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___________________________

CUSTOMER 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

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

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 ________________________________

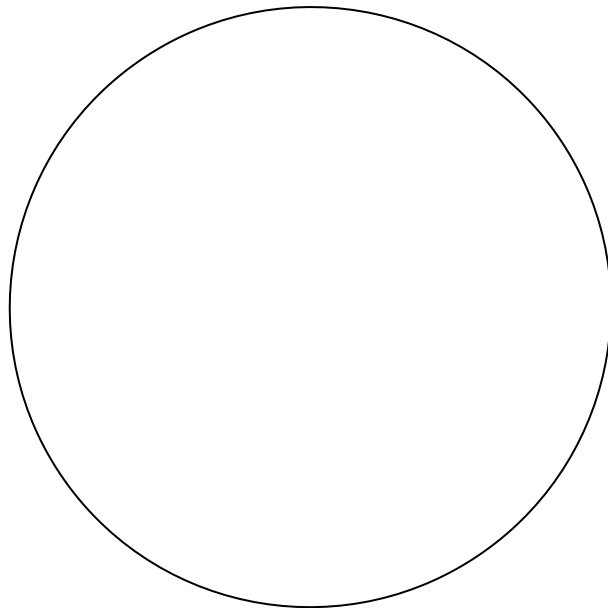
K. ADDITIONAL RESOURCES/NEEDS:

___ 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____
____
____
____
____
____
____
____
____

Customer Name ____ Date __________________

Clock Draw



Certificate of CARE Assessment

This certificate is evidence of completion of a CARE assessment. Keep it with your medical records.

If you want to live in a nursing facility, you must take a copy of this certificate with you when you apply for admission. If you want to live in your home or other community-based setting, the Area Agency on Aging can help you find appropriate services.

This certificate is good for one year. If your health status or abilities change, you may request a new assessment. Should you need additional copies of this certificate or your completed two-page assessment, or want additional information, contact your Area Agency on Aging at: ____

I certify that I have completed a CARE assessment for ______________________________
(client's name)

on ______________________ . The preadmission requirement found in Public Law 100-203 has been met.
(date)

The Preadmission Screening and Annual Resident Review (PASARR) portion of the assessment:

___ did not indicate a need for further evaluation.
___ indicated a need for further evaluation. I am referring the client to a Level II assessor.

I am referring the client to a community-based service:

___ Area Agency on Aging ___ DCF Adult Services ___ Independent Living ___ Other ___________

No referral is necessary, the client:

___ does not need / does not wish help in finding community-based services.
___ has selected a nursing facility. ___ has not made final LTC decision.

______________________________ ______________________________
(Assessor Signature) (Assessor Number)

I hereby acknowledge that I have received a copy of the ***Notice of Right to Request a Fair Hearing*** attached to my copy of the Certificate of CARE Assessment.

______________________________ ______________________________
(Client's Signature) (Date)

Notice of Right to Request A Fair Hearing

If you do not agree with the determination of the PASARR column (Section II of the Level I CARE Assessment) referral regarding a Level II assessment as set forth on your CARE Certificate, you have the right to request a fair hearing to appeal this decision. This determination was made in accordance with the Health Care Financing Administration Rules and Regulations relating to Preadmission Screening and PASARR, 42 CFR Section 483.100 et. seq.

To request a fair hearing in accordance with K.A.R. 30-7-64 et. seq., **your request shall be in writing and delivered, or mailed to the following address so that it is received by the agency at the *Department of Administration Office of Administrative Hearings, 1020 S. Kansas, Topeka, KS 66612* within 30 days from the date on this Certificate of CARE Assessment.** (Pursuant to K.S.A. 77-531, an additional three days shall be allowed if you receive this certificate by mail.) Failure to timely request or pursue a fair hearing may adversely affect your rights.

At the hearing you will be given the opportunity to explain why you disagree with the agency action. You may represent yourself or be represented at the hearing by legal counsel, a friend, a relative, or other spokesperson.

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.

