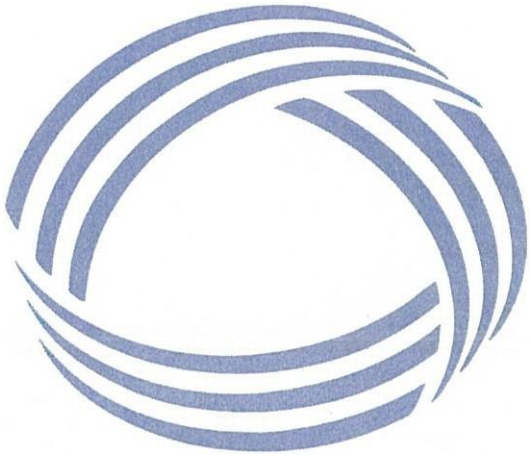
EDWP Services Options Using Resources in Community Environments DOCUMENTS



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

October 1, 2021

DOCUMENTS LIST

REFERRAL

SOURCE Screening Form
Determination of Need – Revised (DON-R) and Instructions

INITIAL/ANNUAL PAPERWORK

EDWP Fact Sheet - English
Case Management Agency List
Abuse, Neglect, and Exploitation Fact Sheet
Medicaid and Estate Recovery Fact Sheet
Rights and Responsibilities
Authorization to Release Information and Instructions
Program Participation Form
Member Choice of Provider Form
Level of Care and Placement Instrument and Instructions
Discharge Planning Checklist and Instructions

ASSESSMENTS

MDS-HC Version 9
Medication List
Intermediate Level of Care Criteria and Instructions
RN Review and Signature Form
EDWP Physicians Evaluation
MMSE and Instructions
SLUMS and Instructions
PHQ-9
Nutritional Assessment
Direction for Alliant Uploads
SOURCE Assessment Addendum (Optional)
EDWP Modified Reassessment

CARE PATHS

Care Paths
Discharge Care Path
Incontinence Care Path

DOCUMENTATION

Monthly/Quarterly Contact Sheet and Instructions
Alternate Quarterly Contact Sheet and Instructions
Legal Medical Records Standards
Disease Management Physician Letter

FORMS USED IN COURSE OF BUSINESS

Waiver Transfer Form and Instructions
SOURCE Referral Form
Case Management Agency Monthly Report and Instructions
Member Information Form (MIF) and Instructions
EDWP SOURCE Case Conference and Complaint Resolution
Standards of Promptness
Notice of Denial, Termination, and Reductions of Services and Instructions

BILLING

SOURCE Billing Instructions
National Codes and Rates

INFORMATION

Waiver Program Services at a Glance
Georgia Advance Directives
Georgia Families See General Services Manual
The Affordable Care Act See General Services Manual
Level of Care Criteria from Nursing Home Manual
DCH Privacy Notice

REFERRAL

SOURCE Screening Form

SCREENER _____ REFERRAL DATE_____

___ SCREENING DATE_____

NAME _____ DOB_____,_____,_____

SEX M___F_____ SSN_____

MEDICAID YES/ NO MEDICAID NUMBER_____

__ SSI: YES NO_____

IF NO, IS MONTHLY INCOME SSI LEVEL OR BELOW? _____

___ MEDICARE NUMBER_____

ADDRESS:_____ PHONE_____

HOUSING: ALONE___ WITH RELATIVE/FRIEND_____ HOSPITAL_____

PERSONAL CARE HOME_____ NURSING HOME OTHER__

PHYSICIAN_____

DATE OF LAST VISIT_____

DIAGNOSES_____

INITIAL CALLER_____

REFERRED BY_____

REFERRAUSCREENING NOTES

_____

_____

_____

_____

PRIMARY CAREGIVER RELATIONSHIP _____

____ PHONE ( )_____

STREET ADDRESS_____

City State._____ Zip._____

WILLING TO USE SOURCE PCP YES NO

REFERRED FOR SOURCE ASSESSMENT YES NO

NOT ELIGIBLE REASON_____

REFERRED FOR OTHER SERVICES_____

OTHER----------

DETERMINATION OF NEED-REVISED (DON-R)

Tool to determine appropriateness for services based on the applicant's medical and financial status.

When Completed: The screening and intake is completed within three business days of receiving the referral or inquiry.

Inform applicant of screening process before you begin.

Instructions for completion of the Determination Of Need-Revised (DON-R) Functional Assessment are outlined below.

DETERMINATION OF NEED -REVISED FUNCTIONAL ASSESSMENT (DON-R)

The Determination of Need (DON) defines the factors which help determine a person's functional capacity and any unmet need for assistance in dealing with these impairments. The DON-R allows for independent assessment of both impairment in functioning on Basic Activities of Daily Living (BADL) and Instrumental Activities of Daily Living (IADL) and the need for assistance to compensate for these impairments.

Assess both Column A Level of Impairment, and Column B Unmet Need for Care on all applicants.

A minimum score of 15 is required in Column A Level of Impairment along with identified Unmet Need for Care in Column 8, before a client is referred for assessment. If the Level of Impairment score is less than 15 refer client to other available services through the Area Agency on Aging or other resource.

The central question to determining the level of need for care is whether a person can pertorm activities of daily living (ADL). Table 1 presents the list of ADL included in the DON under two headings: BASIC AND INSTRUMENTAL.

Table 1 - Activities of Daily Living Included in the Determination of Need (DON)

BASIC ACTIVITIES OF DAILY LIVING (BADL)	INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)
Eating	Managing Money

DETERMINATION OF NEED- REVISED (DON-R)

Bathing	Telephone
Grooming	Preparing Meals
Dressing	Laundry
Transfer (In and Out of Bed/Chair)	Housework
Bowel/Bladder Continence	Outside Home
	Routine Health
	Special Health
	Being Alone

ITEM DEFINITIONS

1. EATING:

A. Is the client able to feed himself/herself?

Assess the client's ability to feed oneself a meal using routine or adapted table utensils and without frequent spills. Include the client's ability to chew, swallow, cut food into manageable size pieces, and to chew and swallow hot and cold foods/beverages. When a special diet is needed, do not consider the preparation of the special diet when scoring this item (see "preparing meals" and "routine health" items).

B. Is someone available to assist the client at mealtimes?

If the client scores at least (1) in Column A, evaluate whether someone (including telephone reassurance) is available to assist or motivate the client in eating.

2. BATHING

A. Is the client able to shower or bathe or take sponge baths for the purpose of maintaining adequate hygiene as needed for the client's circumstances?

Assess the client's ability to shower or bathe or take sponge baths for the purpose of maintaining adequate hygiene. Consider minimum hygiene standards, medical prescription, or health related considerations such as incontinence, skin ulcer, lesions, and frequent profuse nose bleeds. Consider ability to get in and out of the tub or shower, to turn faucets, regulate water temperature, wash and dry fully. Include douches if required by impairment.

B. Is someone available to assist or supervise the client in bathing?

If the client scores at least (1) in Column A, evaluate the continued availability of resources to assist in bathing. If intimate assistance is available but inappropriate and/or opposed by the client, consider the assistance unavailable.

3. GROOMING

A. Is the client able to take care of his/her personal appearance?

Assess client's ability to take care of personal appearance, grooming, and hygiene activities. Only consider shaving, nail care, hair care, and dental hygiene.

B. Is someone available to assist the client in personal grooming tasks?

If the client scores at least (1) in Column A, evaluate the continued personal assistance needed, including health professionals, to assist client in grooming.

4. DRESSING

A. Is the client able to dress and undress as necessary to carry out other activities of daily living?

Assess the client's ability to dress and undress as necessary to carry out the client's activities of daily living in terms of appropriate dress for weather and street attire as needed. Also include ability to put on prostheses or assistive devices. Consider fine motor coordination for buttons and zippers, and strength for undergarments or winter coat. Do not include style or color coordination.

B. Is someone available to assist the client in dressing and undressing?

If someone scores at least one (1) in Column A, evaluate whether someone is available to help dressing and/or undressing the client at the times needed by the client. If intimate assistance is available but inappropriate and/or opposed by the client, consider the assistance unavailable.

5. TRANSFER

A. Is the client able to get into and out of bed or other usual sleeping place?

Assess the client's ability to get into and out of bed or other usual sleeping place, including pallet or armchair. Include the ability to reach assistive devices and appliances necessary to ambulate, and the ability to transfer (from/to) between bed and wheelchair, walker, etc. Include ability to adjust the bed or place/remove handrails, if applicable and necessary. When scoring, do not consider putting on prostheses or assistive devices.

B. Is someone available to assist or motivate the client to get in and out of bed?

If the client scores at least one (1) in Column A, evaluate the continued availability of resources, (including telephone reassurance and friendly visiting) to assist or motivate the client in getting into and out of bed.

6. CONTINENCE

A. Is the client able to take care of bladder/bowel functions without difficulty?

Assess the client's ability to take care of bladder/bowel functions by reaching the bathroom or other appropriate facility in a timely manner. Consider the need for reminders.

B. Is someone available to assist the client in performing bladder/bowel functions?

If the client scores at least (1) in Column A, evaluate whether someone is available to assist or remind the client as needed in bladder/bowel functions.

NOTE: When using the MDS-HC, the DON question regarding continence is incorporated in the MDS-HC question for toilet use.

7. MANAGING MONEY

A. Assess the client's ability to handle money and pay bills. Include ability to plan, budget, write checks or money orders, exchange currency, and handle paper work and coins. Include the ability to read, write and count sufficiently to perform the activity. Do not increase score based on insufficient funds.

C. Is someone available to help the client with money management and money transactions?
If the client scores at least (1) in Column A. evaluate whether an appropriate person is available to plan and budget or make deposits and payments on behalf of the client. Consider automatic deposits, banking by mail, etc.

