



Assessment/Support Plans: LTC Level of Care Eligibility Assessment (Legacy ULTC 100.2)

Member Information		
Last Name:	First Name:	M.I.:
Medicaid ID#:	Date of Birth:	
Mailing Address:		

Assessment Information	
Assessment Date:	Date Verified:
Date Completed:	
<p>Event Type:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 6 Month Review <input type="checkbox"/> Appeal - Decision Overturned <input type="checkbox"/> Continued Stay Review <input type="checkbox"/> DI <input type="checkbox"/> Initial Review <input type="checkbox"/> Nursing Facility Transfer <input type="checkbox"/> Reverse DI <input type="checkbox"/> Unscheduled Review <input type="checkbox"/> Waitlist 	
<p>Potential Programs:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Children's Extensive Support Waiver (CES) <input type="checkbox"/> Brain Injury (BI) <input type="checkbox"/> Children's Habilitation Residential Program Waiver (CHRP) <input type="checkbox"/> Children's Home & Community Based Services Waiver (CHCBS) <input type="checkbox"/> Children with Life Limiting Illness (CLLI) <input type="checkbox"/> Community Mental Health Supports Waiver (CMHS) <input type="checkbox"/> Complementary and Integrative Health (CIH) Waiver <input type="checkbox"/> Developmental Disabilities Waiver (DD) <input type="checkbox"/> Elderly, Blind & Disabled Waiver (EBD) <input type="checkbox"/> Family Support Services Program (FSSP) <input type="checkbox"/> Home Care Allowance (HCA) <input type="checkbox"/> Hospital Back Up Plan (HBU) <input type="checkbox"/> Intermediate Care Facility/Intellectual/Developmental Disability (ICF/IID) <input type="checkbox"/> Long Term Care Pending <input type="checkbox"/> Long Term Home Health (LTHH) <input type="checkbox"/> Supported Living Services Waiver (SLS) <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Nursing Facility OBRA Specialized Services <input type="checkbox"/> PACE 	

Assessment Information

Assessment Admission Source:

- ACF
- Community
- Hospital
- Nursing Home

ACTIVITIES OF DAILY LIVING & LEVEL OF CARE DETERMINATION**Activities of Daily Living & Level of Care Determination**

General Instructions:

To qualify for Medicaid long-term care services, the recipient/applicant must have deficits in 2 of 6 Activities of Daily Living, ADLs, (2+ score) or require at least moderate (2+ score) in Behaviors or Memory/Cognition under Supervision.

Bathing

Definition: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene.

ADL Scoring Criteria

- 0 - The member is independent in completing the activity safely.
- 1 - The member requires oversight help or reminding; can bathe safely without assistance or supervision but may not be able to get into and out of the tub alone.
- 2 - The member requires hands on help or line of sight standby assistance throughout bathing activities in order to maintain safety, adequate hygiene and skin integrity.
- 3 - The member is dependent on others to provide a complete bath.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairment

- Amputation
- Balance Problems
- Decreased Endurance
- Falls
- Limited Range of Motion
- Muscle Tone
- Neurological Impairment
- Open Wound
- Oxygen Use
- Pain
- Paralysis
- Sensory Impairment
- Shortness of Breath
- Stoma Site
- Weakness
- N/A

Supervision

- Behavior Issues
- Cognitive Impairment
- Difficulty Learning
- Lack of Awareness
- Memory Impairment