<table>
<tr>
<td>

Providing the information: **Person(s)/Organization(s)** (check all that applies)

_____ Community mental health center(s): *Numbers* ________________________
_____ Community developmental disability organization(s): *Numbers*_________
_____ Adult Protective Services: Names ________________________________
_____ Hospitals/nursing facility/LEO: Names_____________________________
____

Other(s): name/address/phone__________________________________

____
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</td>
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Receiving the information:
Person(s)/Organization(s) (check all that applies)

____ Area Agency on Aging:
name ______________________________________
____ Kansas Department for Aging and Disability Services

____ Healthsource Integrated Solutions

Other(s):
name/address/phone__________________________________

____
____
____
____
____
____

</td>
</tr>
</table>

Description of Information to be Used or Disclosed (place a check mark or an "x" next to the item(s) to be used or disclosed):
___ Recent History and Physical within the last 2 years; ___Medical records for inpatient psych hospitalizations within the last 2 years; ___ List of dates showing increase services to a CMHC, VA, etc. for more than 30 days in the last 2 years; ___ LEO/APS/Housing Interventions/ reports last 2 years; ___ IQ test or documentation including score; ___ Partial Hospitalizations or day services to CMHC, VA or the like in the last 2 years

The purpose of the Use or Disclosure: *Completion of a PASRR Evaluation and for continuum of care ***Return requested documentation to: ATTN: CARE at KDADS.CARE@KS.GOV or FAX to (785)291-3427*

The Individual or the Individual's Representative must read or have the following read to them and initial by each item below:

_____ *(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) Date Description of Authority

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

	CDDO		CMHC
1	Achievement Services for Northeast Kansas	**1**	Bert Nash Community Mental Health Center Inc.
2	Arrowhead West, Inc	**2**	Central Kansas Mental Health Center
3	Big Lakes Developmental Center, Inc	**3**	Comcare of Sedgwick County
4	Brown County Developmental Services, Inc.	**4**	Community Mental Health Center of Crawford County
5	Butler County CDDO	**5**	Compass Behavioral Health
6	CDDO of Southeast Kansas	**6**	Crosswinds
7	Cottonwood, Inc.	**7**	Elizabeth Layton Center, Inc.
8	Cowley County Community Dev. Disability Org	**8**	Family Services & Guidance Center
9	Developmental Services of Northwest Kansas, Inc.	**9**	Four County Mental Health Center
10	Disability Planning Organization of Kansas	**10**	High Plains Mental Health Center
11	East Central Kansas AAA-CDDO	**11**	Horizons Mental Health Center
12	Futures Unlimited, Inc	**12**	Iroquois Center for Human Development, Inc
13	Harvey - Marion County CDDO	**13**	Johnson County Mental Health Center
14	Hetlinger Developmental Services, Inc	**14**	Kanza Mental Health & Guidance
15	Johnson County Developmental Supports	**15**	Labette Center for Mental Health Services
16	McPherson County CDDO	**16**	Pawnee Mental Health Services
17	Nemaha County Training Center	**17**	Prairie View, Inc
18	New Beginnings Enterprises, Inc.	**18**	South Central Mental Health Counseling Center, Inc
19	Reno County CDDO	**19**	Southeast Kansas Mental Health Center
20	Riverside Resources, INC	**20**	Southwest Guidance Center
21	Sedgwick Co. Developmental Disability Org.	**21**	Spring River Mental Health & Wellness
22	Shawnee County CDDO	**22**	Sumner County Mental Health Center
23	Southwest Developmental Services Inc.	**23**	The Center for Counseling and Consultation
24	Tri-Ko, Inc.	**24**	The Guidance Center, Inc
25	Tri-Valley Developmental Services, Inc	**25**	Valeo Behavioral Healthcare
26	Twin Valley Developmental Services Inc.	**26**	Wyandot Center for Community Behavioral Health Inc.
27	Wyandotte County CDDO		

Instructions to Complete the KDADS Authorization for Release of Protected Health Information (ARPHI) Form for the CARE Program

Name/SSN/DOB Fields

Name of Client	Please complete this field using the client's full legal name.
Social Security Number	If a copy of the Social Security Number is available, please enter the number as it appears on the card. If the number cannot be verified, leave field blank. This field is optional.
DOB:	Enter the client's full date of birth (MM/DD/YYYY)

"Providing the Information" Box

This box will include the organizations, doctors, and/or family members KDADS will need to contact to obtain the paperwork required to initiate a CARE Level II assessment, Resident Review, or Change of Condition.

