

Forms Section

- Level I assessment form**
- Authorization for Release of PHI**
- Emergency Admission Fax Memo**
- Terminal Illness Fax Memo**
- Clock Draw**

WE NEED IT!

A. IDENTIFICATION

1. Social Security # (Optional)

_____ - _____ - _____

2. Customer Last Name

LEGAL NAME

First Name _____ MI _____

3. Customer Address

Street _____

City _____ County _____

State _____ Zip _____

Phone _____

4. Date Of Birth _____/_____/_____

5. Gender Male Female

6. Date of Assessment ____/____/____

7. Assessor's Name _____

8. Assessment Location _____

9. Primary Language

- Arabic Chinese English
- French German Hindi
- Pilipino Spanish Tagalog
- Urdu Vietnamese
- Sign Language Other _____

10. Ethnic Background

- Hispanic or Latino
- Non Hispanic or Latino

11. Race

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian, or Other Pacific Islander
- White
- Other _____

12. Contact Person Information

Name _____

Street _____

City _____

State _____ Zip _____

Phone _____

Guardian Yes No

B. PASRR

1. Is the customer considering placement in a nursing facility?

Yes No

2. Has the customer been diagnosed as having a serious mental disorder?

Yes No

3. What psychiatric treatment has the customer received in the past 2 years (check all that apply)?

- 2 Partial hospitalizations
- 2 Inpatient hospitalizations
- 1 Inpatient & 1 Partial hospitalization
- Supportive Services
- Intervention
- None

For those individuals who have a mental diagnosis and treatment history please record that information _____

4. Level Of Impairment?

- Interpersonal Functioning
- Concentration/ persistence/ and pace
- Adaptation to change
- None

5. Has the customer been diagnosed with one of the following conditions prior to age 18 for Mental Retardation / Developmental Disability, or age 22 for related condition, and the condition is likely to continue indefinitely?

- Developmental Disability (IQ _____)
- Related Condition
- None

For those individuals who have a development disability or related condition please record that information: _____

6. Referred for a Level II assessment?

Yes No

C. SUPPORTS

1. Live alone Yes No

2. Informal Supports available Yes Inadequate No

3. Formal Supports available Yes Inadequate No

D. COGNITION

1. Comatose, persistent vegetative state Yes No

2. Memory, recall

- ___ Orientation
- ___ 3-Word Recall
- ___ Spelling
- ___ Clock Draw

E. COMMUNICATION

1. Expresses information content, however able

- Understandable
- Usually understandable
- Sometimes understandable
- Rarely or never understandable

2. Ability to understand others, verbal information, however able

- Understands
- Usually understands
- Sometimes understands
- Rarely or never understands

F. RECENT PROBLEMS / RISKS

___ Falls (6 mo) ___ Falls (1 mo)

- Injured head during fall(s)
- Neglect/ Abuse/ Exploitation
- Wandering
- Socially inappropriate/ disruptive behavior
- Decision Making
- Unwilling/Unable to comply with recommended treatment
- Over the last few weeks / months - experienced anxiety / depression.
- Over the last few weeks/ months - experienced feeling worthless
- None

G. CUSTOMER CHOICE FOR LTC

- Home without services
- Home with services
- ALF/ Residential/ Boarding Care
- Nursing Facility (name below): _____

Anticipated less than 90 days

Street _____

City _____ Zip _____

Phone _____

CUSTOMER NAME: LEGAL NAME

The line in front of each activity is to put the current (Average Day) level of functioning:

1=Independent; 2=Supervision Needed; 3=Physical Assistance Needed; 4=Unable to Perform

The line in front of each service is for the availability code: 0=Assessor does not know if available; 1=Service is available; 2=Service is available but waiting list; 3=Service available but customer does not have resources to pay; 4=Service is not available; 5=Service is available but customer chooses not to use; or 6=Service does not exist.

