

# **CARE Level I Assessment Policy and Procedures**

# Background

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## What is CARE?

- CARE is an acronym for the Client Assessment, Referral, and Evaluation program.
- This program's purpose is for data collection, individual assessment, providing information on community-based services and referral to those services, and appropriate placement in long-term care facilities.
- It also fulfills the federal pre-admission screening and resident review (PASRR) requirement within the state of Kansas.

Reference: K.S.A. 39-968 and KDADS Field Services Manual (FSM) 2.1.1

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## When is a CARE assessment completed?

- When an individual wants to be admitted to a Medicaid-certified nursing facility (NF) or long-term care unit; and
- The individual does not have a [valid proof of PASRR](#).
- Exceptions to this rule are referred to as [provisional admissions](#).

Note: Individuals must be at least 16 years or older to be admitted to a nursing facility in Kansas.

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## What is PASRR?

- PASRR is an acronym for Pre-Admission Screening and Resident Review
- It is a federal requirement.
- The purpose of PASRR is to determine whether an individual with mental illness, mental retardation, or other developmental disability, needs nursing facility services or specialized mental health or mental retardation/developmental disability services.
- It requires all individuals to have a PASRR screening prior to admission to a Medicaid-certified nursing facility.
- The PASRR screening in Kansas is the CARE assessment.

References: Social Security Act, Section 1919(e)(7) and 42 CFR 483.100-483.138.

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## What is a valid proof of PASRR?

Regardless of where the PASRR is completed, the documentation must state that NF care is appropriate before an individual is admitted to the NF. If PASRR does not state that NF care is appropriate, the person cannot be admitted to the facility.

The current valid proof of PASRR documentation in Kansas is the CARE certificate. If the CARE certificate indicates a Level II evaluation is needed, the Letter of Determination becomes the proof of PASRR and it must state that NF placement is appropriate in order for the customer to be admitted to a Nursing Facility.

**What is a  
valid proof of  
PASRR?  
(continued)**

**KANSAS PROOFS OF PASRR  
(FSM 2.1.6)**

Date of Assessment	Proof of PASRR
Prior to 1989	None required (All NF residents were grandfathered unless MR/DD)
January 1, 1989 - December 1992	SRS's form 2123
January 1993 - June 1993	Kansas Foundation for Medical Care (KFMC) letter
July 1993 - December 1994	Bock & Associates letter
January 1, 1995 – present	CARE Certificate

Other states have different forms as the proof of PASRR.

Questions about whether a proof of PASRR from Kansas or another state is valid should be directed to Kansas Department for Aging and Disability Services CARE Program Manager.

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## CARE Assessor Job Description

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**Who may conduct a CARE assessment?**

An assessor must be one of the following:

- An employee of an ADRC who is designated as an assessor by the ADRC;
- An independent contractor of the ADRC who is designated as an assessor by the ADRC; the contractor may not subcontract its assessment duties;
- An employee who is designated by a hospital to be a CARE assessor, such as a discharge planner, social worker, or registered nurse (RN); or
- An employee that is designated by a Nursing Facility to be a CARE assessor, such as a social worker or RN. (Note: May only complete Sections A and B of the CARE form).

**What are experience and educational requirements for assessors?**

Each assessor must meet the following experience and education requirements:

- Meet one (1) of the following education requirements:
  - Four-year degree from an accredited college or university with a major in one (1) of the following fields- gerontology, nursing, health, social work, counseling, human development, family studies, or related area as defined by the KDADS; or
  - Licensed to practice in Kansas as a Registered Nurse.
- Attend all KDADS required trainings for CARE assessors.
- Maintain a thorough and current knowledge of the community- based service system in their area. Verification of this effort may be requested at the discretion of the KDADS CARE Manager.
- Any assessor that has not conducted a CARE assessment within the last year must retrain in order to learn changes to the program during his or her absence.

Reference: FSM 2.1.2

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**What are the CARE assessor's job duties?**

- To maintain the highest level of courtesy, respect, and professionalism possible when serving as a CARE assessor and making referrals;
  - To inform the customer of the assessment process;
  - To conduct an assessment so that the individual understands the questions and can answer them accurately;
  - To make arrangements for additional languages or interpreters, assistive devices, and provisions to adhere to the Americans with Disability Act;
    - If you are a hospital assessor, try to utilize the hospital's services to communicate effectively with the customer.
    - If you are an ADRC assessor, contact the ADRC for assistance.
  - To query as many sources as possible so that complete and accurate information is obtained regarding the individual's functional status and abilities; these sources include the customer, family members, guardians, other primary caregivers, health care professionals, and/or the customer's medical records;
  - To maintain customer confidentiality;
  - To provide individuals and families with complete information about community-based long-term care services; and
  - To document their answers on a Level I assessment.
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**What are the assessment standards the assessor must follow?**