8. TELEPHONING

A. Is the client able to use the telephone to communicate essential needs?
Assess the client's ability to use a telephone to communicate essential needs. The client must be able to use the phone: answer, dial, articulate and comprehend. If the client uses special adaptive telephone equipment, score the client based on the ability to perform this activity with that equipment. Do not consider the absence of a telephone in the client's home. (Note: the use of an emergency response system device should not be considered.

B. Is some available to assist the client with telephone use?
If the client scores at least (1) in Column A, evaluate whether someone is available to help the client reach and use the telephone or whether someone is available to use the telephone on behalf of the client. Consider the reliability and the availability of neighbors to accept essential routine calls and to call authorities in an emergency.

9. PREPARING MEALS

A. Is the client able to prepare hot and/or cold meals that are nutritionally balanced or therapeutic, as necessary, which the client can eat?
Assess the client's ability to plan and prepare routine hot and/cold, nutritionally balanced meals. Include ability to prepare foodstuffs, to open containers, to use kitchen appliances, and to clean up after the meal, including washing, drying and storing dishes and other utensils in meal preparation. Do not consider the ability to 12lfilLtherapeutic or prescribed meals.

B. Is someone available to prepare meals as needed by the client?
If the client scores at least one (1) in Column A, evaluate the continued availability of resources (including restaurants and home delivered meals) to prepare meals or supervise meal preparation for the client. Consider whether the resources can be called upon to prepare meals in advance for reheating later.

LAUNDRY

A. Is the client able to do his/her laundry?
Assess the client's ability to do laundry including sorting, carrying, and loading, unloading, folding, and putting away. Include the use of coins where needed and use of machines and/or sinks. Do not consider the location of the laundry facilities.

B. Is someone available to assist with the performing or supervising the laundry needs of the client?
If the client scores at least one (1) in Column A, evaluate the continued availability of laundry assistance, including washing and/or dry cleaning. If public laundries are used, consider the reliability of others to insert coins, transfer loads, etc.

11. HOUSEWORK

A. Is the client able to do routine housework?
Assess the client's ability to do routine housework. Include sweeping, scrubbing, and vacuuming floors. Include dusting, cleaning up spills, and cleaning sinks, toilets, bathtubs. Minimum hygienic conditions for client's health and safety are required. Do not include laundry, washing and drying dishes or the refusal to do tasks if refusal is unrelated to the impairment.

B. Is someone available to supervise, assist with, or perfonn routine household tasks for the client as needed to meet minimum health and hygiene standards?
If the client scores at least one (1) in Column A, evaluate the continued availability of resources, including private pay household assistance and family available to maintain the client's living space. When the client lives with others, do not assume the others will clean up for the client. This item measures only those needs related to maintaining the client's living space and is not to measure the maintenance needs of living space occupied by others in the same residence.

12. OUTSIDE HOME

A. Is the client able to get out of his/her home and to essential places outside the home?
Assess the client's ability to get to and from essential places outside the home. Essential places may include the bank, post office, mail box, medical offices, stores, and laundry if nearest available facilities are outside the home. Consider ability to negotiate stairs, streets, porches, sidewalks, entrance and exits of residence, vehicle, and destination in all types of weather. Consider the ability to secure appropriate and available transportation as needed, will increase the score. However, in scoring, do not consider the inability to afford public transportation.

B. Is someone available to assist the client in reaching needed destinations?
If the client scores at least one (1) in Column A, evaluate the continued availability of escort and transportation, or someone to go out on behalf of the client. Consider banking by mail, delivery services, changing laundramats, etc., to make destinations more accessible.

NOTE: When using the MDS-HC, the DON question regarding outside home is incorporated in the MDS· HG question for transportation.

13. ROUTINE HEALTH CARE

A. Is the client able to follow the directions of physicians, nurses, or therapists, as needed for routine health care?
Assess the client's ability to follow directions from a physician, nurse, or therapist, and to manipulate equipment in the performance of routine health care. Include simple dressings, special diet planning,

monitoring of symptoms and vital signs (e.g., blood pressure, pulse, temperature and weight), routine medications, routine posturing and exercise not requiring services or supervision of a physical therapist.

B. Is someone available to carry out or supervise routine medical directions of the client's physician or other health care professionals?

If the client scores at least one (1) in Column A, evaluate the continued availability of someone to remind, supervise or assist the client in complying with routine medical directions. If the assistance needed involves intimate care, and the care giver is inappropriate and/or opposed by the client, consider the assistance unavailable.

14. SPECIAL HEALTH CARE

A. Is the client able to follow directions of physicians, nurses or therapists as needed for specialized health care?

Assess the client's ability to perform or assist in the performance of specialized health care tasks which are prescribed and generally performed by licensed personnel including physicians, nurses, and therapists. Include blood chemistry and urinalysis; complex catheter and ostomy care; complex or non-routine posturing/suctioning; tub feeding; complex dressings and decubitus care; physical, occupational and speech therapy; intravenous care; respiratory therapy; or other prescribed health care provided by a licensed professional. Score "O" for clients who have no specialized health care needs.

B. Is someone available to assist with or provide specialized health care for the client?

If the client scores at least one (1) in Column A, evaluate the continued availability of specially trained resources as necessary to assist with or perform the specialized health care task required by the client.

15. BEING ALONE

A. Can the client be left alone?

Assess the client's ability to be left alone and to recognize, avoid, and respond to danger and/or emergencies. Include the client's ability to evacuate the premises or alert others to the client's need for assistance, if applicable, and to use appropriate judgment regarding personal health and safety.

B. Is someone available to assist or supervise the client when the client cannot be left alone?

If the client scores at least one (1) in Column A. evaluate the continued availability of someone to assist or supervise the client as needed to avoid danger and respond to emergencies. Consider friendly visiting, telephone reassurance, and neighborhood watch programs.

BADL's refer to those activities and behaviors that are the most fundamental self-care activities to perform and are an indication of whether the person can care for his or her own physical needs.

IADL's are the more complex activities associated with daily life. (They are applications of the BADL's.) Information regarding both BADL and IADL are essential to evaluating whether a person can live independently in the community.

The DON-R Functional Assessment is a unique measure of functional assessment in that it differentiates between impairment in functional capacity and the need for care around a particular functional capacity. Furthermore, it is an ordinal scale with clearly defined meanings for each level of unmet need for care and each functional activity. Because of its ordinal nature, it permits quantification of scores so that changes in

scores in subscales for BADL's and IADL's and for Total Impairment represent actual changes in impairment, and changes in scores for unmet need for care in BADL's, IADL's and Total Unmet Need for Care represent actual changes in unmet need for care.

Ask if client has a medical/health problem/diagnosis with functional impairment. Take the following action as appropriate:

1. If answer is "no", inform applicant of CCSP/SOURCE ineligibility and right to appeal. If applicant agrees, refer client to other resources as appropriate. (If client appeals, please complete the case management form under Appendix Z6) Attempt to give member/family **county** specific resources as well as state offerings. Gather resources through contacts, from internet, the local health department https://dhs.georgia.gov/ and others as appropriate. Focus resources on what the member identifies as the reason for the application to the program i.e. if needs monitoring refer to ADH or churches/ similar programs; if member needs food, refer to food banks, food stamps, meals on wheels etc; if family needs respite, search for respite offerings in community. https://dhs.georgia.gov/

2. If applicant's answer is yes, continue screening process answering each area with appropriate number (0·3).

Some general comments about the DON-R are provided to assist in the completion of the instrument.

The "Case Comments" space to the right of Column B in the functional status section is used to:

- Note special reasons for impairment or unmet need.
- Describe the type of service, caregiver support or assistive devices that decreases the client's unmet need.
- Record the primary care giver's name or other pertinent information.

Column Rules:

Use the following criteria to decide when to stop asking questions for a particular Functional Status item or when to skip Column B:

1. Ask each Functional Status item, starting with Column A, Level of Impairment.
2. If Column A, "level of impairment" is scored "O", score Column B "O".
3. If Column A is scored greater than "O", ask Column B, Unmet Need for Care.

Column A: Level of Impairment

DETERMINATION OF NEED· REVISED (DON·R)

Each one of the BADLs and IADLs needs to be discussed in terms of level of impairment. How the assessor mentions functional impairment is not as important as encouraging the client to report difficulties with the activity. Sample questions could include:

- Are you able to do...?
- How much difficulty do you have in doing...?

NOTE: If an applicant is living in a personal care home or nursing home, determine Impairment Level using Column A of the DON·R. The objective is to gather sufficient information to determine the most appropriate score.

Answers to these questions should address the degree of unmet need for care if discharge occurs.

Score 0 ·Performs or can perform all essential components of the activity, with or without an assistive device, such that:

- No significant impainment of function remains; or
- Activity is not required by the client (IADLs: medication management, routine and special health only); or
- Client may benefit from but does not require verbal or physical assistance.

Score 1 - Performs or can perform most essential components of the activity with or without an assistive device, but some impairment of function remains such that client requires some verbal or physical assistance in some or all components of the activity.

This includes clients who:

- Experience minor, intermittent fatigue in performing the activity; or
- Take longer than would be required for an unimpaired person; or
- Require some verbal prompting to complete the task

Score 2 - Cannot perform most of the essential components of the activity, even with an assistive device, and/or requires a great deal of verbal or physical assistance to accomplish the activity.

This includes clients who:

- Experience frequent fatigue or minor exertion in performing the activity; or
- Take an excessive amount of time to perform the activity; or
- Must perform the activity much more frequently than an unimpaired person; or

- Require frequent verbal prompting to complete the task.

Score 3 - Cannot perform the activity and requires someone else to perform the task, although applicant may be able to assist in small ways; or requires constant verbal or physical assistance.