H. ACTIVITIES OF DAILY LIVING

- Bathing Dressing Toileting
- Transferring Walking/Mobility Eating
- ASTE - Assistive Technology
- ATCR - Attendant Care (Personal or Medical)
- BATH - Bathroom (Items)
- INCN - Incontinence Supplies
- PHTP - Physical Therapy
- MOBL - Mobility/Aids/Assistive technology/custom care

J. OTHER SERVICES

- APSV - Abuse/ Neglect/ Exploitation Investigation
- ADCC - Adult Day Care
- ALZH - Alzheimer Support Service
- CMGT - Case Management
- CNSL - Counseling
- HOUS - Community Housing/Residential Care/Training
- HOSP - Hospice
- IAAS - Information & Assistance
- LGLA - Legal Assistance
- NRSN - Nursing/ShortTerm Skilled/PartTime/Inpatient
- NSPT - Night Support
- OCCT - Occupational Therapy
- PAPD - Prevention of Depression Activities
- PEMRI - Personal Emergency Response System
- RESP - Respite Care
- RMNR - Repairs/Maintenance/Renovation
- SENS - Sensory Aids
- SLPT - Speech & Language Therapy
- VIST - Visiting
- OTEM - OTHER _____

I. INSTRUMENTAL ACTIVITIES for DAILY LIVING

- Meal Preparation Shopping
- Money Management Transportation
- Telephone Laundry/Housekeeping
- Management of Medication/Treatments
- CHOR - Chore
- CMEL - Congregate Meals
- HHAD - Home Health
- HMEL - Home Delivered Meals
- HMKR - Homemaker
- MEDIC - Medication Issues
- MFMA - Money/Financial Management Assistance
- MMEG - Medication Management Education
- NCOU - Nutrition Counseling
- SHOP - Shopping
- TPHN - Telephoning
- TRNS - Transportation

K. ADDITIONAL RESOURCES/NEEDS:

- ALVG - Assisted Living Facility
- EMPL - Employment
- GUAR - Guardianship/Conservator
- MCID - Medicaid Eligibility
- VBEN - Veteran's Benefits
- HINS - Home Injury Control Screening
- CMHC - Community Mental Health Center
- CDDO - Community Developmental Disability Organization
- CILS - Centers for Independent Living Services
- RPCC - Regional Prevention Center Contacts

COMMENTS _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, Social Security Number: ____ - ____ - _____ DOB ____/____/____
Name of client [optional]

hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that signing this form is voluntary. I understand by not signing this form I may experience a delay in accessing long term care and/or community services.

<p><u>Providing the information:</u> Person(s)/Organization(s) (check all that applies)</p> <p><input type="checkbox"/> Community mental health center(s) <i>name</i> _____</p> <p><input type="checkbox"/> Intermediate care facility/nursing facility/hospital <i>name</i> _____</p> <p><input type="checkbox"/> State institutions for mental retardation or mental illness <i>name</i> _____</p> <p><input type="checkbox"/> State psychiatric hospital(s) <i>name</i> _____</p> <p><input type="checkbox"/> Community developmental disability organization(s) <i>name</i> _____</p> <p>Other(s): name/address/phone _____ _____ _____</p>
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<p><u>Receiving the information:</u> Person(s)/Organization(s) (check all that applies)</p> <p><input type="checkbox"/> CARE Program staff & affiliates</p> <p><input type="checkbox"/> Area Agency on Aging: <i>name</i> _____</p> <p><input type="checkbox"/> Kansas Department on Aging and Disability Services</p> <p><input type="checkbox"/> Kansas Health Solutions</p> <p><input type="checkbox"/> Health care provider(s)/hospital/NF <i>name</i> _____</p> <p><input type="checkbox"/> Community mental health center(s) <i>name</i> _____</p> <p><input type="checkbox"/> State psychiatric hospital(s) <i>name</i> _____</p> <p><input type="checkbox"/> Community developmental disability organization(s) <i>name</i> _____</p> <p>Other(s): name/address/phone _____ _____ _____</p>
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The purpose of the Use or Disclosure:

The CARE Assessment is in compliance with the State & Federal regulations governing Preadmission Screening & Resident Review (PASRR). A PASRR assessment is part of the pre-admission criteria to a Medicaid certified nursing facility in the state of Kansas.

The organization requesting this Release will not receive any financial or in-kind compensation in exchange for using or disclosing the health information described above.

The Individual or the Individual's Representative must read and initial the following:

(Initials) I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that the refusal to sign this authorization may mean that the use and/or disclosure described in this form will not be allowed.

(Initials) I understand this Release is valid for one year from today's date.

(Initials) I understand that I may revoke this Release at any time by notifying the providing organization in writing. It will not have an effect on actions that were taken prior to the revocation.

(Initials) I understand that once the uses and disclosures have been made pursuant to this authorization, the information released may be subject to re-disclosure by any recipient and will no longer be protected by federal privacy laws.

(Initials) This will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I certify that I agree to the uses and disclosures listed above and that I have received a copy of this Authorization. (Form must be completed before signing).