- To perform assessments that are:
  - Completed in a timely manner, and according to the CARE Program's Policy and Procedures and the Instructions for the Completion of the CARE Level I Assessment;
  - Accurate (Note: If a mistake is made strike through it and correct it on the inside column of the form, initial, and date);
  - Legible; and
  - Written in black ink for copying and faxing purposes;
- To fax the completed Level I assessment to the AAA within **one (1) working day** upon assessment completion;
- To make determinations regarding the need for a Level II assessment;
- To make appropriate referrals of Level II assessments. All referrals must be made within **one (1) working day** upon assessment completion. The [Level II Referrals and Assessments section](#) contains the documentation needed; and
- To make referrals for community-based services as needed (e.g., Community Developmental Disability Organization, Community Mental Health Center, Center for Independent Living); all referrals must be made within **one (1) working day** upon assessment completion.

Reference: FSM 2.1.3.C, 2.1.3.D, and 2.1.3.E

## Assessment

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### What is an assessment?

An assessment is an evaluation of an individual's health and functional status to determine their need for long-term care services and to identify appropriate service options which meet those needs. The CARE assessment information is recorded on the CARE form.

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### What is the difference between a CARE Level I and a Level II assessment?

- Level I assessments are completed for customers who want to enter a NF and do not have a valid proof of PASRR. Unless it triggers a Level II assessment, the Level I will not restrict admission to a NF.
  - Level II assessments are completed if Section B of the Level I assessment [triggers the need for a Level II assessment](#).
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### Is the Functional Assessment Instrument different from the CARE Level I Assessment?

Yes. While the Functional Assessment Instrument (FAI) assesses the same ADLs and IADLs as the CARE Level I assessment, it does not contain the PASRR screening that must be completed on the Level I assessment. The FAI is completed for customers who have requested community-based services, which are coordinated by either an ADRC or Center for Independent Living (CIL).

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### How long is a CARE assessment valid?

- The CARE Level I assessment is valid for 365 days unless the customer has a significant change in condition.
  - A customer may need to be reassessed if he or she did not go to a nursing home after the previous assessment, but remained in the community.
  - If the customer goes to an NF, the Level I assessment is valid indefinitely. Please consult the [resident review](#) criteria.
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**If possible, contact individual and a family member or other representative to be present for the assessment. Call or notify the individual to verify a good time to complete the assessment.**

**When is another assessment required?**

Another assessment must be completed if the most current Level I assessment indicates one (1) or more of the following:

- 1) The assessment is over 365 days old; or
- 2) The individual had a significant change in condition, which means one (1) or more of the following has occurred:
  - a) Individual codes have changed in two (2) or more of the following:
    - i) Activities of Daily Living (ADLs);
    - ii) Independent Activities of Daily Living (IADLs);
    - iii) Cognition Factors;
    - and/or iv) Risk Factors.
  - b) The customer's current mental health status would now trigger a Level II assessment due to:
    - i) A new diagnosis of serious mental illness;
    - ii) A change in the individual's level of impairment;
    - or iii) A change to their treatment history.

**When is an assessment not required?**

Reference: FSM 2.1.3.B

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- Is **returning** to an NF/long-term care unit after a hospital stay.
- Is **transferring** from an NF/long-term care unit to another NF/long-term care unit, including out-of-state facilities.
- Is **entering a non-Medicaid certified** NF/long-term care unit.
- Is **entering an** NF/long term care unit owned or managed by a recognized church or religious denomination for the purpose of providing care and services for those who depend upon spiritual means, through prayer alone, for healing.
- Is transferred to a **swing bed** in a hospital.
- Is transferred to a long-term care unit of the hospital that is not licensed as a **skilled unit and is not Medicaid certified**.
- Is expected to **stay 30 days or less** in an NF as documented in writing by a physician. (See the [provisional admission process](#).)
- Has a **Primary Medical Condition** documented through official medical records including one of the following:
  - a. **Terminal Illness**: This condition as defined for Hospice purposes, which includes a medical prognosis of a life expectancy six months or less if the illness runs its normal course; or
  - b. **Coma or persistent vegetative state**.

The documentation must be sent to the KDADS CARE Program Staff for processing and generation of a Terminal/Severe Physical Illness Letter, which shall be maintained in the customer's medical record with the supporting documentation.