<input type="checkbox"/> Seizures <input type="checkbox"/> N/A
Mental Health <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Paranoia <input type="checkbox"/> N/A
Comments - Bathing
There has been no change in the client's functional level since the last assessment was performed. <input type="checkbox"/> Yes <input type="checkbox"/> No
Dressing
Definition: The ability to dress and undress as necessary. This includes the ability to put on prostheses, braces, anti-embolism hose or other assistive devices and includes fine motor coordination for buttons and zippers. Includes choice of appropriate clothing for the weather. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit.
ADL Score Criteria <input type="checkbox"/> 0 - The member is independent in completing the activity safely. <input type="checkbox"/> 1 - The member can dress and undress, with or without assistive devices, but may need to be reminded or supervised to do so on some days. <input type="checkbox"/> 2 - The member needs significant verbal or physical assistance to complete dressing or undressing, within a reasonable amount of time. <input type="checkbox"/> 3 - The member is totally dependent on others for dressing and undressing.
Due To: (Score must be justified through one or more of the following conditions)
Physical Impairment <input type="checkbox"/> Amputation <input type="checkbox"/> Balance Problems <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Falls <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Muscle Tone <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Open Wound <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Pain <input type="checkbox"/> Paralysis <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Stoma Site <input type="checkbox"/> Weakness <input type="checkbox"/> N/A
Supervision <input type="checkbox"/> Behavior Issues

<input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Seizures <input type="checkbox"/> N/A
Mental Health <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Paranoia <input type="checkbox"/> N/A
Comments - Dressing
There has been no change in the client's functional level since the last assessment was performed. <input type="checkbox"/> Yes <input type="checkbox"/> No
Toileting
Definition: The ability to use the toilet, commode, bedpan, or urinal. This includes transferring on/off the toilet, cleansing of self, changing of apparel, managing an ostomy or catheter and adjusting clothing.
ADL Score Criteria <input type="checkbox"/> 0 - The member is independent in completing the activity safely. <input type="checkbox"/> 1 - The member may need minimal assistance, assistive device, or cueing with parts of the task for safety, such as clothing adjustment, changing protective garment, washing hands, wiping and cleansing. <input type="checkbox"/> 2 - The member needs physical assistance or standby with toileting, including bowel/bladder training, a bowel/bladder program, catheter, ostomy care for safety or is unable to keep self and environment clean. <input type="checkbox"/> 3 - The member is unable to use the toilet. The member is dependent on continual observation, total cleansing, and changing of garments and linens. This may include total care of catheter or ostomy. The member may or may not be aware of own needs.
Due To: (Score must be justified through one or more of the following conditions)
Physical Impairment <input type="checkbox"/> Amputation <input type="checkbox"/> Balance Problems <input type="checkbox"/> Bladder Incontinence <input type="checkbox"/> Bowel Incontinence <input type="checkbox"/> Catheter <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Fine Motor Impairment <input type="checkbox"/> Impaction <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Muscle Tone <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Ostomy

<input type="checkbox"/> Oxygen Use <input type="checkbox"/> Pain <input type="checkbox"/> Paralysis <input type="checkbox"/> Physiological Defect <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Weakness <input type="checkbox"/> N/A
Supervision <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Seizures <input type="checkbox"/> N/A
Mental Health <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Paranoia <input type="checkbox"/> N/A
Comments - Toileting
There has been no change in the client's functional level since the last assessment was performed. <input type="checkbox"/> Yes <input type="checkbox"/> No
Mobility
Definition: The ability to move between locations in the individual's living environment inside and outside the home. Note: Score member's mobility without regard to use of equipment other than the use of prosthesis.
ADL Score Criteria <input type="checkbox"/> 0 - The member is independent in completing the activity safely. <input type="checkbox"/> 1 - The member is mobile in their own home but may need assistance outside the home. <input type="checkbox"/> 2 - The member is not safe to ambulate or move between locations alone; needs regular cueing, stand-by assistance, or hands on assistance for safety both in the home and outside the home. <input type="checkbox"/> 3 - The member is dependent on others for all mobility.
Due To: (Score must be justified through one or more of the following conditions)
Physical Impairment <input type="checkbox"/> Amputation <input type="checkbox"/> Balance Problems <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Fine Motor Impairment <input type="checkbox"/> Gross Motor Impairment <input type="checkbox"/> Limited Range of Motion