Signature _____ Date

Signature of Personal Representative (if applicable) _____ Description of Authority

**EMERGENCY ADMISSION FAX MEMO
FOR NURSING FACILITY USE ONLY**

To: _____ FAX _____

From: _____ Title: _____

Nursing Facility: _____ Phone: _____

Date: _____

Customer Name: _____ Date of Admission: _____

Reason for the Admission: (check one and add comments)

- An admission is requested by Social and Rehabilitation Services (SRS) Adult Protective Services (APS);
- A natural disaster occurs;
- The primary caregiver becomes unavailable, due to a situation beyond the caregiver's control (e.g., caregiver becomes ill or an accident involving the caregiver occurs);
- An admission from an out-of-state community to a nursing facility that is beyond the individual's control, i.e., an individual being admitted from their place of residence in another state on a weekend when an AAA CARE assessor is not available; or
- A physician ordered immediate admission due to the individual's condition.
(condition/situation should be noted in comments)

Comments:

NOTE: The nursing facility must complete the first two sections (A & B) of the CARE assessment, and fax the partial assessment with a copy of the KDADS emergency admission fax memo to the ADRC **within one working day**. If there is an emergency not listed in this policy, please contact the ADRC immediately for further clarification and authorization of the emergency admit without proof of PASRR.

____ Yes Check if Section **A and B** of the CARE Assessment form have been attached.

*The information contained in this facsimile transmission and the documents accompanying it are **CONFIDENTIAL AND PRIVILEGED** and are intended solely for the use of the person named above. If you are the intended recipient, you are hereby notified that the disclosure, copying, or dissemination of this communication is strictly prohibited except for the necessary disclosure of information among health care providers involved in the assessment and/or treatment. If you have received this facsimile in error, please notify us immediately.*

KDOA 03/3/2008

Terminal Illness Certification FAX MEMO

PSA -

TO: _____

Pages _____

FAX #: _____

From: _____

Date _____

Phone #: _____

Customer Name _____ Customer DOB: _____

Customer SS# _____ Terminal Illness Diagnosis: _____

I certify that _____ is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course

Please print the customer name, the terminal illness diagnosis and the information required for the proposed nursing facility so that they are legible.

Attending Physician	
Signature _____	Date _____
Printed Name: _____	
Address: _____	

Phone #: _____	
FAX #: _____	

Proposed Nursing Facility	
Facility Name _____	
Address: _____	
City: _____	Zip _____
ADMIT DATE _____	
Phone #: _____	
FAX #: _____	

NOTE: This is the information REQUIRED for a determination letter to be generated. The determination letter along with this documentation must then be retained in the person's chart in place of a CARE Certificate /Proof of PASRR. A determination letter is generated only when a terminally ill customer goes to a nursing facility.