**Letter is provided by KDADS.**

Reference: FSM 2.1.3.A

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**Which forms and information are taken to an assessment?**

- CARE Level I Assessment Form (2 pages total)
- CARE Certificate
- Consent to Release Information
- CARE Brochure
- Your organization's privacy notice
- Explore Your Options Guide

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**What sources of information are consulted when completing a CARE assessment?**

- The customer should be your primary source of information.
- The family and other individuals that assist the customer.
- The customer's physician, if necessary to discuss the customer's medical condition.
- The customer's medical record.

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**After the assessment is completed, who gets which forms and other information?**

Type of Information/ Form	Provide to customer	Place in Your File	to ADRC
CARE Assessment	X	X	X
CARE Certificate	X	X	X
CARE Release of Information	X	X	X
CARE Brochure	X		
Assessing Organization's Privacy Notice	X		
Explore Your Options	X		
Guardianship Papers for Level II referral only		X	X
Medical history for Level II referral only		X	X

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**How is the assessment information used?**

- The information may be used for one (1) or more of the following reasons:
- Determine appropriate placement for individuals with mental illness and/or mental retardation and or related conditions;
  - Determine functional eligibility for Medicaid coverage for long-term care needs;
  - Determine and discuss potential community-based service options; and
  - Determine potential gaps in service needs.
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**What are the outcomes of the Level I assessment?**

There are several possible outcomes after an individual has received a CARE Level I assessment. The individual may:

- Enter a nursing facility because he or she requires that level of care and there are no community-based service options available;
- Remain in the community with community-based services or in an alternate living environment, such as an assisted living facility;
- Remain in the community without community-based services because those services are not available; and
- Remain in the community without services because the customer does not want them.

**Note:** For the purposes of the Level I assessment, the term “community” includes Assisted Living Facilities and other congregate living environments, a family member’s or friend’s home, and the customer’s own home.

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## Assessments by ADRC Assessors

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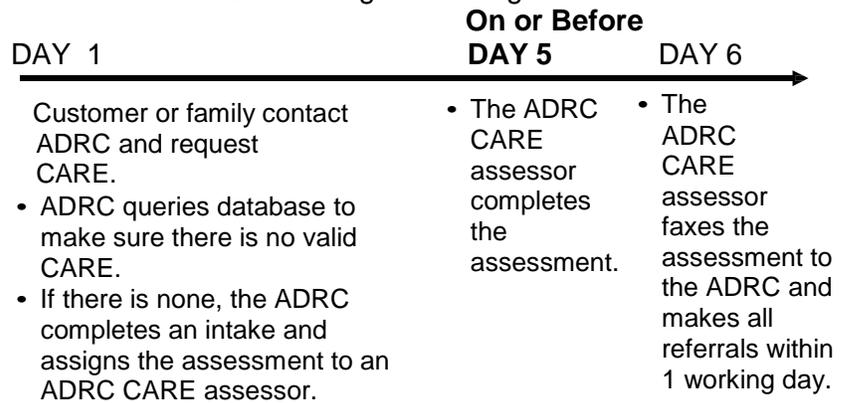
**When does an ADRC complete a CARE assessment?**

A customer will be assessed by an ADRC assessor when the customer is considering NF placement and resides in the community.

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**How long does an ADRC CARE assessor have to complete the assessment?**

- The ADRC CARE assessor has a maximum of **five (5) working days** to complete the assessment.
- Requests for exceptions to this timeframe must be submitted to the KDADS CARE Program Manager.