Column B: Unmet Need tor Care

In scoring this column, the idea is both to obtain information from the applicant about his or her perceptions regarding need for care and to use obseJVational skills to determine the impact on the applicant should care or assistance not be provided, or a caregiver is unable to continue providing care at the current level. The availability of an appropriate caregiver also needs to be assessed.

Assess the degree to which the caregiver feels overwhelmed or burdened by the caregiving situation. The Zari!burden scale or the Caregiver Hassels Scale are formal assessments that may be used to assess caregiver burden.

Questions that might be asked of applicants and caregivers are:

- Do you feel burdened by providing care to your family member or friend?
- How often do you feel this way: frequently (daily), occasionally (weekly), sometimes (monthly), rarely (less than monthly?
- How long will you be willing/able to provide care at the current level?

Questions that might be asked of applicants and caregivers are:

- Can you tell me if you are getting enough help in meeting your needs with...?
- Do you think you need more help with...?

If the applicant is living in a personal care home or nursing home, score the applicant according to the care he would receive if discharged. To determine the future need for care, include the following questions:

a. Who will/would provide care in the home if the person was discharged?
b. How much care will the person need?
c. How much can the person do for him/herself?
d. How often will assistance be provided/available?
e. How long would this plan last?

NOTE: Answers to these questions should address the degree of unmet need for care if discharge occurs. ObseJVe the applicant's mobility, level of clutter, personal appearance, unpaid bills, forgetfulness, etc., to assess the level of risk to health or safety if current levels of assistance are not maintained, or if additional assistance is not added.

Score O - The applicant's need for assistance is met to the extent that the applicant is at no risk to health or safety if additional assistance is not acquired; or the applicant has no need for assistance; or additional assistance will not benefit the applicant.

DETERMINATION OF NEED- REVISED (DON-R)

Score 1 - The applicant's need for assistance is met most of the time, or there is minimal risk to the health and safety of the applicant if additional assistance is not acquired.

Score 2 - The applicant's need for assistance is not met most of the time, or there is moderate risk to the health and safety of the applicant if additional assistance is not acquired.

Score 3 - The applicant's need for assistance is seldom or never met; or there is severe risk to the health and safety of the applicant that would require acute medical inteivention if additional assistance is not acquired.

Comments - Ask applicant "If you are not able to get these seivices, what will happen" and record the answer in applicant's own words

DETERMINATION OF NEED·REVISED (DONR)

Date:		Member Name Important Diagnosis: Caregiver {CG) name:	
	Column A	Column B	Comments:
Function	Level of Impairment	Unmet Need for Care	If scores 1-3 explain why client needs assistance ie bad leg, weak arm, dementia etc
1. Eating			
2. Bathing			
3. Grooming			
4. Dressing			
5. Transferring			
6. Continence			

Column A Functional Impairment

Score O - Performs or can perform all essential components of the activity, with or without an assistive device, such that:

- No significant impairment of function remains; • Activity is not required by the client • Client may benefit from but does not require verbal or physical assistance.

Score 1 - Pertorms or can perform most essential components of the activity with or without an assislive device, but some impairment of function remains such that client requires some verbal or physical assistance insome or all components of the activity.

This includes clients who: • Experience minor, intermittent fatigue inperforming the activity; or • Take longer than would be required for an unimpaired person; • Require some verbal prompting to complete the task

Score 2 ·Cannot perform most of the essential components of the activity, even with an assistive device, and *for* requires a great deal of verbal or physical assistance to accomplish the activity. This includes clients who:

- Experience frequent fatigue or minor exertion in performing the activity; •Take an excessive amount of time to perform the activity; • Must perform the activity much more frequently than an unimpaired person• Require frequent verbal prompting to complete the task.

3 • Cannot perform the activity and requires someone else to perform the task, althoug"i applicant may be able to assist in small ways; or requires constant physical assistance.

Column B: Unmet Need for Care

Score O·The appficanfs need for assistance is met to the extent that the applicant is at no risk to health or safety if additional assistance is not acquired; or the applicant has no need for assistance; or additional assistance will not benefit the applicant.

Score 1 - The applicant's need for assistance is met most of the time, or there is minimal risk to the health and safety of the applicant if additional assistance is not acquired.

Score 2 - The applicant's need for assistance is not met most of the time, or there is moderate risk to the health and safety of the applicant if additional assistance is not acquired.

Score 3 - The applicanfs need for assistance is seldom or

DETERMINATION OF NEED- REVISED (DON-R)

			Member's Name:
Function	Column A LOl	Column B Unmet Need	Comments: If scores 1-3give reason why client needs assistance ie bad leg, weak arm, dementia etc
7. Managing Money			
8. Tephoning			
9. Preparing Meals			
10. Laundiy			
11. Housework			
12.Outside Home			
13. Routine Health			
14. Special Heallh			
15. Being Alo ne			
Total Hi(AOL)			
Total 7-15 (IAOL)			
Total 1-15 (AOL+ IAOL)			

Column A Functional Impairment

Score O - Performs or can perform all essential components of the activity, with or without an assistive device, such that:

- No significant impairment of functioo remains; • Activity is not required by the client • Client may benefit from but does not require verbal or physical assistance.

Score 1 • Performs or can perform most essential components of the activity with or without an assistive device, but some impairment of function remains such that client requires some verbal or physical assistance in some or all components of the activity.

This includes clients who: • Experience minor, intermittent fatigue in performing the activity; or • Take longer than would be required for an unimpaired person; • Require some verbal prompting to complete \he lask

Score 2 - Cannot perform most of the essential components of the activity, even with an assislive device, and/or requires a great deal of verbal or physical assistance to accomplish the activity. This includes clients who:

- Experience frequent fatigue or minor exertion in performing the activity; • Take an excessive amount of time to perform the activity; • Must perform the activity much more frequently than an unimpaired person • Require frequent verbal prompting to complete the task.

3 - Cannot perform the activity and requires someone else to perform the task, although applicant may be able to assist in small ways; or requires constant physical assistance.

Column 8: Unmet Need for Care

Score O - The applicanfs need for assistance is met to the extent that the applicant is at no risk to heallh or safety if additional assistance is not acquired; or the applicant has no need for assistance; or additional assistance will not benefit the applicant.

Score 1 - The applicanfs need for assistance is met most of the time, or there is minimal risk to the health and safety of the applicant if additional assistance is not acquired.

Score 2 - The applicant's need for assistance is not met most of the Ime, or there is moderate risk to the health and safety of the applicant if additional assistance is not acquired.

Score 3 - The applicant's need for assistance is seldom or never met; or there is severe risk to the health and safety of the applicant that would require acute medical intervention if additional assistance is not acquired.

INITIAL/ANNUAL PAPERWORK

THE ELDERLY AND DISABLED WAIYER PROGRAM (EDWP)

What is the EDWP Program?

SOURCE + CCSP (Traditional/Enhanced) are part of the EDWP. Both SOURCE and CCSP assists individuals who are elderly and/or functionally impaired to remain in their homes and/or communities. For eligible consumers, EDWP offers community-based services as an alternative to nursing facility placement. The Department of Community Health administers and operates the EDWP.

What services are available through this program?

Adult Day Health
- Daytime care and supervision in an adult day center
- Nursing and medical social services
- Planned therapeutic activities
- Physical, speech, and occupational therapy
- Meals, including prescribed diets

Alternative Living Services
- Alternative residence for persons unable to remain independent in their own homes
- Meals, personal care, and supervision

Emergency Response Services
- In-home electronic support system providing two-way communication between isolated persons and a medical control center
- Service available 24 hours a day, seven days a week

Home-Delivered Services
- Skilled nursing services
- Physical, speech and occupational therapy
- Medical social services and home health aide assistance
- Personal care and assistance with meals

Personal Support Services
- Assistance with meal preparation, hygiene and nutrition
- Light housekeeping, necessary errands, and other support services
- In-home respite care provided by an aide

Consumer-Directed Personal Support Services option
Same as Personal Support Services, except:
- Consumer hires and supervises worker(s) of choice
- Clients enrolled in the option are requ ired to choose a Financial Management Services provider that will issue paychecks and adhere to federal and state tax laws on behalf of the client

Structured Family Caregiver
- Provides support, education and oversight on behalf of waiver members whose family caregiver lives in the home with the member.
- Live-in family member works with SFC provider's health coach while supporting the member to maximize the highest level of independence for the member by provid ing necessary care and suppo1t.

Out-of Home Respite Care
- Out-of-home overnight respite care in an approved facility with 24-hour supervision

Home Delivered Meals
- Prepared outside the home and delivered to the client

Case Management (Enhanced and Traditional)
- Process which includes assessing, implementing, coordinating, monitoring, evaluating options and services requ ired to meet individual needs and making referrals as needed

Who is eligible for EDWP?
The eligibility criteria for EDWP include the following:
- Functional impairment caused by physical limitations NOTE: Alzheimer's and dementia are physical conditions.
- Unmet need for care
- Approval of an intermediate level of care (LOC) certification for nursing home placement
- Approval of care plan by client's physician
- Med icaid eligible or potentially eligible after admission to EDWP
- Client chooses community-based, rather than institutional services
- Services fall within the average annual cost of Med icaid reimbmsed care provided in a nursing facility. Health and safety needs can be met by EDWP
- Paiticipation in one waiver program at a time
- Medicare home health services or hospice (Medicare or Med icaid) does not meet consumer need for services
- Home Delivered Meals is not the only service need
- The home environment is free of illegal behavior and threats of bod ily harm to other persons.

A client is not required to be homebound to receive EDWP se1vices.

How does an individual obtain EDWP Services?

Step 1: The individual contacts the Area Agency on Aging for an EDWP assessment for Traditional/Enhanced care. The individual with active full Medicaid can contact the AAA or a SOURCE site for assessment.