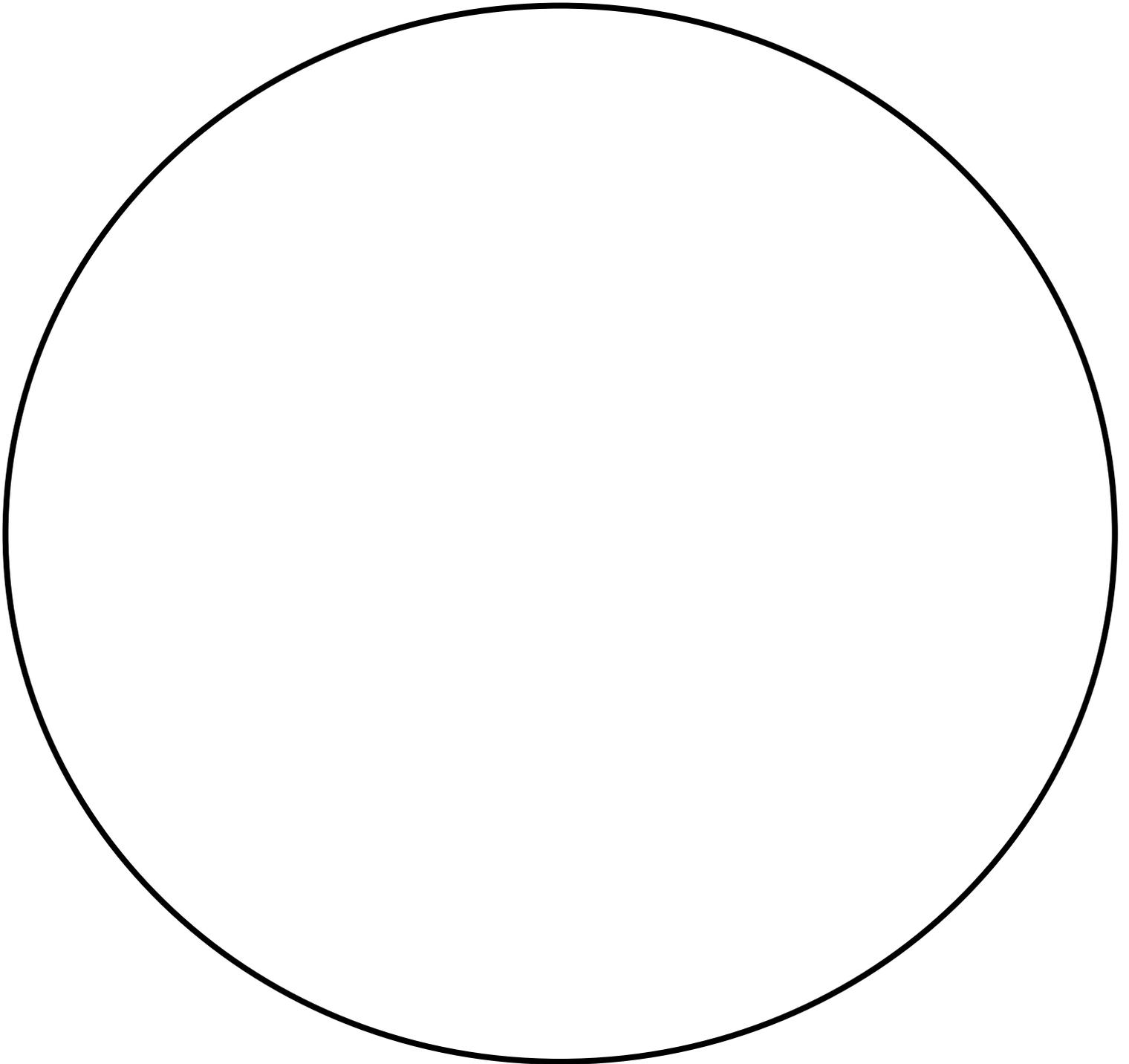
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CONFIDENTIAL

Clock Drawing Test

Patient's Name: _____

Date: _____



Instructions for the Clock Drawing Test:

- Step 1: Give patient a sheet of paper with a large (relative to the size of handwritten numbers) predrawn circle on it. Indicate the top of the page.
- Step 2: Instruct patient to draw numbers in the circle to make the circle look like the face of a clock and then draw the hands of the clock to read "10 after 11."

Scoring:

Score the clock based on the following six-point scoring system:

Score	Error(s)	Examples
1	"Perfect"	No errors in the task
2	Minor visuospatial errors	a) Mildly impaired spacing of times b) Draws times outside circle c) Turns page while writing so that some numbers appear upside down d) Draws in lines (spokes) to orient spacing
3	Inaccurate representation of 10 after 11 when visuospatial organization is perfect or shows only minor deviations	a) Minute hand points to 10 b) Writes "10 after 11" c) Unable to make any denotation of time
4	Moderate visuospatial disorganization of times such that accurate denotation of 10 after 11 is impossible	a) Moderately poor spacing b) Omits numbers c) Perseveration: repeats circle or continues on past 12 to 13, 14, 15, etc. d) Right-left reversal: numbers drawn counterclockwise e) Dysgraphia: unable to write numbers accurately
5	Severe level of disorganization as described in scoring of 4	See examples for scoring of 4
6	No reasonable representation of a clock	a) No attempt at all b) No semblance of a clock at all c) Writes a word or name

(Shulman et al., 1993)

Higher scores reflect a greater number of errors and more impairment. A score of ≥ 3 represents a cognitive deficit, while a score of 1 or 2 is considered normal.

Sources:

- Kirby M, Denihan A, Bruce I, Coakley D, Lawlor BA. The clock drawing test in primary care: sensitivity in dementia detection and specificity against normal and depressed elderly. *Int J Geriatr Psychiatry*. 2001;16:935-940.
- Richardson HE, Glass JN. A comparison of scoring protocols on the clock drawing test in relation to ease of use, diagnostic group, and correlations with Mini-Mental State Examination. *J Am Geriatr Soc*. 2002;50:169-173.
- Shulman KI, Gold DP, Cohen CA, Zuccherro CA. Clock drawing and dementia in the community: a longitudinal study. *Int J Geriatr Psychiatry*. 1993;8:487-496.