<input type="checkbox"/> Muscle Tone <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Pain <input type="checkbox"/> Paralysis <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Weakness <input type="checkbox"/> N/A
Supervision <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> History of Falls <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Seizures <input type="checkbox"/> N/A
Mental Health <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Paranoia <input type="checkbox"/> N/A
Comments - Mobility
There has been no change in the client's functional level since the last assessment was performed. <input type="checkbox"/> Yes <input type="checkbox"/> No
Transferring
Definition: 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 assisted devices, including properly functioning prosthetics, for transfers. Note: Score member's ability to transfer without regard to use of equipment.
ADL Score Criteria <input type="checkbox"/> 0 - The member is independent in completing the activity safely. <input type="checkbox"/> 1 - The member transfers safely without assistance most of the time, but may need standby assistance for cueing or balance; occasional hands-on assistance needed. <input type="checkbox"/> 2 - The member transfer requires standby or hands on assistance for safety; member may bear some weight. <input type="checkbox"/> 3 - The member requires total assistance for transfers and/or positioning with or without equipment.
Due To: (Score must be justified through one or more of the following conditions)

Physical Impairment <input type="checkbox"/> Amputation <input type="checkbox"/> Balance Problems <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Falls <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Pain <input type="checkbox"/> Paralysis <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Weakness <input type="checkbox"/> N/A
Supervision <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Seizures <input type="checkbox"/> N/A
Mental Health <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Paranoia <input type="checkbox"/> N/A
Comments - Transferring
There has been no change in the client's functional level since the last assessment was performed. <input type="checkbox"/> Yes <input type="checkbox"/> No
Eating
Definition: The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew and swallow food. Note: If a person is fed via tube feedings or intravenously, check box 0 if they can do independently, or box 1, 2, or 3 if they require another person to assist.
ADL Score Criteria <input type="checkbox"/> 0 - The member is independent in completing the activity safely. <input type="checkbox"/> 1 - The member can feed self, chew and swallow foods but may need reminding to maintain adequate intake; may need food cut up; can feed self if food brought to them, with or without adaptive feeding equipment. <input type="checkbox"/> 2 - The member can feed self but needs line of sight standby assistance for frequent gagging, choking, swallowing difficulty; or aspiration resulting in the need for medical intervention. The member

needs reminder/assistance with adaptive feeding equipment; or must be fed some or all food by mouth by another person.

- 3 - The member must be totally fed by another person; must be fed by another person by stomach tube or venous access.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairment

- Amputation
- Aspiration
- Choking
- Decreased Endurance
- Fine Motor Impairment
- IV Feeding
- Limited Range of Motion
- Neurological Impairment
- Oxygen Use
- Pain
- Paralysis
- Poor Dentition
- Sensory Impairment
- Shortness of Breath
- Swallowing Problems
- Tremors
- Tube Feeding
- Weakness
- N/A

Supervision

- Behavior Issues
- Cognitive Impairment
- Difficulty Learning
- Lack of Awareness
- Memory Impairment
- Seizures
- N/A

Mental Health

- Delusional
- Hallucinations
- Lack of Motivation/Apathy
- Paranoia
- N/A

Comments - Eating

There has been no change in the client's functional level since the last assessment was performed.

- Yes
- No

Supervision Behavior

Definition: The ability to engage in safe actions and interactions and refrain from unsafe actions and interactions. (Note: Consider the member's inability versus unwillingness to refrain from unsafe actions and interactions).