Step 2: If the individual is eligible for EDWP, the care coordinator and the member/representative collaborate to detennine which services the applicant needs.

How are services arranged?

Step 1: The case management arranges for EDWP service agencies to provide the needed services.
Service agencies are approved Medicaid providers who bill the Department of Community Health directly for services rendered to EDWP clients. Care coordinators also anange for client services through other service agencies and fund sources.

Step 2: If the individual is not a Medicaid recipient, she/he applies for Medicaid at the local county office of the Division of Family and Children Services.

Step 3: The case management maintains regular contact with EDWP clients to assure that services are appropriate and that individuals' needs are met. Client /family representative participates in the development of the client care plan.

What are the financial eligibility requirements?

The following information summarizes the financial eligibility criteria for the EDWP.

- SSI category: Persons who receive Supplemental Security Income (SSI) and are eligible for medical assistance. The Social Security Administration takes applications for SSL

- Medical Assistance Only (MAO) category: Persons who do not receive cash benefits under the SSI program may qualify for medical assistance under another Medicaid category. The county Depaiiments of Family and Children Services take applications for MAO. MAO pa1iicipants may have to pay toward the cost of services.

	SSI Income Limits:*	**Waiver Medicaid/ MAO Income Limits:**	**SSI and Waiver Medicaid Resource Limits:**
Individual	Below $783/ Month	$2,349/month	$2,000 or less
Couple (both in EDWP)	Below $1,175/ Month	$2,349/month per individual	$3,000 or less
Individual in EDWP, But married	Below $1,175/Month	$2,349/month	$2,000 or less for SSI $126,420 (combined) or less for EDWP Medicaid**

* These limits change when the Social Security Administration increases Social Security and SSL

** If the EDWP Medicaid applicant has a spouse who is neither in EDWP nor in an institution, the assets of the spouse MUST be considered in the eligibility determination. The combined total of **countable** assets of the individual and the spouse must be $126,420.00 or less. The EDWP client must transfer assets in his/her name in excess of $2,000 to the community spouse within one year from the month Medicaid eligibility begins. A waiver Medicaid eligible person may dive1t up to $3160.50 per month of income to a legal spouse who is neither in the EDWP nor an institution. The legal spouse's income is deducted from the $3,160.50 limit before determining the amount of income to dive1t.

Elderly and Disabled Waiver
Aging and Disability Resource Connection and Geographic Service Areas

Listed below are Georgia's 12 Planning & Service Areas. Each agency, called Area Agency on Aging (AAA), coordinates a variety of services and resource information for the elderly and disabled, including assessment and referral to programs including EDWP (Traditional/Enhanced + Source). The AAA serves as the EDWP's entry point, determines both consumer eligibility and the type of services needed.

ATLANTA REGIONAL COMMISSION
EDWP Information- (404) 463-3333 (Atlanta)
Area Agency on Aging- (404) 463-3100 (Atlanta)
Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Rockdale, and Henry.

CENTRAL SAVANNAH RIVER
EDWP Information- 1-888-922-4464 or (706) 210-2018
Area Agency on Aging (706) 210-2018 (Augusta)
Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington and Wilkes.

COASTAL GEORGIA
EDWP Information - 1-800-580-6860
Area Agency on Aging- (912) 437-0800
Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long and Mcintosh.

HEART OF GEORGIA /ALTAMAHA
EDWP Information - 1-888-367-9913 or (912) 367-3648
Area Agency on Aging - (912) 367-3648 (Baxley)
Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler and Wilcox.

LEGACY LINK
EDWP Information- 1-800-845-LINK or (770) 538-2650
Area Agency on Aging - (770) 538-2650 (Oakwood)
Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union and White.

MIDDLE GEORGIA
EDWP Information- (478) 751-6466
Area Agency on Aging (478) 751-6466 or 1-888-548-1456
Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs and Wilkinson.

NORTHEAST GEORGIA
EDWP Information-1-800-4 74-7540 or (706) 583-2546
Area Agency on Agency - (706) 583-2546
(Athens) Barrow, Clarke, Elbe1t, Greene,
Jackson, Jasper, Mad ison, Morgan, Newton,
Oconee, Oglethorpe and Walton.

NORTHWEST GEORGIA
EDWP Information - 1-800-759-2963 or (706) 802-5506
Area Agency on Aging- (706) 295-6485
Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd,
Gilmer, Gordon, Haralson, Murray, Pauld ing, Pickens,
Polk, Walker and Whitfield.

RIVER VALLEY REGIONAL COMMISSION
EDWP Information- (706) 256-2900 or 1-800-615-4379
Area Agency on Aging- (706) 256-2900 (Columbus)
Chattahoochee, Clay, Crisp, Dooly, Harris, Macon,
Marion, Muscogee, Qu itman, Randolph, Schley,
Stewait, Sumter, Talbot, Taylor and Webster.

SOUTHERN GEORGIA
EDWP Information- (912) 287-5888 or 1-888-732-4464
Area Agency on Aging - (912) 285-6097(Waycross)
Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks,
Charlton, Cl inch, Coffee, Cook, Echols, Irwin, Lanier,
Lowndes, Pierce, Tift, Turner and Ware.

SOUTHWEST GEORGIA (SOWEGA)
EDWP Information- (229) 432-1124
(Albany) Area Agency on Aging- 1-800-282-
6612 or (229) 432-1124 (Albany)
Baker, Calhoun, Colquitt, Decatur, Dougherty, Early,
Grady, Lee, Miller, Mitchell, Seminole, Terrell,
Thomas and Wmth.

THREE RIVERS REGIONAL COMMISSION
EDWP Information-(706) 675-6721 or (770) 854-6026
Area Agency on Aging - 1-866-854-5652
678-552-2838 (Franklin) (770) 854-6026 (Atlanta)
Butts, Carroll, Coweta, Heard, Lamar, Meriwether,
Pike, Spalding, Troup and Upson.

CCSP

360 LLC Case Management TCM/ECM

Main Number: 803-226-0236
Fax: 803-226-0335
35 Varden Dr., Suite A
Aiken, South Carolina 29803

Counties: Burke, Columbia, Jefferson, Lincoln, McDuffie, Richmond, Warren, Washington and Wilkes

A Step Above Case Management, Inc. TCM/ECM

50 Hurt Plaza SE Unit 1108
Atlanta, GA 30303
404-790-0317
FAX:

Counties: Clayton, Cobb, DeKalb, Douglas, Fulton, Gwinnett and Henry

Action Pact TCM/ECM

Waycross + Administration
P.O. Box 1965 Waycross, GA 31502
2100 Riverside Avenue
Waycross, GA 31501
Main Number: 912-285-6083
Fax: 912-285-6284

Counties: Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner and Ware

Reidsville
P.O. Box 1550
111 Medical Arts Drive
Reidsville, GA 30453
Main Number: 912-557-6687
Emergency Number: 229-868-8407
Fax: 912-557-3039

Counties: Appling, Bleckley, Bryan, Bulloch, Candler, Chatham, Dodge, Emanuel, Evans, Glynn, Jeff Davis, Johnson, Laurens, Liberty, Long, McIntosh, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler and Wilcox.

Andrea Monday Case Management Services TCM

105 Troy Edwards Rd.
Eatonton, Ga 31024
(706) 473-3662

Counties: Baldwin, Bibb, Cobb, Crawford, DeKalb, Fulton, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs and Wilkinson

B & B Care Services Inc TCM/ECM

Springfield
303 S Laurel St.
PO Box 1040
Springfield Ga 31329
Main Number: 912-754-0817
Fax: 888-284-6039

Regions- Coastal, CSRA and NE

Macon
3676 Fairmont Ave
PO Box 1040
Macon, GA 31204
Phone: (912) 754-0817
Fax: 888-284-6039

Regions- ARC, Ga. Mtns, Heart, Middle, River Valley, SOWEGA and Three Rivers

Care Assurance Aging Care Management TCM/ECM

310 Horseshoe Bend
Woodstock, Ga 30189
Main Number- 770-835-4085 ext 800
Fax- 770-828-0502

Counties: Bartow, Cherokee, Clayton, Cobb, Coweta, DeKalb, Fulton, Gwinnett, Henry and Rockdale

Care Lync Georgia, LLC TCM/ECM

1372 Peachtree St NE
Atlanta, GA 30309
Main Number- 833-333-5962
Fax- 215-904-5073

Counties: Cherokee, Clayton, Cobb, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry and Rockdale

Creative Case Management

280 Beckenham Walk Dr.
Dacula, Ga 30019
Ph: 678-668-0222
Fax: 678-535-2963

Counties: Barrow, Clarke, Clayton, Cobb, DeKalb, Fulton, Gwinnett, Henry, Rockdale and Walton

Crew Consulting Services

200 Suddeth St
Winterville, GA 30683
Ph: 706-338-5544
Fax:

Counties: Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe and Walton

D&B Case Management Firm, LLC TCM/ECM

1216 Dawson Rd STE 211
Albany, GA 31707
Ph: 229.446.7332
Fax: 229.446.7435

Counties: Baker, Colquitt, Dougherty, Early, Grady, Lee, Mitchell, Terrell, Thomas and Worth

Diversified Resources Inc. TCM/ECM

Waycross + Admin
147 Knight Avenue Circle
P.O. Box 1099
Waycross, GA 31502
Main Number: 912-285-3089
Fax: 912-285-0367
Emergency Number: 800-283-0041

Counties: Appling, Atkinson, Bacon, Brantley, Camden, Charlton, Clinch, Coffee, Glynn, Jeff Davis, Liberty, Long, McIntosh, Pierce, Ware and Wayne

Camilla
34 S Scott St.
Camilla, GA 31730
Main Number: 229-522-3770
Fax: 229-522-3161
Toll Free: 888-597-3511

