Kansas
Department for Aging and Disability Services

KDADS CARE Special Admission Fax Memo

Fax: 785-291-3427 or E-mail to KDADS.CARE@Ks.gov

CONFIDENTIAL

Client Name_____

Admission Date to Nursing Facility_____# of pages_____

From/Title_____

Nursing Facility Name _____

Nursing Facility Address_____

Phone/e-mail_____

Please attach Sections A&B of the level 1 CARE assessment with each Special Admission. Please select the admission type below.

☐ **#1 – Emergency Admission**

***Emergency Admissions are only valid for 7 days.**

Check the reason for the Emergency:

☐ 1. An admission is requested by Department for Children and Families (DCF) Adult Protective Services (APS);

☐ 2. A natural disaster has occurred that substantially impacts the individual's current living situation;

☐ 3. The individual's primary caregiver is unavailable, due to circumstances beyond the caregiver's control (e.g., caregiver dies, becomes ill or is injured);

☐ 4. A physician-ordered immediate admission due to the individual's condition; or

☐ 5. The admission to the nursing facility is from an out-of-state community due to circumstances beyond the individual's control, (e.g., admitted from the individual's place of residence in another state on a weekend when an ADRC CARE assessor is not available).

Please send the APS (PPS 10510) form if selecting reason 1, and the physician-signed orders if selecting reason 4.

****Send Emergency Admission to your local ADRC/AAA for the Level 1 CARE Assessment.**

☐ **#2 – Respite Stay**

Respite Stay is a planned, short-term stay for fewer than 30 days. Please include orders signed by a physician. The orders should include planned date of admission and planned date of discharge.

☐ **#3 – Less than 30-day Admission**

Please send the less than 30-day order from the hospital signed by the attending physician. Orders must come from the hospital sending the individual.

On day 20 from the date of the signed order, if the individual is still in the nursing facility and it does not appear they will be leaving at the end of the 30 days, please contact the ADRC/AAA and have a CARE Assessment completed.

#4 – Out-of-State Admission

☐ Please send the out-of-state PASRR for the admission. The Out-of-state PASRR must be complete, signed, and dated.

#5 – Terminal Illness

☐

☐ Certification

- Please send the physician-signed order stating the resident has six months or fewer to live.

☐ Re-Certification date:_____

- Please send a NEW physician-signed order stating the resident has six months or fewer to live.
- Please send original Section A&B of the Level 1 CARE assessment

*request a Level 1 if the client is in your facility at the end of the Re-Cert (12 months)

A. IDENTIFICATION

1. Social Security # (Optional)

___ ___ ___ - __ __ - ___ ___ ___ ___

2. Customer Last 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_____