**KDADS Screens for Continued Stay (SCS) for NFMH Residents**

**Date of Resident’s Last Screen for Continued Stay:**

*(****Do not use date of last PASRR or Resident Review****)*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **SECTION I SUMMARY SHEET** | | | | | | | | | | | | | **SCREENER DETERMINATION** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | | | Recommended Disposition: | | | | | Continued Stay: | | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | Discharge: | | | | | | | | | |
| **Date of Screen:** | | | | | |  | | | | | | Courtesy Screen: | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Resident Name:** | | | | | |  | | | | | | Screener Comment/Current S.M.A.R.T goals | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Maiden Name (if applicable):** | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Birthdate:** | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Gender:** | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Social Security Number:** | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medicaid ID Number:** | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date of Admission:** | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Responsible CMHC****:** | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Resident NFMH:** | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Screener Name:** | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Screener Number:** | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Screener CMHC:** | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Facilitator Name:** | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Facilitator Number:** | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Select Resident’s Preferred Living Arrangement:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | |
|  | | | | | | | | | | | | **Signature & Credentials** | | | | | | | | | | | | | | | | | | | | **Date** | | | | | |
| **FACILITATOR DETERMINATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Facilitator Comment: | | | | | | | | | | | |  | | | | | | | | | | Recommended  Disposition: | | | | | | | | | | | Continued Stay: | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | Discharge: | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | **Facilitator unavailable at this time.** | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | **Reason:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Signature & Credentials** | | | | | | | | | **Date** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **KDADS DETERMINATION:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | Approved | | | | | | | | | | | | Conditional | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | Not Approved | | | | | | | | | | | | (See Comments) | | | |
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|  | | | | | | | | |  | | |  | | | | | | | | **Office Use Only:** | | | | | | | | | | | | | | | | | |
| **Signature & Credentials** | | | | | | | | | **Date** | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | |  | Approved for payment | | | | | | | | | Date | | | | | Initials | |  |
|  | | | | | | | | | | | |  | | | | | | | |  |  | | | | | | | | |  | | | | |  | |  |
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| ***Route to: CMHC, NFMH, KDADS-BHS*** | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | |
| **SECTION II DIAGNOSIS AND TREATMENT HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Please select the client’s DSM-5 principle/tier 1 diagnoses from the following list** | | | | | | | | | | | | | | | | | | | | | | | | | | **Hospitalizations:** | | | | | | | | | | | | |
|  | Schizophrenia | | | | | | | | | | | | | | | | | | | | (F20.9) | | | |  | Number of hospitalizations in: | | | | | | | | | | | | |
|  | Schizoaffective Disorder, Bipolar Type | | | | | | | | | | | | | | | | | | | | (F25.0) | | | |  | State Hospitals: | | | | | | | | | |  | | |
|  | Schizoaffective Disorder, Depressive Type | | | | | | | | | | | | | | | | | | | | (F25.1) | | | |  | Community Hospitals: | | | | | | | | | |  | | |
|  | Bipolar Disorders that are Severe, and/or  with Psychotic Features | | | | | | | | | | | | | | | | | | | | (F31.2) | | | |  | Where Hospitalized: | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | (F31.5) | | | |  |  | | | | | | | | | | | | |
|  | Major Depressive Disorder, Recurrent, Severe  with Psychotic Features | | | | | | | | | | | | | | | | | | | | (F33.3) | | | |  |  | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | |  | | | |  |  | | | | | | | | | | | | |
|  | Other Specified Schizophrenia Spectrum and  Other Psychotic Disorder | | | | | | | | | | | | | | | | | | | | (F28) | | | |  |  | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | |  | | | |  |  | | | | | | | | | | | | |
| **Please indicate any additional diagnoses the client may have:** | | | | | | | | | | | | | | | | | | | | | Code: | | | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |  | | | |  | Any Stays of 2 years or more? | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |  | | | |  | Yes  No | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **History of high-risk behaviors:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate whether the resident displays any of the included high-risk behaviors listed in the available dropdown boxes. Include frequency of behavior and the date of the most recent occurrence of such. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Behavior** | | | | | | | | | | | **Frequency** | | | | | | | | | | | | | **Most Recent Occurrence** | | | | | | | | | | | | | | |
| Choose an item. | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Choose an item. | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Choose an item. | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Choose an item. | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Choose an item. | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Choose an item. | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Choose an item. | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
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| **Reason(s) for referral to the nursing facility** *(as stated on PASRR form/letter):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (check all that apply) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | Needed medication management assistance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | Needed assistance with Activities of Daily Living and Instrumental Activities of Daily Living | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | Had medical need or needs for special treatments requiring 24-hour nursing care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | Displayed behaviors not tolerated by the community | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | Exhibited dangerous behaviors | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION III SERVICES AND RESOURCES AVAILABLE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| The purpose of this section is to build a picture of the service resources, both formal and informal, used by the resident in the course of his or her treatment. Where possible, identify by name or by agency the resource used. If the resident is currently receiving services or support from an agency or individual, indicate this in the “Presently Available” column. In instances where a resource or support will be available to the resident in their community of choice, indicate this availability in the “Would Be Available” column. Information gathered during this section should be kept in mind when completing the Strengths Assessment portion of the screening. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has lived independently or semi-independently in the past? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How recently? | | | | | | | | | | | | | | For how long? | | | | | | | | | | | | | | | | | | | | | | | | |
