type="checkbox"/> U <input type="checkbox"/> PF <input type="checkbox"/> PP <input type="checkbox"/> N
TELEPHONE	1. Ability to Use Phone <input type="checkbox"/> 1a Independent—has cognitive and physical abilities to make calls and answer calls (with assistive devices currently used by this person) <input type="checkbox"/> 1b Lacks cognitive or physical abilities to use phone independently 2. Access to Phone <input type="checkbox"/> 2a Currently has working telephone or access to one <input type="checkbox"/> 2b Has no phone and no access to a phone	<input type="checkbox"/> U <input type="checkbox"/> PF <input type="checkbox"/> PP <input type="checkbox"/> N
TRANSPORTATION	<input type="checkbox"/> 1a Person drives regular vehicle <input type="checkbox"/> 1b Person drives adapted vehicle <input type="checkbox"/> 1c Person drives regular vehicle but there are serious safety concerns <input type="checkbox"/> 1d Person drives adapted vehicle but there are serious safety concerns <input type="checkbox"/> 2 Person cannot drive due to physical, psychiatric, or cognitive impairment. Includes no driver's license due to medical problems (e.g., seizures, poor vision). <input type="checkbox"/> 3 Person does not drive due to other reasons	<input type="checkbox"/> U <input type="checkbox"/> PF <input type="checkbox"/> PP <input type="checkbox"/> N

Notes:

OVERNIGHT CARE or OVERNIGHT SUPERVISION and EMPLOYMENT**Does person require overnight care or overnight supervision?**

- 0 No
- 1 Yes—caregiver can get at least six hours of uninterrupted sleep per night
- 2 Yes—caregiver cannot get at least six hours of uninterrupted sleep per night

Employment

This section concerns the need for assistance to perform employment-specific activities – that is, job duties. Since the need for help with ADLs and other IADLs (e.g., transportation, personal care) is captured in other sections, this section essentially concerns supports necessary for successful performance of work tasks.

A. Current Employment Status

- 1 Retired (Does not include people under 65 who stopped working for health or disability reasons)
- 2 Not working (No paid work)
- 3 Working full time (Paid work averaging 30 or more hours per week)
- 4 Working part-time (Paid work averaging fewer than 30 hours per week)

B. If Employed, Where?

- 1 Paid work where the environment and the work tasks are designed for people with disabilities (e.g. sheltered workshop)
- 2 Paid work in other group situation for people with disabilities (e.g. work crew/enclave)
- 3 Paid work outside the home (situations other than those described in B1 and B2)
- 4 Paid work at home

C. Need for Assistance to Work

Mandatory for ages 18-64; otherwise optional

- 0 Independent (with assistive devices if uses them)
- 1 Needs help weekly or less (e.g., if a problem arises)
- 2 Needs help every day but does not need the continuous presence of another
- 3 Needs the continuous presence of another person
- 4 Not applicable

Notes:

DIAGNOSES

Check diagnosis here if 1) it is provided by a health care provider, or 2) you see it written in a medical record (including hospital discharge forms, nursing home admission forms, etc.), or 3) if person or informant can state them **EXACTLY**—except for mental retardation, psychiatric, behavioral, and dementia diagnoses which must be confirmed by health care provider, medical records, the Children's LTS FS, or the disability determination from the Social Security Administration.

No current diagnoses (screen type must be 01)

A. Developmental Disability (DD)

- 1 Mental Retardation **IQ Score:** _____
- 2 Autism
- 3 Brain Injury with onset before age 22
- 4 Cerebral Palsy
- 5 Prader-Willi Syndrome
- 6 Seizure Disorder with onset before age 22
- 7 Otherwise meets state or federal definitions of DD
- 8 Down's Syndrome

B. Endocrine / Metabolic

- 1 Diabetes Mellitus
- 2 Hypothyroidism / Hyperthyroidism
- 3 Dehydration / Fluid and Electrolyte Imbalances
- 4 Liver Disease (hepatic failure, cirrhosis)
- 5 Other Disorders of Digestive System (mouth, esophagus, stomach, intestines, gall bladder, pancreas)
- 6 Other Metabolic Disorders (e.g., B-12 deficiency, high cholesterol, Hyperlipidemia)
- 7 Other disorders of Hormonal or Metabolic system
- 8 Obesity
- 9 Malnutrition
- 10 Eating Disorders

C. Heart / Circulation

- 1 Anemia / Coagulation Defects / Other Blood Diseases
- 2 Angina / Coronary Artery Disease / Myocardial Infarction (M.I.)
- 3 Disorders of Heart Rate or Rhythm
- 4 Congestive Heart Failure (CHF)
- 5 Disorders of Blood Vessels or Lymphatic System
- 6 Hypertension
- 7 Hypotension (low blood pressure)
- 8 Other heart / circulatory conditions (including valve disorders)