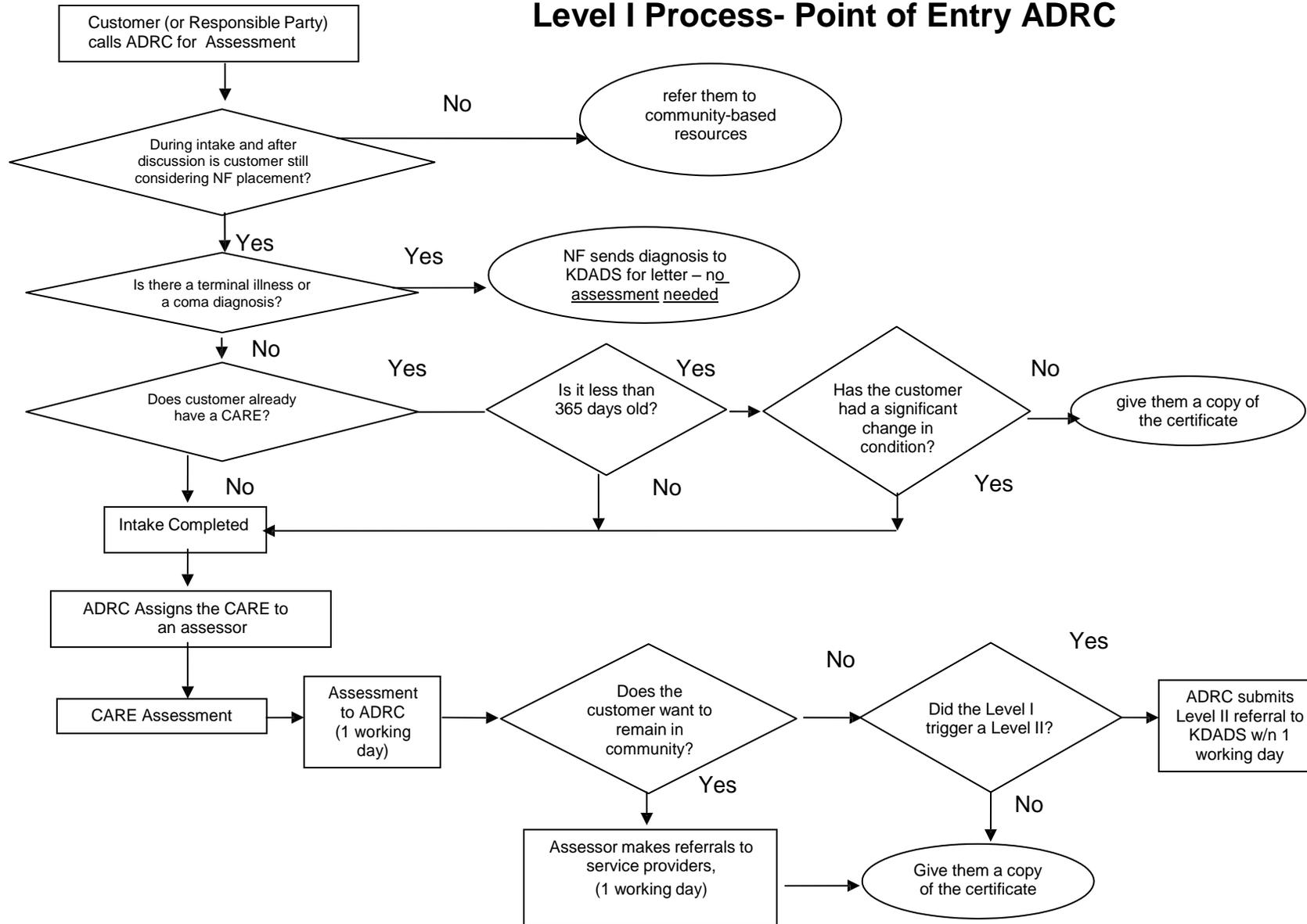
**What process does the ADRC CARE assessor follow when completing the CARE assessment?**

1. Note the date the referral is received. The assessor has **five (5) working days** from date of intake to complete the assessment.
2. Schedule assessment with customer, family, guardian, health care professional, caregiver, and/or other important sources of information.
3. Adhere to ADA requirements.
4. Arrange for culturally sensitive assessment including provision for language interpreters, assistive devices, etc.
5. Provide a legible and accurate assessment that is written in black ink.
6. Complete each question and provide supporting comments on the form. Incomplete assessments will be returned to the assessor for correction.

**What process does the ADRC CARE assessor do when a Level II assessment referral needs to be made?**

7. If a Level II is needed, the assessor must:
    - Follow Level II Checklist (refer to the Reference Section of the Manual);
    - Obtain Consent to Release Information;
    - Include the guardian's name, phone, and address, if one has been appointed;
    - Document the diagnosis of MI, dates of hospitalizations, and county of responsibility for those customers with an MI diagnosis; or
    - Document the IQ score for MR/DD and date of onset for those with a related condition.
    - Try to obtain a copy of legal guardianship papers, (if one has been appointed) and the customer's medical history.
  8. Fax Level I assessment, CARE Certificate, Consent to Release Information, and supporting documentation to the KDADS.
  9. Provide the Customer:
    - copy of CARE Assessment;
    - copy of CARE certificate;
    - copy of Consent to Release Information.
  10. Once the Consent to Release Information is signed, you must make appropriate referrals within **one (1) working day** to:
    - ADRC;
    - Center for Independent Living;
    - Other community service centers as needed, including CDDO or CMHC.
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## Level I Process- Point of Entry ADRC



## Assessments by Hospital Assessors

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### **When does a hospital assessor complete a CARE assessment?**