| Has used community support services (CSS) in past? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CMHC** | | | | | | | **Has Used In Past** | | | | | | | | | | **Presently Available** | | | | | | | | | | **Would be available** | | | | | | | | | | | |
| **RESOURCES** | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |
| Case Manager | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |
| Psychologist | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |
| Therapist | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |
| Attendant Care | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |
| Crisis Stabilization Services | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |
| Medication Assistance | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |
| Psychosocial | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |
| Psychiatrist | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |
| Housing Services | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |
| Supported Employment | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |
| Supported Education | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |
| Other? | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |
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| **FAMILY & FRIENDS**  **Please identify** | | | | | | | | **Has Used In Past** | | | | | | | | | | **Presently Available** | | | | | | | | | | | **Would be Available** | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
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| **OTHER COMMUNITY RESOURCES** | | | | | | | | **Has Used In Past** | | | | | | | | | | **Presently Available** | | | | | | | | | | | **Would be Available** | | | | | | | | | |
| Consumer-Run Organizations | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
| Primary Care Physician | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
| Guardian  (if applicable)  **(If a guardian is indicated, you must include all contact information)** | | | | | | | | Name: | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
|  | | | | | | | | Address: | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
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|  | | | | | | | | Phone #: | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
| Payee  (if applicable)  **(If a guardian is indicated, you must include all contact information))** | | | | | | | | Name: | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
|  | | | | | | | | Address: | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
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|  | | | | | | | | Phone #: | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
| Independent Living Center | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
| Respite Care | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
| In-home  skills teaching | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
| Home Health  Care | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
| Community Psychologist/  Psychiatrist | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | |
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| **SECTION IV ASSESSMENT OF FUNCTIONAL LIMITATIONS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **A. Need for a level of care equal to that provided in an NFMH:**  **Presence of one or more of the following conditions, despite adequate treatment including a reliable medication regimen, would indicate the need for a level of service equaling the intensity of nursing facility care. These conditions are indicators of the intensity of service needed, not necessarily where the service would be provided.**  *Note: These categories indicate severe levels of impairment continuing despite intensive treatment. They should not be checked unless there are on-going behaviors causing an inability to complete the majority of activities of daily living even with substantial assistance.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Check all that apply) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **(1)** Presence of a severe cognitive impairment, or combination of cognitive and physical impairments, which render the individual unable to provide even minimally for their basic health and safety needs (e.g. wandering from their living space with no regard for personal safety, inability to feed themselves or clothe themselves, inability to manage toileting, bathing, etc. either independently or with prompting.) Note: This refers to the lack of the basic skill to accomplish the task, not to the appropriateness of dress, meal choices, or personal hygiene.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **(2)** Presence of severe psychiatric symptoms which cause extreme withdrawal and social isolation, in combination with a thought disorder which prevents independent or semi-independent functioning for the majority of instrumental activities of daily living such as: shopping, meal preparation, laundry, basic housekeeping, money management, taking medications. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **(3)** Presence of severe psychiatric symptoms which cause frequent socially inappropriate behaviors that are not easily tolerated in the community (e.g. screaming, minor self-abusive acts, inappropriate sexual behavior, verbal harassment of others), or that cause a long-standing pattern of dangerous behaviors (e.g. serious self-harm, violence toward others, fire-setting, etc.) that occur unpredictably and despite on-going aggressive treatment. in combination with a thought disorder which prevents independent or semi-independent functioning for the majority of instrumental activities of daily living such as: shopping, meal preparation, laundry, basic housekeeping, money management, taking medications.  List date and nature of most recent episode: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **(4)** Presence of an on-going alcohol or drug addiction in combination with severe psychiatric symptoms causing a long-standing pattern of dangerous behaviors (e.g. serious self-harm or violence toward others) that occur unpredictably and despite current treatment efforts.  List date and nature of most recent episode: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **(5)** Medical issues requiring nursing assistance and monitoring.  Describe: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Assistance needed for activities of daily living:**