D. Musculoskeletal / Neuromuscular

- 1 Amputation
- 2 Arthritis (Osteoarthritis, Rheumatoid Arthritis, etc.)
- 3 Hip Fracture / Replacement
- 4 Other Fracture / Joint Disorders / Scoliosis / Kyphosis
- 5 Osteoporosis / Other Bone Disease
- 6 Contractures / Connective Tissue Disorders
- 7 Multiple Sclerosis / ALS
- 8 Muscular Dystrophy
- 9 Spinal Cord Injury
- 10 Paralysis Other than Spinal Cord Injury
- 11 Spina Bifida
- 12 Other chronic pain or fatigue e.g., fibromyalgia, migraines, headaches, back pain (including disks), CFS
- 13 Other Musculoskeletal, Neuromuscular, or Peripheral Nerve Disorders

E. Brain / Central Nervous System

- 1 Alzheimer's Disease
- 2 Other Irreversible Dementia
- 3 Cerebral Vascular Accident (CVA, stroke)
- 4 Traumatic Brain Injury AFTER age 22
- 5 Seizure Disorder with onset after age 22
- 6 Other brain disorders

F. Respiratory

- 1 Chronic Obstructive Pulmonary Disease (COPD) / Emphysema / Chronic Bronchitis
- 2 Pneumonia / Acute Bronchitis / Influenza
- 3 Tracheostomy
- 4 Ventilator Dependent
- 5 Other Respiratory Condition
- 6 Asthma

Notes:

DIAGNOSES (Continued)**G. Disorders of Genitourinary / Reproductive System**

- 1 Renal Failure, other Kidney Disease
- 2 Urinary Tract Infection, current or recently recurrent
- 3 Other Disorders of GU System (bladder, urethra, etc.)
- 4 Disorders of Reproductive System

H. DOCUMENTED Mental Illness

- 1 Anxiety Disorder (phobias, post-traumatic stress disorder, obsessive-compulsive disorder)
- 2 Bipolar / Manic-Depressive
- 3 Depression
- 4 Schizophrenia
- 5 Other Mental Illness Diagnosis (e.g., Personality Disorder)

I. Sensory

- 1 Blind
- 2 Visual Impairment (e.g., cataracts, retinopathy, glaucoma, macular degeneration)
- 3 Deaf
- 4 Other Sensory Disorders

J. Infections / Immune System

- 1 Allergies
- 2 Cancer in Past 5 Years
- 3 Diseases of Skin
- 4 HIV Positive
- 5 AIDS Diagnosed
- 6 Other Infectious Disease
- 7 Auto-Immune Disease (besides rheumatism)

K. Other

- 1 Substance Use Issue
 - 2 Behavioral Diagnoses (not found in part H above)
 - 3 Terminal Illness (prognosis less than or equal to 12 months)
 - 4 Wound / Burn / Bedsore / Pressure Ulcer
 - 5 Other, list diagnoses (be sure to review "Cue Sheet"):
-

Notes:

HEALTH RELATED SERVICES

Check only one box per row—Leave row blank if not applicable

Health-Related Services	Person is Independent	Frequency of Help / Services Needed from Other Persons					
		1-3 times/month	Weekly	2-6 times/week	1-2 times/day	3-4 times/day	5+ times a day
Behaviors requiring interventions (wandering, SIB, offensive / violent behaviors)							
Exercises / Range of Motion							
IV Medications , fluids or IV line flushes							
Medication Administration (not IV)—includes assistance with pre-selected or set-up meds							
Medication Management —Set-up and/or monitoring (for effects, side effects, adjustments, pain management)—AND / OR blood levels (e.g., drawing blood sample for laboratory tests or “finger-sticks” for blood sugar levels.)							
Ostomy-related SKILLED Services							
Positioning in bed or chair every 2-3 hours							
Oxygen and / or Respiratory Treatments —tracheal suctioning, C-PAP, Bi-PAP, nebulizers, IPPB treatments (does NOT include inhalers)							
Dialysis							
TPN (total parenteral nutrition)							
Transfusions							
Tracheostomy care							
Tube Feedings							
Ulcer – Stage 2							
Ulcer – Stage 3 or 4							
Urinary Catheter-related skilled tasks (irrigation, straight catheterizations)							
Other Wound Cares (not catheter sites, ostomy sites, or IVs or ulcers)							
Ventilator-related interventions							
Requires Nursing Assessment and Interventions Each of the following four criteria MUST be present: <ul style="list-style-type: none"> • A current health instability that • requires skilled nursing assessment and interventions, AND • involves CHANGES in the medical treatment or nursing care plan, AND • cannot be captured in any other HRS row. 							
Other—Specify:							

Skilled Therapy—PT, OT, SLP (any one or combination, any location) 1-4 sessions / week 5+ sessions / week

Who will help with all health-related needs in next eight (8) weeks (check **all** that apply)

- U** Current **UNPAID** caregiver will continue
- PP** Current **PRIVATELY PAID** caregiver will continue
- PF** Current **PUBLICLY FUNDED** paid caregiver will continue
- N** **Need** to find new or additional caregiver(s)

COMMUNICATION AND COGNITION

Communication (check only **one** box)

Includes the ability to express oneself in one's own language, including non-English languages and American Sign Language (ASL) or other generally recognized non-verbal communication. This includes the use of assistive technology.