- A CARE assessment is completed when a hospital or medical care facility patient seeks NF admission and does not have a valid CARE assessment on file.
  - The hospital does not need to complete a CARE if there has been one done in the past and it is still valid. This is determined by the hospital calling the ADRC and asking if the customer has a valid CARE assessment.
  - If the customer has a valid CARE and has not experienced a significant change in condition, the ADRC will fax a copy to the hospital or admitting NF. A new CARE assessment should not be completed.
  - Hospital-based CARE assessors should fax a copy of the completed CARE to KDADS and place original completed forms with customer's discharge planning papers, unless otherwise instructed by the hospital's records management. Please make sure the NF receives a copy of the CARE certificate.
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### **What happens if a duplicate assessment is completed?**

- If a duplicate assessment is completed, the hospital CARE assessor is required to retrieve the CARE certificate that was issued with the duplicate assessment.
  - The duplicate assessment and the CARE certificate will be considered void.
  - The duplicate CARE certificate must be destroyed.
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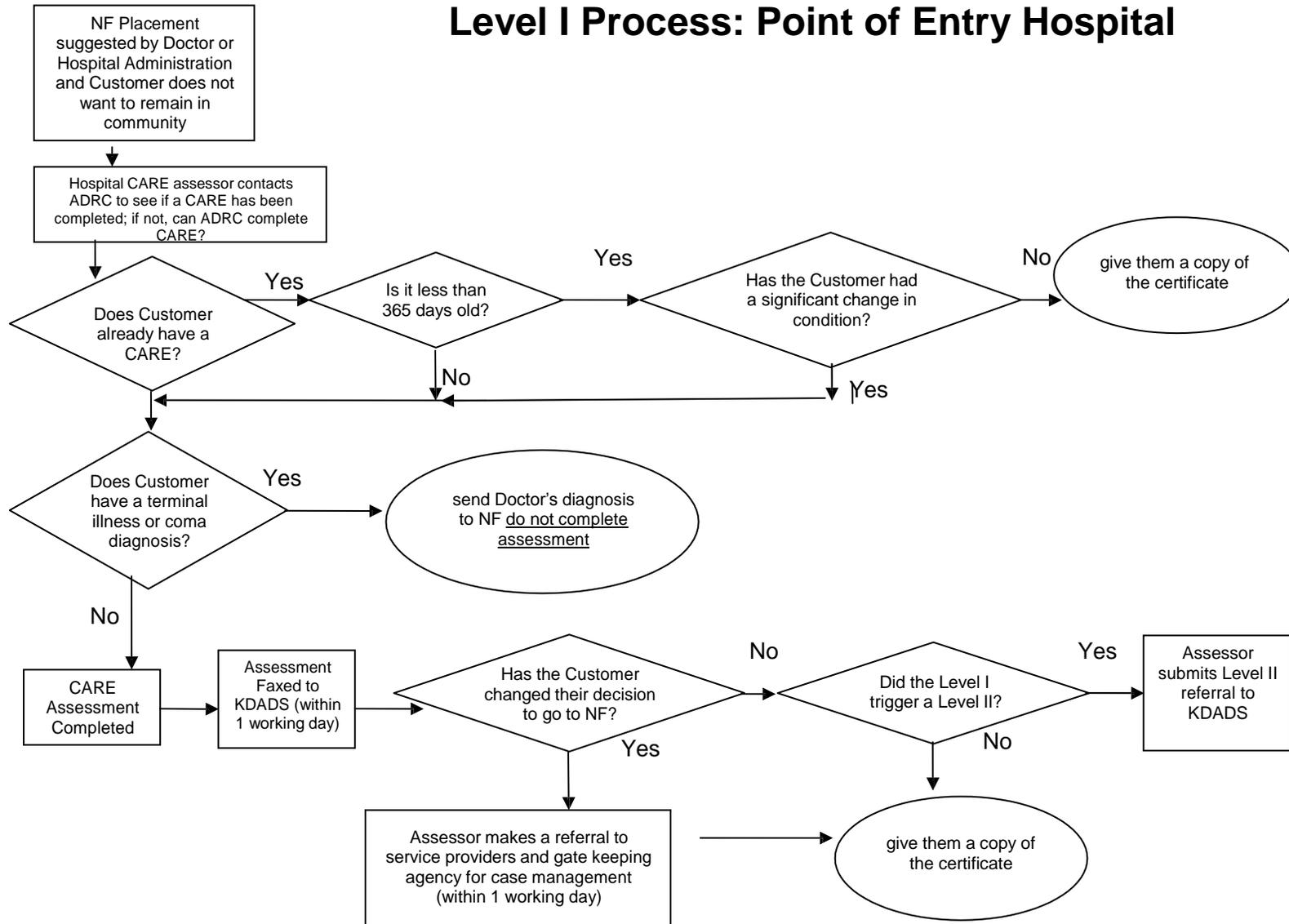
### **What process does the hospital CARE assessor follow when completing the CARE assessment?**

1. Contact the ADRC to determine whether a valid CARE assessment already exists. If there is a valid CARE, you do not need to complete another CARE.
2. Schedule assessment with customer, family, guardian, physician, caregiver, or other important sources of information.
3. Adhere to ADA requirements.
4. Arrange for culturally sensitive assessment including provision for language, assistive devices, interpreters, etc.
5. Provide a legible and accurate assessment that is written in black ink.
6. Complete the CARE as part of the discharge planning or other hospital discharge process, but before discharge to an NF.
7. Prior to a short-term, NF admission, assessors must send the nursing facility a physician's statement that certifies the stay will be 30 days or less.