Check the box that best describes the amount of assistance the resident feels they need in the following skill areas. If the NFMH staff indicates a different opinion, space has been provided to indicate both perspectives.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | |  | |
| Resident Assessment | Screener Assessment |
|  |
|  |  |
|  | 1. Taking Medications | |  |  |
|  | 2. Managing health care | |  |  |
|  | 3. Money management | |  |  |
|  | 4. Grocery shopping | |  |  |
|  | 5. Meal preparation & preparation | |  |  |
|  | 6. Laundry | |  |  |
|  | 7. Hygiene | |  |  |
|  | 8. Housekeeping | |  |  |
|  | 9. Structuring free time: | |  |  |
|  |  | Weekdays |  |  |
|  | Evenings |  |  |
|  | Weekends |  |  |
|  |
|  | | | | | | |
| *Additional comments regarding skills:* | | | | | | |
| **SECTION V POTENTIAL FOR DISCHARGE TO THE COMMUNITY** | | | | | | |
| The assessment of the level of care needs for an NFMH resident must include a comprehensive review of the individual’s strengths and goals, as well as, their service, support, and financial needs, and the community’s capacity to respond to those needs, prior to the determination that continued nursing facility placement is the best option. Therefore, a “Consumer Strengths Assessment,” similar to that used in Community Support Services programs across Kansas, has been included as part of the screening tool. It is strongly recommended that the screening facilitator complete this section of the Screen for Continued Stay. Continuing NFMH care should only be recommended for individuals whose needs cannot be met in the community. Therefore, a review of the community’s capacity to provide needed support is a critical piece of the assessment. Both formal and informal sources of support should be considered. | | | | | | |
| *Note: If the screener and facilitator are unfamiliar with services in the resident’s home community (or community of choice), the mental health center in that community should be contacted for assistance in identifying the needed resources.* | | | | | | |

#### **Strengths Assessment**

*Consumer’s Name Facilitator’s Name*

     

|  |  |  |
| --- | --- | --- |
| **Current Status:**  What is going on today?  What’s available now? | **Individual’s Desires, Aspirations:**  What do I want? | **Resources, Personal Social:**  What have I used in the past? |
|  | **(Life Domain)**  **Daily Living Situation** |  |
|  | **Financial/Insurance** |  |
|  | **Vocational/Educational** |  |
|  | **Social Supports** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Health** | | |  | |
|  | **Leisure/Recreational Supports** | | |  | |
|  | **Spirituality** | | |  | |
|  |  | | |  | |
| *What are my priorities?* | | |  | | |
| *1.* | | | *3.* | | |
| *2.* | | | *4.* | | |
| Consumer Comments: | | | Facilitator’s Comments: | | |
|  | |  |  | |  |
| **Consumer’s Signature** | | **Date** | **Facilitator’s Signature** | | **Date** |
|  | | |  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **A. Home Community** (List city the resident would choose to return to or move to if he/she were discharged from the NFMH): | | | | |
|  |  |  |  |  |
| **B. Resources that would be necessary to assist the individual to live successfully in the community listed above:** (If this community is outside of the Screener’s catchment area, list name and phone number of person contacted to assist in identification of needed services) | | | | |
| Name: | | Phone Number: | |  |