ADL Score Criteria

- 0 - The member demonstrates appropriate behavior; there is no concern.
- 1 - The member exhibits some inappropriate behaviors but not resulting in injury to self, others and/or property. The member may require redirection. Minimal intervention is needed.
- 2 - The member exhibits inappropriate behaviors that put self, others or property at risk. The member frequently requires more than verbal redirection to interrupt inappropriate behaviors.
- 3 - The member exhibits behaviors resulting in physical harm to self or others. The member requires extensive supervision to prevent physical harm to self or others.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairment

- Acute Illness
- Choking
- Chronic Medical Condition
- Communication Impairment (does not include ability to speak English)
- Neurological Impairment
- Pain
- Sensory Impairment
- N/A

Mental Health

- Delusional
- Hallucinations
- Lack of Motivation/Apathy
- Mood Instability
- Paranoia
- N/A

Supervision Needs

- Aggressive Behavior
- Agitation
- Cognitive Impairment
- Constant Vocalization
- Difficulty Learning
- Disassociation
- Disruptive to Others
- Impaired Judgment
- Medication Management
- Memory Impairment
- Memory Loss-Long Term
- Memory Loss-Short Term
- Seizures
- Self-Neglect
- Self-Injurious Behavior
- Sleep Deprivation
- Verbal Abusiveness
- Wandering
- N/A

Comments - Supervision Behavior

There has been no change in the client's functional level since the last assessment was performed.

- Yes
- No

Supervision Memory

Definition: The age-appropriate ability to acquire and use information, reason, problem solve, complete tasks or communicate needs in order to care for oneself safely.

ADL Score Criteria

- 0 - Independent no concern
- 1 - The member can make safe decisions in familiar/routine situations but needs some help with decision making support when faced with new tasks, consistent with individual's values and goals.
- 2 - The member requires consistent and ongoing reminding and assistance with planning or requires regular assistance with adjusting to both new and familiar routines, including regular monitoring and/or supervision, or is unable to make safe decisions, or cannot make his/her basic needs known.
- 3 - The member needs help most or all of time.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairment

- Acute Illness
- Chronic Medical Condition
- Communication Impairment (does not include ability to speak English)
- Neurological Impairment
- Pain
- Sensory Impairment
- N/A

Mental Health

- Delusional
- Hallucinations
- Lack of Motivation/Apathy
- Mood Instability
- Paranoia
- N/A

Supervision Needs

- Agitation
- Cognitive Impairment
- Constant Vocalization
- Difficulty Learning
- Disassociation
- Disorientation
- Impaired Judgment
- Lack of Awareness
- Medication Management
- Memory Impairment
- Perseveration
- Receptive Expressive Aphasia

<input type="checkbox"/> Seizures <input type="checkbox"/> Self-Injurious Behavior <input type="checkbox"/> Unable to Follow Directions <input type="checkbox"/> Wandering <input type="checkbox"/> N/A
Comments - Supervision Memory
There has been no change in the client's functional level since the last assessment was performed. <input type="checkbox"/> Yes <input type="checkbox"/> No

Level of Care Determination	
To qualify for Medicaid long-term care services, the recipient/applicant must have deficits in 2 of 6 Activities of Daily Living, ADLs. A deficit is defined by a score of 2 or higher in a ADL area or requires at least a moderate score of 2 or higher in Behaviors or Memory/Cognition under Supervision.	
Client Meets Level of Care?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there a Professional Medical Information page supporting need for HCBS?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, complete the following sections:	
Type of Medical Provider Home Health Hospice Hospital Mental Health Nurse Practitioner Nursing Facility Physician Physician Assistant Physician on PMIP Therapists	
Medical Provider Name:	
Medical Provider's Title:	
Provider Address:	
Provider City:	Provider State:
Provider Zip Code:	Provider Phone Number:
Person Completing Form:	Person's Title Completing Form:
Medical Professional Who Signed Form:	
Medical Professional's Title Who Signed Form	

Level of Care Determination	
Date Information Complete (PMIP Date)	
Provider Comments	
Has Developmental Disability Eligibility been determined? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there a Developmental Disability diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there a Mental Health Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there a Traumatic Brain Injury Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
A diagnosis of dementia must be validated by a neurological exam with documentation by the attending physician. Neurological Exam Date:	

Services Requirements	
Are Waiver Services Needed within 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Waiver Services are not required within 30 days, document referral to community resources:	