- 0 Can fully communicate with no impairment or only minor impairment (e.g., slow speech)
- 1 Can fully communicate **with** the use of assistive device
- 2 Can communicate **only basic** needs to others
- 3 No effective communication

Memory Loss (At least one box must be checked. If "0 No memory impairments" is checked, then no other box should be checked.)

- 0 No memory impairments evident during screening process
- 1 Short-term memory loss (seems unable to recall things a few minutes up to 24 hours later)
- 2 Unable to remember things over several days or weeks
- 3 Long term memory loss (seems unable to recall distant past)
- 4 Memory Impairments are unknown or unable to determine. Explain why: _____

Cognition for Daily Decision Making (check only **one** box)

- 0 **Independent**—Person can make decisions that are generally consistent with his / her **own** lifestyle, values, and goals (not necessarily with professionals' values and goals)
- 1 Person can make safe decisions in **familiar / routine situations**, but needs some help with decision-making when faced with new tasks or situations
- 2 Person needs help with reminding, planning, or adjusting routine, **even with familiar routine**
- 3 Person **needs help** from another person most or all of the time

Physically Resistive to Care (check only **one** box)

- 0 No
- 1 Yes, person is physically resistive to cares due to a cognitive impairment

Notes:

BEHAVIORS / MENTAL HEALTH**Wandering**

Defined as a person with cognitive impairments leaving residence / immediate area without informing others. *Person may still exhibit wandering behavior even if elopement is impossible due to, for example, facility security systems.*

- 0 Does not wander
- 1 Daytime wandering but sleeps nights
- 2 Wanders at night, or day and night

Self-Injurious Behaviors

Behaviors that cause or could cause injury to one's own body. *Examples include physical self-abuse (hitting, biting, head-banging, etc.), pica (eating inedible objects), and water intoxication (polydipsia).*

- 0 No injurious behaviors demonstrated
- 1 Some self-injurious behaviors require interventions **weekly or less**
- 2 Self-injurious behaviors require interventions 2-6 times per week **OR** 1-2 times per day
- 3 Self-injurious behaviors require intensive one-on-one interventions more than twice each day

List behavior: _____

Offensive or Violent Behavior to Others

Behavior that causes others significant pain, substantial distress, or is at a point that law enforcement would typically be called to intervene.

- 0 No offensive or violent behaviors demonstrated
- 1 Some offensive or violent behaviors require occasional interventions **weekly or less**
- 2 Offensive or violent behaviors require interventions 2-6 times per week **OR** 1-2 times per day
- 3 Offensive or violent behaviors require intensive one-on-one interventions more than twice each day

List behavior: _____

Mental Health Needs (check **only one** of the four boxes below)**No known diagnosis of mental illness:**

- 0 No mental health problems or needs evident. *No symptoms that may be indicative of mental illness; not on any medications for psychiatric diagnosis.*
- 1 Person may be at risk and in need of some mental health services. Examples could include symptoms or reports of problems that may be related to mental illness, requests for help by the person or family / advocates, or risk factors for mental illness. *Examples of risk factors are symptoms of clinical depression that have lasted more than two weeks and/or interfere with daily life, recent trauma, or loss.*

Person has current diagnosis of mental illness:

- 2 Is currently stable (with or without medication). *"Stable" means the person is functioning well with routine periodic oversight / support, and is currently receiving such oversight / support.*
- 3 Is currently not stable. *Needs intensive mental health services (whether they are currently getting them or not, they need them).*

Substance Use Issue (More than one box may be checked, if appropriate)

- 0 No active substance use issues evident at this time
- 1 Person or others indicate(s) a current problem, or evidence suggests possibility of a current problem or high likelihood of recurrence without significant ongoing support or interventions.
- 2 In the past year, the person has had significant problems due to substance use issues. *Examples are police intervention, detox, inpatient treatment, job loss, major life changes.*

Notes:

RISK

Part A – Current APS or EAN Client

- A1 Person is known to be a current client of Adult Protective Services (APS)
- A2 Person is currently being served by the lead Elder Adult/Adult at Risk (EA/AAR) agency

Part B – Risk Evident During Screening Process

At least one box must be checked. Check all applicable boxes, however, if box "0" is checked, do not check boxes 1, 2, 3, or 4.