Counties: Baker, Calhoun, Decatur, Dougherty, Early, Miller, Mitchell, Seminole

Tifton
1411 U.S. Highway 41N
P.O. Box 7614
Tifton, GA 31793
Main Number: 229-386-9296
Fax: 229-386-9271
Emergency Number: 800-575-7004

Counties: Ben Hill, Colquitt, Irwin, Lee, Telfair, Terrell, Tift, Turner, Wilcox and Worth

Valdosta
2700-C N. Oak Street
Valdosta, GA 31601
Main Number: 229-253-9995
Fax: 229-253-9930
Emergency Number: 800-706-9674

Counties: Berrien, Brooks, Cook, Echols, Grady, Lanier, Lowndes and Thomas

Faith Health Services of GA Inc. TCM/ECM

770-416-1910
Fax: 770-925-1448
5325 Oakbrook Pkwy, Norcross, GA, 30093

Counties: Barrow, Carroll, Cherokee, Clarke, Cobb, Coweta, Clayton, Dekalb, Douglas, Fayette, Fulton, Forsyth, Gwinnett, Hall, Henry, Newton, Oconee, Paulding, Rockdale, Spalding and Walton

Ga Infirmary DBA St. Joseph's/Candler Health System TCM/ECM

Savannah
912-819-1520 or 866-218-2259
Fax 912-819-1548
1900 Abercorn Street, Savannah, GA 31401

Counties: Brantley, Bryan, Bulloch, Camden, Candler, Chatham, Effingham, Glynn, Liberty, McIntosh

Baxley
866-835-0709 or 912-367-6108
Fax 912-367-0392
68 North Oak St. Suite E Street, Baxley, GA 31513

Counties: Appling, Bacon, Brantley, Coffee, Dodge, Emanuel, Evans, Jeff Davis, Liberty, Long, Montgomery, Pierce, Tattnall, Telfair, Toombs, Treutlen, Ware, Wayne and Wheeler

Legacy Link Inc TCM/ECM

Oakwood
Main Number: 770-538-2650 or 1-800-845-LINK Fax: 770-538-2660 or 770-538-2791

Counties: Banks, Barrow, Cherokee, Clarke, Dawson, Elbert, Forsyth, Franklin, Gwinnett, Hall, Habersham, Hart, Jackson, Lumpkin, Madison, Rabun, Stephens, Towns, Union, and White

Legacy Link Inc TCM/ECM (cont')

Rome
901 N. Broad St. STE 220
Rome, Ga. 30161
Main Number:678.252.3000
Link Fax: 706.622.2399

Counties: Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, , Murray, Paulding, Pickens, Polk, Walker, and Whitfield

Lower Chattahoochee Direct Services TCM/ECM

Americus
P.O. Box 1668
Americus, GA 31709
Main Number: (229) 928-8730
Fax: (229) 928-8732

Counties: Crisp, Dooly, Macon, Marion, Schley, Stewart, Sumter, Taylor, and Webster

Columbus
1500 Second Avenue
Columbus, GA 31901
Main Number: 706-321-9545
Fax: (706) 596-8517

Counties: Chattahoochee, Clay, Harris, Muscogee, Quitman, Randolph, and Talbot

McIntosh Trail Mgmt. Services- TCM/ECM

Franklin
P.O. Box 310
Franklin, GA 30217-0310
Main Number: 706-675-2985 or 706-675-6495 or 770-854-4463 Fax: 706-675-1648

Counties: Carroll, Coweta, Harris, Heard, Meriwether and Troup

McIntosh Trail Mgmt. Services- TCM/ECM

Macon
2719 Sheraton Drive, Suite C-120
Executive Drive North
Macon, GA 31204
Main Number: 478-752-3260
Fax: 478-752-1058

Counties: Baldwin, Bibb, Crawford, Houston, Jones, Macon, Monroe, Pulaski, Peach, Putnam, Twiggs and Wilkinson

McIntosh Trail Mgmt. Services- TCM/ECM

Griffin
246 O'Dell Rd. STE 5 Griffin, GA 30224
Main Number: 770-567-5948 Fax: 770-567-5953

Counties**:** Butts, Fayette. Lamar, Pike, Spalding, and Upson

On My Watch TCM/ECM

Athens

1711 Prince Avenue
Athens, GA 30606
Main Number: 706-354-1621 or
Toll Free 1-800-689-5123
Fax: 706-354-0837
Emergency / On-Call Number: 706-540-5934

Counties: Banks, Barrow, Clarke, DeKalb, Elbert, Franklin, Fulton, Greene, Gwinnett, Hall, Hart, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Putnam, Rockdale, and Walton

On My Watch TCM/ECM

Augusta

119 Davis Road, Suite 9A
Martinez, GA 30907
Main Number: 706-707-8005 or
Toll Free 1-800-371-1352
FAX: 706-869-2295
Emergency/On-Call Number: 706-466-1005

Counties: Baldwin, Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes and Wilkinson

Savannah- Served via the Augusta office
Main Number: 912-544-4699
FAX: 912-544-4698

Counties: Bryan, Bulloch, Chatham, Effingham, Evans, and Liberty,

Pruitt Health Home First TCM/ECM

Regional Directors
800-632-2101
6050 Appalachian Highway
Blue Ridge, Georgia 30513

770- 925-1143
1626 Jergens Court.
Norcross, GA 30093

Athens Home First

706-549-3315, Fax: 706-543-3841
1751 Meriweather Drive Watkinsville, Georgia 30677

Counties: Banks, Barrow, Clarke, Elbert, Franklin, Greene, Habersham, Hart, Jackson, Madison, Morgan, Oconee, Oglethorpe, Stephens, Walton

Pruitt Health Home First TCM/ECM

Atlanta Home First

770-925-1143 Fax: 678 533-6488
1626 Jeurgens Court Norcross GA 30093

Counties: Carroll, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Newton, Paulding, Polk, Rockdale and Troup

Blue Ridge Home First

706-632-9263, Fax 706-632-0028
6050 Appalachian Hwy Blue Ridge, GA 30513

Counties: Bartow, Catoosa, Cherokee, Chattooga, Dade, Dawson, Fannin, Floyd, Gilmer, Gordon, Lumpkin, Murray, Pickens, Rabun, Towns, Union, Walker, White, Whitfield

Macon Home First

478-474-0979 Fax: 478-474-2068
6060 Lakeside Commons Drive Macon, GA 31210

Counties: Baldwin, Bibb, Butts, Crawford, Harris, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriwether, Monroe, Montgomery, Peach, Pike, Putnam, Spalding, Talbot, Taylor, Treutlen, Twiggs, Upson, Wheeler, Wilkinson

Savannah Home First

912-925-9181 Fax: 912-925-9341
9100 White Bluff Rd STE 303 Savannah, Ga 31406

Counties: Appling, Bacon, Bryan, Bulloch, Brantley, Camden, Candler, Charlton, Chatham, Effingham, Evans, Glynn, Liberty, Long, McIntosh, Pierce, Tattnall, Toombs and Wayne

SOURCE Care Management dba NextStep Care TCM/ECM

Columbus

2320 Double Churches Rd. STE A
Columbus Ga 31909
Main Number: 888-762-2420
Fax: 706-257-1006

Counties: Chattahoochee, Clay, Harris, Marion, Meriwether, Muscogee, Quitman, Randolph, Schley, Stewart, Talbot, Troup and Webster

Macon

2000 A Northside Crossing
Macon, Ga 31210
Main Number: 888-762- 2420
Fax: 478-621-7538

Counties: Baldwin, Bibb, Bleckley, Butts, Crawford, Dodge, Houston, Jones, Lamar, Macon, Monroe, Peach, Pike, Pulaski, Putnam, Spalding, Taylor, Twiggs, Upson and Wilkinson.

Visiting Nurse Health System TCM/ECM

Atlanta

5775 Glenridge Drive, NE Suite E200
Atlanta, GA 30328
Ph: 404-581-4782; Fax: 404-527-0606

Counties: Barrow, Butts, Carroll, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Jasper, Newton, Rockdale, Spalding and Walton

Rome
109 W. 8th Ave.
Rome, Ga. 30161
Ph: 706.525.6053 Fax: 404.443.1296

Counties: Bartow, Chattooga, Cherokee, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk and Whitfield.

SOURCE

360 LLC Case Management SOURCE

803-226-0236
Fax: 803-226-0335
35 Varden Dr., Suite A
Aiken, South Carolina 29803

Counties: Burke, Columbia, Lincoln, McDuffie, Richmond, Washington and Wilkes

Ace Care Management SOURCE

Ph: 844-937-4223, Fax: 844-937-4223
(follow prompts)
236 Auburn Ave., Ste. 205
Atlanta, Georgia 30303

Counties: Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Rockdale, Spalding and Walton

Albany ARC SOURCE

(229) 883-2334; Fax: (229) 883-2710
2200 Stuart Ave., Albany, Georgia 31707

Counties: Baker, Calhoun, Clay, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth

Atlanta Pro Health LLC SOURCE

Office: 404-832-5030
Fax: 470-275-6812
6251 Smithpoint Dr.
Norcross, GA 30092

Counties: Bartow, Cherokee, Clayton, Cobb, DeKalb, Floyd, Fulton, Gwinnett, Rockdale and Walton

Care Assurance Aging Care Management TCM/ECM

310 Horseshoe Bend
Woodstock, Ga 30189
Main Number- 770-835-4085 ext 800
Fax- 770-828-0502

Counties: Bartow, Cherokee, Clayton, Cobb, Coweta, DeKalb, Fulton, Gwinnett, Henry and Rockdale

Care Lync Georgia, LLC TCM/ECM

1372 Peachtree St NE
Atlanta, GA 30309
Main Number- 833-333-5962
Fax- 215-904-5073

Counties: Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry and Rockdale

Crew Consulting Services (Pending)