Long Term Care Certification Information	
Program Eligibility Decision <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Withdrawn <input type="checkbox"/> Waitlist Only <input type="checkbox"/> Closed	
Agency:	
Authorizing Decision (Agency Administrator):	
County:	
Start Date:	End Date (A valid date is 1 year from start date or 1/1/2099.):

Programs Information
Target Group <input type="checkbox"/> Brain Injury (16-64) <input type="checkbox"/> Developmental Disability/MR <input type="checkbox"/> Frail Elderly (65+) <input type="checkbox"/> Pediatric (<13) <input type="checkbox"/> Physically Disabled (13-17) <input type="checkbox"/> Physically Disabled (18-64)
Program Approval <input type="checkbox"/> HCBS <input type="checkbox"/> CCT - Legacy Only <input type="checkbox"/> HBU <input type="checkbox"/> ICF/IID <input type="checkbox"/> Home Connections - Legacy Only <input type="checkbox"/> NF <input type="checkbox"/> PACE <input type="checkbox"/> LTHH Only
Program:
Wait List Start Date

Additional Program Information
Open End Date for Nursing Facility, PACE, or ICF/IID Cases <input type="checkbox"/> Yes <input type="checkbox"/> No
SEP, CCB, PACE, ICF/IID or NF name:
Date Admitted to Nursing Facility or ICF/IID

MEDICAL

Diet
Diet Order Description:
Diet Source <input type="checkbox"/> PMIP <input type="checkbox"/> Other Source
Other, specify:

Prognosis
Prognosis Description:
Prognosis Source <input type="checkbox"/> PMIP <input type="checkbox"/> Other Source
Other, specify:

Medical Supports
Medical Support Needs <input type="checkbox"/> Able to recognize and tell others when medical support is needed <input type="checkbox"/> Needs help recognizing and telling others when medical support is needed <input type="checkbox"/> Needs health support due to age <input type="checkbox"/> Has chronic health support needs <input type="checkbox"/> Able to safely take medication independently <input type="checkbox"/> Needs help taking medications
General Medical Support comments:

Institutionalization	
Report Entry Date:	
Colorado Choice Transitions (CCT) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Institutionalization Admit Date:	Institutionalization Estimated Admit Date:
Institutionalization Discharge Date:	Institutionalization Estimated Discharge Date:
Type of Facility <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> ICF/IID <input type="checkbox"/> Jail	
Number of Institutionalized Days:	CIRS Report: <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for Institutionalization <input type="checkbox"/> Scheduled Institutionalization <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Illness (existing medical condition) <input type="checkbox"/> Illness (new medical condition) <input type="checkbox"/> Injury	

Institutionalization

- Exacerbation of MI Symptoms
- Unknown
- Other

Other, specify:

ASSESSMENT DEMOGRAPHICS**Demographics**

Location of Assessment:

- Applicant's Private Residence/Home
- Nursing Home
- Hospital/Other Health Care Facility
- Assisted Living
- Agency Office
- Relative's Home
- Telephone
- Other

Other, specify:

Present at Interview:

- Applicant Only
- Caregiver(s) Only
- Applicant and Caregiver(s)
- Applicant and Others
- Other

Other, specify:

Most of the interview information was provided by:

- Applicant
- Caregiver
- Medical Record
- Facility Staff
- All of the above
- Other

Living Environment:

- Safe
- Safe with feasible modifications
- Services cannot be delivered here

Demographics

- Client needs to move so services can be delivered
- Client needs to move to a safer environment
- Special home assessment needed
- Unknown

Adult Protective Services Risk:

Person is known to be a current client of Adult Protective Services (APS)

- Yes
- No

Eligibility Assessment Summary:

Risk Evident During Assessment: (Check any that apply)

- No risk factors or evidence of abuse or neglect apparent at this time.
- Risk factors present; however, LTC services may resolve issues. No APS referral being made at this time.
- 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.
- There are statements of, or evidence of, possible abuse, neglect, self-neglect, or financial exploitation.

Referring to APS now?

- Yes
- No