- 0 No risk factors or evidence of abuse or neglect apparent at this time
- 1 The individual is currently failing or is at high risk of failing to obtain nutrition, self-care, or safety adequate to avoid significant negative health outcomes
- 2 The person is at imminent risk of institutionalization (in a nursing home or ICF-MR) if they do not receive needed assistance OR person is currently residing in a nursing home or ICF-MR
- 3 There are statements of, or evidence of, possible abuse, neglect, or exploitation
 - Not Applicable
 - Referring to APS and/or EA/AAR now
- 4 The person's support network appears to be adequate at this time, but may be fragile in the near future (within next 4 months)

Notes:

SCREEN COMPLETION

Date of Screen Completion (mm/dd/yyyy): _____

Time to Complete Screen	Hours	Minutes
Face-to-face contact with the person (This can include an in-person interview, or observation if person cannot participate in the interview.)		
Collateral Contacts (Either in person or indirect contact with any other people, including the person's guardian, family, advocates, providers, etc.)		
Paper Work (Includes review of medical documents, etc.)		
Travel Time		
Total Time to Complete Screen		

COP LEVEL 3 AND NO ACTIVE TREATMENT (NAT)

COP Level 3 (for Home and Community-Based Waiver counties only)

Part A—Alzheimer’s and related diseases

1. The person has a physician’s written and dated statement that the person has Alzheimer’s and / or another qualifying irreversible dementia.
 NA Yes No
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 need, but not regular nursing care.
 NA Yes No

Part B—Interdivisional Agreement 1.67

1. The person resided in a nursing home or received CIP II / COP-W services and was referred through an Interdivisional Agreement 1.67 in accordance with s. 46.27(6r)(b)(3).
 NA Yes No

No Active Treatment (for Family Care, IRIS, PACE, Partnership counties only)

Part A—Criteria that can be documented prior to enrollment:

1. The person has a terminal illness.
 NA Yes No
2. The person has an IQ above 75.
 NA Yes No
3. The person is ventilator-dependent.
 NA Yes No

Part B—Criteria that can be documented after enrollment:

1. The person has physical and mental incapacitation due to advanced age such that his / her needs are similar to those of geriatric nursing home residents.
 NA Yes No
2. The person is elderly (generally over age 65) and would no longer benefit from active treatment.
 NA Yes No
3. The person has severe chronic medical needs that require skilled nursing level of care.
 NA Yes No

DEFINITIONS FOR TARGET GROUP QUESTION

Refer to LTC Functional Screen instructions

FRAIL ELDER means an individual aged 65 or older who has a physical disability, or irreversible dementia, that restricts the individual's ability to perform normal daily tasks or that threatens the capacity of the individual to live independently. (DHS 10.13(25m)).

PHYSICAL DISABILITY means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly interferes with or significantly limits at least one major life activity of a person" (WI Statutes 15.197(4)(a) 2).

"**Major life activity**" means any of the following: A. Self-care. B. Performance of manual tasks unrelated to gainful employment. C. Walking, D. Receptive and expressive language, E. Breathing, F. Working, G. Participating in educational programs, H. Mobility, other than walking, I. Capacity for independent living." (WI Statutes 15.197(4)(a)1).

FEDERAL DEFINITION OF DEVELOPMENTAL DISABILITY: A person is considered to have mental retardation if he or she has: i) A level of retardation described in the American Association on Mental Retardation's Manual on Classification in Mental Retardation , or ii) A related condition as defined by 42 CFR 435.1009 which states, "Person with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

1. It is attributable to
 - a) Cerebral palsy or epilepsy or
 - b) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.
2. It is manifested before the person reaches age 22
3. It is likely to continue indefinitely
4. It results in substantial functional limitations in three or more of the following areas of major like activity: self-care; understanding and use of language; learning; mobility; self-direction; or capacity for independent living.

STATE DEFINITION OF DEVELOPMENTAL DISABILITY: "'Developmental disability' means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. 'Developmental disability' does not include senility which is primarily caused by the process of aging or the infirmities of aging" (WI Statutes 51.01(5)(a)).

DEMENTIA means Alzheimer's' disease and other related irreversible dementias involving degenerative disease of the central nervous system characterized especially by premature senile mental deterioration and also includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder (WI Statues 46.87(1)(a)).

TERMINAL CONDITION: means death is expected within one year from the date of screening.

SEVERE AND PERSISTENT MENTAL ILLNESS: means a mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration. "Chronic mental illness" includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include organic mental disorders or a primary diagnosis of mental retardation or alcohol or drug dependence. [DHS 63.02(7)].

NO TARGET GROUP: means the person does not appear to meet any of the statutory definitions for a LTC FS target group.