Community Mental Health Center (CMHC): Locate the correct CMHC from those listed on Page 2 of the ARPHI form and write the number(s) associated with the CMHC(s) client has been visiting for increased supportive service for 30 consecutive days above and beyond routine visits. If the CMHC is not listed or not a Kansas CMHC, please list the name of the CMHC in the "Other" section in this box.

Community Developmental Disability Organization (CDDO): Locate the correct CDDO from those listed on Page 2 of the ARPHI form and write the number associated with the CDDO(s) the client has been visiting for services and/or the CDDO from which the IQ score can be obtained. If the CDDO is not listed or not a Kansas CDDO, please list the name of the CDDO in the "Other" section in this box.

Adult Protective Services (APS): If client currently has an open case or has had a case filed with APS in the last two (2) years due to a mental health concern, please list the name(s) and location(s) of the APS office(s) where the report(s) were filed. Please use the lines under the "Other" section if more room is needed.

Hospital/Nursing Facility/LEO: If client was admitted for an inpatient psychiatric stay at a facility within the last two (2) years, provide the full name and location of the hospital and/or facility. Do not use abbreviations. Use the lines under the "Other" sections if more room is needed.

When the client has records at a nursing facility or a nursing facility is submitting a Resident Review or Change in Condition, provide the full name of the facility. Use the lines under the "Other" section if more room is needed.

When client has had interactions with law enforcement, please list the agency and location of the interaction. (i.e., Shawnee County Sheriff's Office, Topeka Police Department, etc.)

Others: Please list the following entities under this section, when applicable:

- Law enforcement agency
- Housing authority
- Family member(s)
- Physician(s)
- Organization(s)
- Out-of-state facility
- Any other persons or entities able to provide additional information, such as, IQ, H&P, police record, medication list, psychiatric evaluation(s), inpatient hospital admissions, eviction notices, and/or other important documents required for the CARE Level II referral.

"Receiving the Information" Box

This box will include the organizations and persons receiving information (i.e., CARE Level II Determination Letter).

Area Agency on Aging (AAA): Choose this option if CARE Level I assessment was completed by a AAA assessor.

Kansas Department for Aging and Disability Services: Check this option since CARE Level I information will be received on behalf of KDADS, including any additional information that will need to be obtained to complete the CARE Level II assessment process.

Healthsource Integrated Solutions (HIS): Check this option if the CARE Level I assessment indicates a need for completion of a CARE Level II assessment.

Others: Provide the name, address, and phone number of any person or entity receiving information from the CARE Level II assessment and/or who will need to receive a copy of the Determination Letter.

- Facility
- Hospital
- Organization
- DPOA/Guardian
- Family member
- Case worker

NOTE: Failure to provide the above information will delay the CARE Level II process and/or prevent a timely Determination Letter from the KDADS CARE program. The assessor is responsible to ensure all information needed is complete on this form.

Description of Information to be Used or Disclosed: Place an "X" next to the items needed by KDADS to complete the CARE Level II process.

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The Individual or Individual's Legal Representative must read or have the following section read to him or her in its entirety and then initial as explained below:

- Please have client initial next to each item to indicate client giving permission for each item.
- If the client has a Guardian, then **only the guardian** may initial each item.
- If the client has a DPOA (or spouse) and client is unable to sign on his or her own, the DPOA (or spouse) may initial each item.

Signature and Date Lines:

- If the client does not have a guardian, the client may sign and date the ARPHI on his or her own, validating it for up to one (1) year.

Signature of Personal Representative Line (when applicable):

- **ONLY** the guardian may sign this line and complete the date line.
- **DPOA** may sign if the client is unable to sign on his or her own.
- **Legal Spouse** may sign if the client is unable to sign on his or her own.

Description of Authority Line:

- If Guardian or DPOA signs this document, a copy of the legal documentation must be furnished to verify authenticity.