**What process does the hospital CARE assessor follow when completing the CARE assessment? (continued)**

8. Complete each question and provide supporting comments on the form. Incomplete assessments will be returned to the assessor for correction.
9. If Level II is to be made, you must:
  - Follow Level II Checklist;
  - Obtain Consent to Release Information;
  - Include the guardian's name, phone, and address, if one has been appointed;
  - Document the diagnosis of MI, dates of hospitalizations, and county of responsibility for those customers with an MI diagnosis; or
  - Document the IQ score for MR/DD and date of onset for those with a related condition.
  - Try to obtain a copy of legal guardianship papers, (if one has been appointed) and the customer's medical history.
10. Fax the Level I assessment, CARE Certificate, Consent to Release Information, and supporting documentation to KDADS.
11. Provide the Customer:
  - The Explore Your Options Guide;
  - CARE Brochure;
  - copy of Assessment;
  - copy of CARE certificate;
  - copy of Consent to Release Information.
12. Once the Consent to Release Information is signed, the assessor must make appropriate referrals within **one (1) working day** to:
  - ADRC;
  - Center for Independent Living;
  - Other community services as needed, including CDDO or CMHC.

# Level I Process: Point of Entry Hospital



## Nursing Facility PASRR Responsibilities (FSM 2.1.3.G)

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**Can a nursing facility employee complete a full CARE assessment?**

**No.** As of October 1, 2005, NF employees cannot complete full CARE assessments. If the NF admits someone without proof of PASRR, the NF must complete sections A & B and keep in medical record. If an emergency admission, FAX sections A & B to the ADRC within one working day, and request that a CARE Level I assessment be completed. 30-day provisional information is to be faxed to KDADS CARE staff.

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**What are the nursing facility's PASRR responsibilities?**

Prior to admission, the NF must ensure:

- A PASRR screening has been completed; and
  - The proof of PASRR documentation states the individual is appropriate for NF care.
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**Can an individual be admitted to a nursing facility without addressing PASRR?**

No. The customer may be admitted as a less than 30 day provisional admission, or as an emergency admission, or as a Terminal Illness admission without a Level I, but these are still a form of PASRR.

Note: If an individual with a serious mental illness or MR/DD condition is admitted as a provisional admission and their NF stay will exceed the time limit, there is a chance the Level II determination will not find them appropriate for continued NF care.

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**What is considered a provisional stay?**

A provisional stay is for 30 days or less for the purposes of rehabilitation or respite. The stay must be authorized in writing by the individual's physician.

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**What are the nursing facility's responsibilities if it admits an individual as a provisional admission?**

- Prior to admission, the NF must obtain a dated, signed statement from the customer's physician that states the reason for the admission is either for respite care or rehabilitation, and the stay is expected to be for 30 days or less.
  - The NF's CARE assessor or director of nursing (DON) must complete sections A and B of the Level I assessment. This partial assessment must be kept as part of the individual's medical record and faxed to KDADS CARE staff.
  - If the individual is discharged within 30 days, no other action is necessary. However, if on day "20" it appears that the stay is going to exceed 30 days, the NF must contact the ADRC and arrange for the completion of a full CARE Level I assessment.
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**What is considered an emergency admission?**

An urgent condition or a situation that places the individual's health and/or welfare in jeopardy.

Examples of an emergency admission include, but are not limited to, the following:

- An admission by Adult Protective Services;
- The occurrence of a natural disaster;
- The primary caregiver becomes unavailable due a situation beyond the caregiver's control , *e.g.*, caregiver becomes ill or an accident occurs involving the caregiver;
- A physician orders immediate admission due to the individual's condition; or
- An admission from out-of-state to an NF that is beyond the individual's control, *e.g.*, an individual being admitted from their place of residence in another state on a weekend when an ADRC CARE assessor is not available.