200 Suddeth St
Winterville, GA 30683
Ph: 706-338-5544
Fax:

Counties: Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe and Walton

Crisp Care Management SOURCE

229 276-2126 Fax: 229-271-4669
910 North 5th Street, Cordele, GA 31015

Counties: Crisp, Dooly, Macon, Pulaski, Sumter, Wilcox

Crossroads Community SOURCE

Office: 478-224-6677
Fax: 478-988-0093
311 12th St. West STE 6
Tifton, GA 31794

Counties: Ben Hill, Berrien, Coffee, Colquitt, Cook, Irwin, Lee, Tift, Turner, and Worth

Office: 478-224-6677
Fax: 478-988-0093
1203 Ball St. Perry, GA 31069

Counties: Bibb, Bleckley, Crawford, Crisp, Dodge, Dooly, Houston, Jones, Laurens, Macon, Monroe, Peach, Pulaski, Sumter, Taylor, Telfair, Twiggs, Wilcox and Wilkinson

D&B Case Management Firm, LLC SOURCE

1216 Dawson Rd STE 211
Albany, GA 31707
Ph: 229.446.7332
Fax: 229.446.7435

Counties: Baker, Colquitt, Dougherty, Early, Grady, Lee, Mitchell, Terrell, Thomas and Worth

Diversified Resources Inc. SOURCE

Camilla
Main Number: 229-522-3770
Fax: 229-522-3161
Toll Free: 888-597-3511
34 S Scott St.
Camilla, GA 31730

Counties: Baker, Calhoun, Decatur, Dougherty, Early, Miller, Mitchell, Seminole,

Diversified Resources Inc. SOURCE (continued)

Tifton
229- 386-9296 or 800-575-7004
1411 US Highway 41 North
P.O. Box 7614
Tifton, Georgia 31793

Counties: Ben Hill, Colquitt, Irwin, Lee, Telfair, Terrell, Tift, Turner, Wilcox and Worth

Valdosta
229-253-9995 or 800-706-9674
2700-C N. Oak Street
Valdosta, Ga. 31602

Counties: Berrien, Brooks, Cook, Echols, Grady, Lanier, Lowndes and Thomas

Waycross
912-285-3089 Fax: 912-285-0367
Emergency Number: 800-283-0041
147 Knight Avenue Circle
P. O. Box 1099 (31502)
Waycross, Georgia 31503
Counties**:** Appling, Atkinson, Bacon, Brantley, Camden, Charlton, Clinch, Coffee, Glynn, Jeff Davis, Liberty, Long, McIntosh, Pierce, Ware and Wayne

Faith Health Services of GA Inc. SOURCE

770-416-1910
Fax: 770-925-1448
5325 Oakbrook Pkwy, Norcross, GA, 30093

Counties: Barrow, Carroll, Cherokee, Clarke, Cobb, Coweta, Clayton, Dekalb, Douglas, Fayette, Fulton, Forsyth, Gwinnett, Hall, Henry, Newton, Oconee, Paulding, Rockdale, Spalding and Walton

Ga Infirmary DBA St. Joseph's/Candler Health System SOURCE

Baxley
866-835-0709 or 912-367-6108
Fax 912-367-0392
68 North Oak St. Suite E Street, Baxley, GA 31513

Counties: Appling, Bacon, Brantley, Coffee, Dodge, Emanuel, Evans, Jeff Davis, Liberty, Long, Montgomery, Pierce, Tattnall, Telfair, Toombs, Treutlen, Ware, Wayne and Wheeler

Savannah
912-819-1520 or 866-218-2259
Fax 912-819-1548
1900 Abercorn Street, Savannah, GA 31401

Brantley, Bryan, Bulloch, Camden, Candler, Chatham, Effingham, Glynn, Liberty, McIntosh

Legacy Link Inc SOURCE

Oakwood
770-538-2668; 770-538-2669
4080 Mundy Mill Road, Oakwood, GA 30566

Counties: Banks, Barrow, Cherokee, Clarke, Dawson, Elbert, Forsyth, Franklin, Gwinnett, Habersham, Hall, Hart, Jackson, Lumpkin, Madison, Rabun, Stephens, Towns, Union, and White.

Rome
901 N. Broad St. STE 220
Rome, Ga. 30161
Main Number:678.252.3000
Link Fax: 706.622.2399

Counties: Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, , Murray, Paulding, Pickens, Polk, Walker,Whitfield

Next Step Care SOURCE
Corporate Office
15 Merritt Street
P.O. Box 952
Hawkinsville, GA 31036
Ph: 478-621-2070

Referral Intake
10 South Broad Street, P.O. Box 25 Butler, GA 31006
Ph: 478-862-5886
Alt Number: 888-762-2420
Fax: (478) 862-9111

Next Step Care Offices
Albany
Ph: 888-762-2420
Fax: 229-431-0525
507 N Jefferson St, Albany, GA 31701
Counties: Ben Hill, Crisp, Dooly, Dougherty, Irwin, Lee, Sumter, Terrell, Turner, Wilcox, Worth

Augusta
Ph: 888-762-2420
Fax: 706-737-0250
2100 Central Avenue Suite #5, Augusta 30904

Counties: Burke, Columbia, Richmond

Athens
Ph: 888-762-2420
Fax: 706-543-8293
405 Gaines School Rd., Athens, GA 30605
Counties: Banks, Barrow, Clark, Elbert, Franklin, Habersham, Hart, Jackson, Madison, Oconee, Oglethorpe, Rabun, Stephens, Towns, White

Butler
Ph: 888-762-2420
Fax: 478-862-4844
12 South Broad Street, P.O. Box 89 Butler, GA 31006

Counties: Crawford, Macon, Marion, Peach, Pike, Schley, Spalding, Talbot, Taylor, Upson

Next Step Care Offices (continued)

Columbus
Ph: 888-762-2420
Fax: 706-257-1006
2320 Double Churches Rd. Suite A
Columbus, GA 31909

Counties: Chattahoochee, Clay, Harris, Muscogee, Quitman, Randolph, Stewart, Webster

Conyers
Ph: 888-762-2420
Fax: 770- 388 - 7539
1506 Klondike Road, Conyers, Ga. 30094

Counties: Rockdale, Walton, Newton, Henry, Dekalb

Duluth
Ph: 888-762-2420
Fax: 770-717-2692
2825 Breckenridge Blvd., Suite 130, Duluth, GA 30096

Counties: Gwinnett, Fannin, Gilmer, Pickens, Cherokee, Union, Lumpkin, Dawson, Forsyth, Hall

Eatonton
Ph: 888-762-2420
Fax: 706- 485-4159
951 Harmony Rd, Suite 104, Eatonton, GA 31024
Counties: Baldwin, Greene, Hancock, Jasper, Lincoln, McDuffie, Morgan, Putnam, Taliaferro, Warren, Wilkes

Macon
Ph: 888-762-2420
Fax: 478-621-7538
2000 A Northside Crossing Macon, GA 31210

Counties: Bibb, Bleckley, Butts Dodge Houston, Jones, Lamar, Monroe, Pulaski, Twiggs

Next Step Care Offices (continued)

Metter
Ph: 888-762-2420
Fax: 912- 685-7640
58 SE Broad Street, P.O. Box 631 Metter, GA 30439

Counties: Bulloch, Candler, Emanuel, Evans, Jeff Davis, Jenkins, Montgomery, Screven, Tattnall, Telfair, Toombs, Treutlen, Wheeler, Appling, Atkinson, Bacon, Brantley, Bryan, Camden, Charlton, Chatham, Clinch, Coffee, Effingham, Glynn, Liberty, Long, McIntosh, Pierce, Ware, Wayne

Rome
Ph: 888-762-2420
Fax: 706-378-1330
413 Shorter Ave., Suite 111, Rome, GA 30165

Counties: Bartow, Catoosa, Chattooga, Cobb, Dade, Floyd, Gordon, Haralson, Murray, Paulding, Polk, Walker, Whitfield

Thomasville
Ph: 888-762-2420
Fax: 229- 227- 6156
14004 Hwy. 19 S. Suite 101, Thomasville, GA 31757

Counties: Baker, Brooks, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Miller, Mitchell, Seminole, Thomas, Tift, Berrien, Cook, Lanier, Lowndes, Echols

Tyrone
Ph: 888-762-2420
Fax: 770-742-0913
602 Dogwood Trail, Suite A, Tyrone, GA 30290

Counties: Carroll, Coweta, Douglas, Fayette, Heard, Meriwether, Troup, Fulton, Clayton

Next Step Care Offices (continued)

Wrightsville
Ph: 888-762-2420
Fax: 478- 864-9423
8647 Marcus Street, Wrightsville, GA 31096

Counties: Glascock, Jefferson, Johnson, Laurens, Washington, Wilkinson

On My Watch SOURCE

Athens
1711 Prince Avenue
Athens, GA 30606
Ph: 706-354-1621 or toll free 1-800-689-5123
Fax: 706-354-0837
Emergency/On-Call Number: 706-540-5934

Counties: Banks, Barrow, Clarke, DeKalb, Elbert, Franklin, Fulton, Greene, Gwinnett, Hall, Hart, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Putnam, Rockdale, and Walton

Augusta
119 Davis Road, Suite 9A
Martinez, GA 30907
Ph: 706-707-8005 or toll free 1-800-371-1352
Fax: 706-869-2295
Emergency / On-Call Number: 706-466-1005

Counties: Baldwin, Bryan, Bulloch, Burke, Chatham, Columbia, Evans, Glascock, Hancock, Jefferson, Jenkins, Liberty, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes and Wilkinson