**Check all resources that the resident will need in the community. Then, indicate if the resource is an existing resource, or if it is a currently undeveloped one.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Resource Needed** | **General Assistance:** | | **Existing Resource** | **Resource Not Available/ Developed At This Time** |
|  | 1. Affordable housing or housing subsidy | |  |  |
|  | 2. Attendant care services | |  |  |
|  | 3. Case management services to assist in goal planning, mobilizing community supports, problem solving, assisting the individual to learn to use available resources, and crisis intervention | |  |  |
|  | 4. Community recreational activities | |  |  |
|  | 5. Consumer-Run Drop-In Center or social support activities | |  |  |
|  | 6. Crisis Stabilization/Respite Program available as needed | |  |  |
|  | 7. Housekeeping services | |  |  |
|  | 8. In-home medication services (med. drops, prompts to take meds, etc.) | |  |  |
|  | 9. Meals-on-Wheels or other nutrition assistance | |  |  |
|  | 10. Money management assistance or Conservator or Payee | |  |  |
|  | 11. Natural supports, such as family, roommates, friends, church, etc. | |  |  |
|  | 12. Psychiatric services and medication management | |  |  |
|  | 13. Psychosocial rehabilitation including in-home skills teaching | |  |  |
|  | 14. Transportation assistance | |  |  |
|  | 15. Vocational assistance | |  |  |
|  | **Medical Assistance:** | |  |  |
|  | 16. Assistive devices | |  |  |
|  | 17. Personal care services | |  |  |
|  | 18. Visiting nurses | |  |  |
|  | 19. Friends/Visitors/senior companions or similar program | |  |  |
|  |  | |  |  |
|  | **Substance Abuse Services:** | |  |  |
|  | 20. AA/NA programs appropriate for persons with dual diagnosis | |  |  |
|  | 21. Community in-patient chemical dependency treatment | |  |  |
|  | 22. Community out-patient chemical dependency treatment | |  |  |
|  | **Other services (list)** | |  |  |
|  | 23. | |  |  |
|  | 24. | |  |  |
|  | | | | |
|  | |  | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **SECTION VI SCREENING FINDINGS** | | | | | | | | | | | | | |
| *Note:* | *Homelessness or lack of financial resources should not be the determining factor for continued nursing facility placement. Case management services should be arranged to assist the individual to access temporary housing, benefits, and community resources for which they may be eligible.* | | | | | | | | | | | | |
| **Check A or B.**  *In cases where the resident’s guardian does not support the screening team’s recommendation, please list their concerns in the comments section below the “Screener spoke with the guardian” checkbox.* | | | | | | | | | | | | | |
|  | | **A. Recommend discharge to the community following development and implementation of an appropriate plan for community supports** | | | | | | | | | | | |
|  | | **B. Reasons for continued stay in NFMH** (Indicate reasons below. Check only one.) | | | | | | | | | | | |
|  | | **(1)** At this time the resident’s level of disability due to mental illness appears to be so severe that even the most intensive community services would be insufficient (refer to Section IV) | | | | | | | | | | | |
|  | | **(2)** This person could be served in the community with development of resources listed in the comments section, but at this time, these resources have not been developed. | | | | | | | | | | | |
|  | | **(3)** Medical issues necessitate continued stay (please give further detail in the comment section) | | | | | | | | | | | |
|  | | **(4)** Other (List below) | | | | | | | | | | | |
| Recommendations for additional Community Preparation Skills:  Additional Comments:  *Screener spoke to the NFMH Administrator or designee at the facility regarding this recommendation.*  *Comments*  *Screener spoke to the guardian regarding this recommendation.*  *Guardian agrees with the screener’s recommendation.*  *Comments* | | | | | | | | | | | | | |
| **SPMI Criteria:** Note whether the individual screened meets criteria for having a “severe and persistent mental illness.” | | | | | | | | | | | | | |
| **YES**  **NO**  If the individual does not meet SPMI criteria, or if additional diagnostic assessment is needed in order to make the determination, or if you question the current diagnosis of record, please explain: | | | | | | | | | | | | | |
| **SIGNATURES:** | | | | | | | | | | | | | |
|  | | | | | | | | |  |  | | | |
|  | | | Signature and Credentials of Screener | | | | | |  | Date | | | |
|  | | | | | | |  |  | | | | |  |
|  | | | Community Mental Health Center | | | |  | Screener Number | | | | |  |
| Phone number: | | | | Work: | Cell: | | | Email Address: | | |  | | |
|  | | | | | | | | |  |  | | | |
|  | | | Signature of Qualified Mental Health Professional (QMHP) | | | | | |  | Date | | | |
| Phone number | | | | Work: | Cell: | | | | Email Address | | |  | |
|  | | |  | |  | | | | | | | |  |
| **Within two (2) working days of completing the screen, please email a copy of this form,** **including the completed Consumer Strengths Assessment, to** [**KDADS.ContStay@ks.gov**](mailto:KDADS.ContStay@ks.gov)**. If you have any questions about this form, please contact** [**KDADS.ContStay@ks.gov**](mailto:KDADS.ContStay@ks.gov)**.** | | | | | | | | | | | | | |
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