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**What are the nursing facility's responsibilities if it admits an individual as an emergency admission?**

- When an individual is admitted to the NF because of an emergency, a full CARE Level I assessment must be completed on or before the seventh (7th) day after admission.
- The NF's CARE assessor or DON, must complete Sections A and B of the Level I assessment. (The NF must contact the ADRC within **one (1) working day** after admission.)
- The NF must send sections A and B along with the emergency fax memo to the ADRC. The emergency fax memo must contain the reason for the admission in the comments section.

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**What are the consequences if a nursing facility admits an individual who does not have a valid proof of PASRR?**

Non-compliance with Federal and State Laws

- If the NF admits an individual without valid proof of PASRR, the NF is not in compliance with federal and state laws, which requires anyone admitted to a Medicaid-certified NF to be screened and found appropriate for NF care.

Non-payment by Medicaid

- Medicaid will not pay for an individual's NF care if they do not have valid proof of PASRR. If an individual is admitted as a provisional stay or as an emergency admission, the NF must contact the ADRC within the established timeframes or risk non-payment by Medicaid. **If a Medicaid eligible customer is admitted to an NF and PASRR has not been completed, the customer is not liable for their NF care.** It is the NF's responsibility to ensure PASRR compliance has been met.

**What is the PASRR relationship with Medicaid eligibility?**

All individuals admitted to Medicaid-certified NFs must meet federal PASRR requirements and indicate NF placement is appropriate. In order for Medicaid to pay for NF care, the customer must meet the financial and functional eligibility requirements.

**Financial**

The individual must meet the State's Medicaid financial eligibility requirements. Each state has different criteria. Please do not assume an individual who was eligible for Medicaid payment of NF in one state will be eligible in Kansas.

**Functional**

The individual must meet the State's Medicaid functional eligibility or level of care (LOC) threshold unless the individual triggered a Level II assessment. In that instance, the customer must have a level II determination letter that states NF placement is appropriate. If an individual's Level II assessment determines that NF care is not appropriate, Medicaid will not pay for his or her NF care.

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## Level II Referrals and Assessments

### When is a Level II required?

A Level II is required prior to admission when an individual seeking admission to a Medicaid certified nursing facility meets one of the following criteria:

1. Mental Illness
  - a. The individual must have a clinical diagnosis of a serious mental illness; **AND**
  - b. Must have received inpatient or partial inpatient hospitalizations more than once in the last two years for the mental illness, **OR** an increase in supportive services for 30 consecutive days to maintain functioning at home or in a group home, **OR** have had interventions by law enforcement, Housing Officials, or Adult Protective Services due to their mental illness; **AND**
  - c. Must also have a level of impairment which results in functional limitations during the last three to six months.
2. Developmental Disability
  - a. The individual must have a mental retardation diagnosis as evidenced by an established diagnosis of MR (documentation of an IQ score of 70 or below prior to the age of 18); **OR**
  - b. other developmental disability (such as cerebral palsy, epilepsy, autism, Down's Syndrome or other physical or mental impairments or a condition that has received a dual diagnosis of mental retardation and mental illness) which manifested prior to age 22 and is likely to continue indefinitely.

**An individual who meets all three components for MI (the diagnosis of a serious mental illness, a treatment history, and the necessary level of impairment for that mental illness) OR the criteria for a developmental disability is required by federal law to have a Level II assessment prior to admission to a NF.**

**What documentation is required for the Level II referral?**

In addition to meeting the assessment standards outlined on page 5 of this section, the assessor must obtain the following documentation before making a referral for a Level II assessment:

- a) A copy of the legal guardianship papers, if applicable;
- b) A copy of the customer's medical history. If the assessor does not have access to the medical records, but he or she knows where it is located, this information should be documented in the comments section.
- c) Document in the comment's section:
  - 1) For Mental Illness:
    - Diagnosis;
    - Treatment history; and
    - Level of Impairment;
  - 2) For Mental Retardation/Developmental Disability:
    - IQ score;
    - Date of testing or the Related Condition diagnosis and the age when it manifested;
    - Areas of impairment in major life activities; and
    - Any other relevant information.

**NOTE:** For dually diagnosed individuals, both areas of the PASRR Section B should be completed.

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**What if the customer needing a Level II assessment has a guardian?**

- The assessor must obtain the legal guardian's signature, if applicable, on the Consent to Release Information form.
- If the assessor has difficulty obtaining the signature, the assessor should not delay the Level II referral. In these rare circumstances, the assessor should contact the KDADS CARE Program Manager to inform him or her of the situation.
- If the individual has a legal guardian, the ADRC must notify the legal guardian in writing of the referral for a Level II assessment when a referral has been made. The guardian may participate in the assessment.

**Who completes the Level II assessment?**

The Level II assessment is completed by a QMHP or QMRP/QDDP that is employed by an agency that contracts with The Kansas Health Solutions.