Savannah
Counties: Bryan, Bulloch, Chatham, Effingham, Evans, and Liberty,
Main Number: 912-544-4699
FAX: 912-544-4698

Piedmont Columbus Regional Healthcare System SOURCE

(706) 571-1946; Fax: (706) 660-6279
1900 10th Avenue, STE 100
Columbus GA, 31901

Counties: Chattahoochee, Harris, Marion, Muscogee, Talbot, Stewart, Meriwether, Upson, Pike, Taylor, Troup

Pruitt Health Home First SOURCE

Regional Directors
800-632-2101
6050 Appalachian Highway
Blue Ridge, Georgia 30513

770- 925-1143
1626 Jergens Court.
Norcross, GA 30093

Albany Home First

Ph: 229-878-0128, Fax: 229-878-1093
202 North Westover Blvd. Albany, Georgia 31707

Counties: Baker, Ben Hill, Bleckley, Calhoun, Chattahoochee, Clay, Crisp, Dodge, Dooly, Daugherty, Early, Irwin, Lee, Macon, Marion, Mitchell, Muscogee, Pulaski, Quitman, Randolph, Schley, Stewart, Sumter, Telfair, Terrell, Tift, Turner, Webster, Wilcox, Worth

Athens Home First

706-549-3315, Fax: 706-543-3841
1751 Meriweather Drive Watkinsville, Georgia 30677

Counties: Banks, Barrow, Clarke, Elbert, Franklin, Greene, Habersham, Hart, Jackson, Madison, Morgan, Oconee, Oglethorpe, Stephens, Walton

Pruitt Health Home First SOURCE (Continued

Atlanta Home First

770-925-1143 Fax: 678 533-6488
1626 Jeurgens Court Norcross GA 30093

Counties: Carroll, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Newton, Paulding, Polk, Rockdale, Troup

Augusta Home First

706-651-1535, Fax: 706 863-9401
1220 Augusta West Parkway Augusta, Georgia 30909

Counties: Burke, Columbia, Emanual, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes

Blue Ridge Home First

706-632-9263, Fax 706-632-0028
6050 Appalachian Hwy Blue Ridge, GA 30513

Counties: Bartow, Catoosa, Cherokee, Chattooga, Dade, Dawson, Fannin, Floyd, Gilmer, Gordon, Lumpkin, Murray, Pickens, Rabun, Towns, Union, Walker, White, Whitfield

Macon Home First

478-474-0979 Fax: 478-474-2068
6060 Lakeside Commons Drive Macon, GA 31210

Counties: Baldwin, Bibb, Butts, Crawford, Harris, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriweather, Monroe, Montgomery, Peach, Pike, Putnam, Spalding, Talbot, Taylor, Treutlen, Twiggs, Upson, Wheeler, Wilkinson

Pruitt Health Home First SOURCE (Continued

Savannah Home First

Ph: 912-925-9181, Fax: 912-925-9341
9100 White Bluff Road, Ste. 303 Savannah, Georgia 31406

Counties: Appling, Bacon, Brantley, Bryan, Bulloch, Camden, Candler, Charleton, Chatham, Effingham, Evans, Glynn, Liberty, Long, McIntosh, Pierce, Tattnall, Toombs Wayne

Valdosta Home First
229-241-8750 Fax: 229-241-8940
312 Canna Drive Valdosta, Georgia 31602

Counties: Atkinson, Berrien, Brooks, Clinch, Coffee, Colquitt, Cook, Decatur, Echols, Grady, Jeff Davis, Lanier, Lowndes, Miller, Seminole, Thomas, Ware

Trinity Case Management SOURCE

(706) 507-5510 or (706) 507-5517
Fax: (706) 507-5550
5510 Veterans Parkway Suite 103
Columbus, Ga. 31904

Counties: Chattahoochee, Clay, Harris, Muscogee, Meriwether, Marion, Quitman, Randolph, Stewart, Talbot, and Webster

Visiting Nurse Health System SOURCE

Atlanta
5775 Glenridge Drive, NE Suite E200
Atlanta, GA 30328
Ph: 404-581-4782; Fax: 404-527-0606

Counties: Barrow, Bartow, Butts, Carroll, Chattooga, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Floyd, Forsyth, Fulton, Gordon, Gwinnett, Hall, Haralson, Henry, Jasper, Newton, Paulding, Pickens, Polk, Rockdale, Spalding and Walton

Rome (coming soon)
101 E. 2nd Ave. STE 220
Rome, Ga. 30161
Ph: 706.525.6053 Fax: 404.443.1296

Counties: Bartow, Chattooga, Floyd, Gordon, Haralson, Paulding, Pickens and Polk.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

The Division of Aging Services (DAS) of the Georgia Department of Human Services (DHS) provides Adult Protective Services (APS) for the prevention of abuse, neglect and exploitation of older individuals (65+) or adults (18+) with a disability who do not reside in long-term care facilities. 1.866.552.4464 option 3 http://aging .dhs.georgia.gov

Healthcare Facility Regulation 1.800.878.6442 (Mandated reporters must report abuse in licensed facilities) www.dch.georgia.gov

State Long-Term Care Ombudsman- 1.866.552-4464 (Advocates for resident in long-term care facilities). www.georgiaombudsman .org

Aging and Disability Resource Connection- www.georgiaadrc.com (Web-based resource guide of partnering organizations) 1.866.552.4464 option 2.

- **Abuse –** is defined as any intentional or grossly negligent act or series of acts or intentional or grossly negligent omission to act which causes injury to a client, including but not limited to assault or battery, failure to provide treatment or care, or sexual harassment of the client. Abuse may be mental, verbal, sexual, or physical.
- **Neglect –** is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.
- **Exploitation** -is defined as an unjust or improper use of another person or the person's property through undue influence, coercion, harassment, duress, deception, false representation, false pretense, or other similar means for one's own profit or advantage.
- **Mistreatment –** is defined as any behavior or practice that has the potential to or results in any type of individual exploitation.
- **Unexpected Death** -is defined as death that occurs suddenly when the individual is in apparent good health or as the result of homicide, suicide, or accident.
- **Serious Injury** -is defined as bodily injury that involves a substantial risk of death, unconsciousness, extreme physical pain, sexual assault, violence, protracted and obvious disfigurement or impairment.
- **Elopement –** is defined as a cognitively impaired person successfully leaving a facility unsupervised and undetected.

Office of Inspector General- (OIG/HHS) Medicare /Medicaid Fraud Control Unit-1.800.447.8477 option 5 http://oig.hhs.gov/fraud/hotline

Food Stamp Fraud (OIG/USDA)- 1.800.447.8477 option 1

Social Security Fraud (OIG/SSA) 1.800.447.8477 option 2

Governor's Office of Consumer Protection- 1.800.869.1123 http://consumer.georgia.gov

Member Signature_____ **Date**_____

FACT SHEET

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Medicaid and Estate Recovery

Overview

Estate Recovery is the process to obtain reimbursement for claims paid by Medicaid from the estate of a deceased Medicaid member. The Estate Recovery statute has existed in Georgia since 1981. Only estates valued at $25,000 or less are exempt from Estate Recovery.

States are required to have an Estate Recovery Program under the provisions of the Omnibus Budget Reconciliation Act of 1993.

Estate Recovery applies to Medicaid members who, at the time of their death:

- Were of any age, and an inpatient in a nursing facility or intermediate care facility for people with mental retardation, or in any other mental institution.
- Were 55 years of age or older when they received home- and community-based services instead of being cared for in an institution.

The Definition of "Estate"

For the purposes of Estate Recovery, the estate is defined as "all real and personal property" as defined in the probate code. The estate also includes real property passing by joint tenancy, right of survivorship, life estate, survivorship, trust, annuity, homestead or any other arrangement. The estate includes excess funds from a burial trust or contract, promissory notes, cash and personal property.

Notifiying OCH about a Member's Death

OCH must be notified in writing within 30 days of the death of the Medicaid member. The notice should be mailed to:

Georgia Department of Community Health
Estate Recovery Unit
Circle 75 Parkway, Suite 650
Atlanta, Georgia 30339



HArdship Criteria

The following criteria will be used to determine whether an undue hardship exists:

- rhe asset to be recovered is an income-producing farm of one or more of the heirs, and the annual gross income is $25,000 or less; or

- The recovery of assets would result in the applicant becoming eligible for governmental public assistance based on need and/or medical assistance programs.

NOTE: If the personal representative of an estate makes a distribution either in whole or in part of the property of an estate without having reimbursed the Medicaid agency, the personal representative may be held personally liable for the amount of the Estate Recovery claim.

Delayed Recovery

Recovery is delayed if:

- The deceased member's spouse is alive.
- The deceased member has a living child under the age of 21.
- The deceased member has a living child of any age who is blind or permanently and totally disabled pursuant to Title XIX of the Social Security Act.

For More Information

For additional information, contact the Medicaid Estate Recovery Unit at 770-916-0328 or visit the OCH website at https://dch.georgia.gov/. Members with questions about Medicaid Estate Recovery may submit them to GAEstateRecovery@dch.ga.gov, or write to Georgia Department of Community Health, Estate Recovery Unit, Circle 75 Parkway, Suite 650, Atlanta, GA 30339, or fax to 678-569-0066. For program information, please visit the following website: http://hms.com/ga/medicaidrecovery/

SOURCE Manual

Member Rights and Responsibilities

Goals:

- Provide community support services to eligible, older and disabled Georgians through Traditional/Enhanced Case Management
- Identify resources to prevent and/or maintain level of disability related to chronic illness
- Promote self-care and informal support
- Increase cost efficiency of Medicaid funds through coordination of medical and long-term support in the community setting

Member rights include to:

- Enroll and receive services from only one Medicaid Waiver Program within the same length of stay
- Receive considerate, respectful care, without discrimination of race, religion, sex or national origin.
- Clear and current information about your health, medical treatments and plan of care.
- Choose to receive services from any practitioner, Case Manager, or SOURCE Enhanced Case Management staff member involved in your care.
- Information necessary to give consent before any procedure and/or treatment, and information on potential alternatives.
- Privacy and confidentiality of your treatment and medical records. Information about you will be released only as necessary for providing effective care, and only with your consent.
- Information on how to make a complaint or an appeal about care received through the SOURCE Enhanced Case Management.
- Participate in decisions involving your care.
- Refuse treatment to the extent allowed by law, and to be informed of the likely medical consequences.
- Choose from the SOURCE Program approved list of community service providers.

