



KDADS CARE Resident Review required documentation check list
FAX 785-291-3427 or E-mail to KDADS.CARE@KS.gov

CONFIDENTIAL

A RESIDENT REVIEW is required when an individual, in a Nursing Facility (NF) or Nursing Facility for Mental Health (NFMH), with a PASRR determination letter that authorized a temporary PASRR stay for Level II and the persons stay requires an extended length of time to the facility. Or if the person has had a recent Change in Condition that now meets criteria for a level II PASRR

Client Name _____

Facility Name and Address _____

Name/Title/Phone/Email of contact person from your facility _____

Name/Address/Phone of Client Guardian/DPOA (if applicable) _____

Check List (at the time of submission to KDADS all items below must be provided, if all items are not provided at submission this will cause delays in processing)

_____ KDADS Current Release of Information (ROI) dated/signed

_____ Current Guardianship, DPOA legal documents

_____ Current History & Physical (H & P) (within last 2 years)

_____ Current Medication Administration Record (MAR)

_____ Current Care Plan

_____ Facility Progress Notes in the last 90 days

_____ Discharge summary from any State Hospital, Psych Unit or BHU since the original Level II screen or last resident review.

If applicable:

_____ MDS* (admission MDS and the MDS current that shows there has been a change of condition)

*For a Resident Review Change in Condition: This is a person that has come to your facility on a level I that did not trigger for a level II, but now meets the criteria. Which are 2 inpatient psych hospitalizations, or 2 partial psych hospitalizations, or 1 inpatient and 1 partial psych hospitalizations, or supportive services (CMHC, VA) or Interventions (APS, LEO, Housing Authority) include all the above in the check list and the MDS below.

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.

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.