Qualified Mental Health Professional (QMHP) is an individual who has at least one (1) year of experience working directly with persons with mental illness and an employee of a Mental Health Center, and is one of the following:

- Licensed psychologist;
- Physician;
- Psychiatrist;
- Registered Master's Psychologist;
- Licensed Professional Counselor;
- Licensed Marriage and Family Therapist;
- Social Worker; or
- Psychiatric nurse.

Qualified Mental Retardation Professional (QMRP) is an individual who has at least one (1) year of experience working directly with persons with the condition of mental retardation and an employee of a Community Development Disability Organization, and is one of the following:

- A physician;
- A registered nurse;
- Licensed Psychologist;
- Social worker;
- Occupational Therapist;
- Physical Therapist;
- Speech-language pathologist or audiologist;
- Recreational Therapist; or
- Human Services professional with a Bachelor's degree in a human service field, including, but not limited to, sociology, special education, rehabilitation counseling, and psychology.

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**How long does it take for a Level II determination to be made?**

- The Level II assessor has five (5) consecutive days from receipt of the referral to complete the Level II assessment.
- The completed assessment must be returned to The Kansas Health Solutions for review and faxed to KDADS within one day of assessment completion.
- Within **two (2) working days** of receipt of completed Level II assessment, KDADS will review the completed Level II assessment and make a final determination regarding the need for NF admission or specialized mental health or developmental disability services and provide written notification and other documentation as required to the customer, the customer's legal guardian, the doctor, hospital, and admitting NF.

**When is a Resident Review completed?**

The NF is required to contact KDADS CARE staff and order a Resident Review when an individual meets one (1) or more of the following criteria:

- The resident has had a significant change in condition that would have triggered a Level II assessment, or has had a significant change in condition resulting in a new mental illness diagnosis accompanied by a change in the level of impairment;
- The resident met all the Level II criteria prior to entering the NF but it was not uncovered until after admittance to the NF;
- The resident has a serious mental illness, mental retardation, or other developmental disability and was admitted to the NF prior to 1989; or
- The resident entered the NF with a Level II determination letter authorizing a short-term rehabilitation stay, and the resident's stay will exceed the time frame in the letter. Nursing facility staff should contact the ADRC 10 days prior to the expiration date on the letter to order a resident review.

Note: Whenever an individual improves and no longer needs the level of services provided by the NF, it is expected the NF will make arrangements for discharge back into the community, which includes contacting the appropriate Community Mental Health Center (CMHC) or Community Developmental Disability Organization (CDDO) without ordering a resident review.

## Community-Based Services Referrals

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**Who makes the referrals for community-based services?**

As a CARE assessor, it is your responsibility to make the referral for community-based services. Let the customer know who they will hear from and find out if the contact person should be part of the decision making process.

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**How soon should referrals be made after the assessment?**

Within **one (1) working day**, the assessor must make referrals to the following entities when necessary and appropriate:

- ADRC;
- Center for Independent Living (if customer is age 59 or younger);
- Community Mental Health Centers (CMHCs);
- Community Developmental Disability Organizations (CDDOs); and
- Other community-based service providers.

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**What can the customer appeal?**

An individual has a legal right to appeal any decision made about his or her care. The CARE program will not restrict an individual's admission to an NF unless they are determined, through the Level II process inappropriate for NF placement.

- If a customer makes an application for Medicaid to cover NF services, the Department of Children and Families may use the information contained on the Level I to determine appropriate level of care. If a customer disagrees with an eligibility decision based on this information, the customer may appeal.
- A customer may appeal the CARE assessor's referral for a Level II assessment. In this case, the customer would be appealing through the Kansas Department for Aging and Disabilities, as the customer is questioning his or her need for further mental health or developmental disability assessment. The Kansas Department for Aging and Disabilities will provide an objective appeals hearing committee, comprised of professionals familiar with mental health issues and PASRR. (**Appeal FSM 2.1.4**)

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**When is the customer notified of the right to appeal?**

Level II Referrals

- The assessor must inform the customer of his or her right to appeal the PASRR portion of the assessment if one of the following occur:
  - The customer will be referred for a Level II assessment; or
  - The customer is not referred for a Level II assessment; however he or she wants a Level II assessment.

To inform the customer of their right to appeal, the assessor must provide the customer with the Notice of the Right to Appeal, which is on the CARE certificate (KDOA 152).

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**What are the assessor's responsibilities if the customer appeals a decision?**

In appeal situations, the assessor must be available to answer any and all questions related to the information obtained during an assessment. This availability must be in person, by phone, or in writing, as required by the appeals process.