Member responsibilities include to:

- Be an active partner in working with your Case Manager, practitioner, and community service providers.
- Allow the SOURCE Case Manager to come into the member's residence and evaluate status and need for support on an ongoing basis.
- Provide clear and complete information regarding your overall health and healthcare, including illnesses/injuries, hospitalizations, medications or anything else that may affect how SOURCE delivers medical and supportive services.
- Help develop and carry out your SOURCE plan of care
- Provide complete and timely information to your Case Manager
- Participate in the plan of care including emergency and discharge preparedness
- Carry out assigned responsibilities as you agreed with your Case Manager
- Notify your Case Manager about changes in the ability or failure to carry out responsibilities as agreed (including support provided by self, family, caregivers, paid support, other) in order for other support to be identified
- Work with SOURCE staff to solve problems in key areas, identified by your Case Manager as goals during your enrollment in the program
- Maintain a safe and healthy home environment.
- Treat your Case Manager, doctors, and service providers in a courteous and respectful manner.

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

ELDERLY AND DISABLED WAIVER PROGRAM
Traditional/Enhanced
AUTHORIZATION FOR RELEASE OF INFORMATION
& INFORMED CONSENT

Client Name:_____ID: _____

_____1. This is to certify that the Elderly and Disabled Waiver Program is hereby authorized to release necessary information including medical data to the agencies which will provide services to me as outlined in the Traditional/Enhanced Comprehensive Care Plan.

_____2. This is to certify that I choose to participate in the Elderly and Disabled Waiver Program-Traditional/Enhanced Services and participation is based on annual renewal/approval of level of care.

_____3. This is to certify that I received information about the Consumer-Direction Option for Personal Support Services

_____4. This is to certify that I received educational/referral information about Abuse, Neglect and Exploitation.

_____5. This is to certify that I choose Nursing Home Placement.

_____6. Discharge plan / Emergency Preparedness plan discussed with client/representative.

_____7. This is to certify that I participated in the development of my Comprehensive Care Plan, including determining which services will be provided to me and which providers I choose through the Traditional/Enhanced Services.

_____8. This is to certify that I have been advised to contact my care coordinator with any service issues/problems.

_____9. I acknowledge the responsibility for the completion of the Elderly and Disabled Waiver Program-Traditional/Enhanced Medicaid application and submission of required documents to determine eligibility.

_____10. ALL OF THE MEDICAL, SOCIAL AND FINANCIAL INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

11. _____
SIGNATURE OF CLIENT OR CLIENT'S REPRESENTATIVE DATE

12. _____
SIGNATURE OF CCSP CARE COORDINATOR DATE

Instructions

Elderly and Disabled Waiver Program-Traditional/Enhanced

AUTHORIZATION FOR RELEASE OF INFORMATION & INFORMED CONSENT

Purpose: This form allows care coordinators to release necessary information including medical data to the agencies that will provide services to the client. It also serves as the client's acknowledgment of information received regarding the Traditional/Enhanced and indicates whether the client chooses Traditional/Enhanced EDWP or Nursing Home Placement.

Who Completes/When Completed:

At initial assessment, the Nurse completes all sections of the fonn, except #3,5,9.
At reassessment, the RN/LPN completes all sections of the form, except #3,5,9.
At Care Path Review, the care coordinator completes items 1, 2, 6, 7, 8 and 10 and other applicable items

Instructions:

1. Client initials in the space provided allowing the care coordinator to release necessary information to the agencies which will provide his/her services

2. Client initials if he/she chooses to participate in the Traditional/Enhanced EDWP

3. Client initials if he/she receives information about CD-PSS option

4. Client initials if he/he receives information about Abuse, Neglect and Exploitation.

5. Client initials if he/she chooses Nursing Home Placement

6. Client initials confirming that discharge plan(s) + emergency preparedness plan(s) have been discussed with client/representative and care coordinator

7. Client initials that he/she has received an oppo1tunity to provide input in determining services which will be provided and which providers (list provided) will be i nvolved by Traditional/Enhanced EDWP as ordered in the CCP

8. Client initials that he/she has received instruction to repo1i problems related to Traditional/Enhanced EDWP services to his/her Care Coordinator

9. Client initials that he/she understands the responsibility of the completion of the Medicaid application for EDWP-Traditional/Enhanced

10. Client initials that all medical, social and financial information provided is true and complete to the best of their knowledge

11. Client or representative signs and dates form at all face to face visits.

12. Care coordinator signs and dates form

Distribution: At initial assessment and reassessment, send a copy to providers. Place the original in the case record.

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Name of Individual/Consumer/Patient/Applicant

Date of Birth

IF AVAILABLE:

ID Number Used by Requesting Agency

ID Number Used by Releasing Agency

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize _____

(Name/Address of Person or Agency Requesting Information)

to obtain from:

(Name/Address of Person or Agency Holding the Information)

the following type(s) of information from my records (and any specific portion thereof):

for the purpose of:

I understand that the federal Privacy Rule ("HfPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not befurther released by the recipient. I further understand that my eligibilityfor benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effectfor : (PLEASE CHECK ONE)

D ninety (90) days unless I specify an earlier expiration date here: _____ (Date)

D one (1) year.

D the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state orfederal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

(Date) (Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness) (Title or relationship to Individual) (Date)

(Signature of Parent or other legally Authorized Representative, where applicable) (Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

(Date this authorization is revoked by Individual)

(Signature of Individual or legally authorized Representative)

Instructions for
Form 5459
Authorization for Release of Information

Purpose: This form is used to obtain permission from an EDWP client or prospective client to share or secure information about the client.

Who Completes/When Completed: EDWP Staff, including APS and Public Guardianship Case Managers; Community Care Services Program (Traditional/Enhanced) Care Coordinators; Money Follows the Person Transition Coordinators or Option Counselors; Other appropriate DCH/DAS, Area Agency on Aging or Sub-contractor staff.

Instructions:

Explain the purpose of the form to the client. Complete the form and ask the client to sign or indicate a witnessed mark (X)

****

Name of Individual/Consumer/Patient/ Applicant: Enter the name of the individual/consumer/patient/applicant.

Date of Birth: Enter the birth date of the individual/consumer/patient/applicant.

IF AVAILABLE:

ID Number Used by Requesting Agency: Enter the ID number used by the requesting agency (may be SSN, Medicaid or Medicare Number, Harmony ID, etc.)

ID Number Used by Releasing Agency: Enter the ID number used by the releasing agency (may be SSN, Medicaid or Medicare Number, AIMS ID, etc.)

****

Name of Person or Agency Requesting Information: Enter the name of the agency requesting information. If DCH: include the Department of Community Health, CCSP Traditional/Enhanced, and the Section Name.

Address of Requesting Agency: Enter the complete address of the requesting agency.

Type of Information requested: Enter the type of information requested. Example: Any medical, social, psychological or treatment information.

For the purpose of: Enter the purpose of the information requested.

Duration of request: Specify the duration of the authorization release (not to exceed one year)

Date/Signature of Individual/Consumer/Patient/ Applicant: Enter the date the client signed the form and have client sign in the space indicated.

Signature of witness: Have witness sign in space indicated and include title or relationship to the Individual/Consumer/Patient/Applicant If the client signs by mark (X)

Signature of Parent or other legally Authorized Representative/Date: Signature of parent, guardian or legally authorized representative if Individual/Consumer/Patient/Applicant is incompetent/under age 18 or has a physical disability that prevents his signing. PGO staff sign here for persons under guardianship where DHS is the guardian.

****

If Authorization is Withdrawn:

Enter date and have Individual or legally authorized representative sign where indicated.

****

Routing: At each completion, place the original in the case record and send copies to each agency/person holding information about the client.

SOURCE PROGRAM PARTICIPATION

DATE / /

DEAR._____

WELCOME TO THE ElLDERLY AND DISABLED WAIVER PROGRAM, ENHANCED SERVICES. THE SOURCE MULTI-DISCIPLINARY TEAM REVIEWED YOUR SITUATION AND RECOMMENDED COMMUNITY-BASED SERVICES THROUGH SOURCE.

THE PROVIDERS YOU SELECTED ARE LISTED BELOW. SOMEONE FROM EACH SERVICE AGENCY WILL BE CONTACTING YOU.

1._____
Provider Agency

_____
Contact Person

_____
Telephone #

2._____
Provider Agency

_____
Contact Person

_____
Telephone #

3._____
Provider Agency

_____
Contact Person

_____
Telephone #

4._____
Provider Agency

_____
Contact Person

_____
Telephone #

AS A PARTICIPANT IN THE ELDERLY AND DISABLED PROGRAM:

YOU WILL NOT LOSE ANY MEDICAL ASSISTANCE BENEFITS THAT YOU ARE CURRENTLY RECEIVING BY PARTICIPATING IN THE ELDERLY AND DISABLED PROGRAM.

YOU MAY WITHDRAW FROM SOURCE AT ANY TIME.

PLEASE CONTACT THE CASE MANAGER LISTED BELOW OR YOU MAY HAVE SOMEONE CALL ON YOUR BEHALF IF YOU HAVE QUESTIONS OR NEED ADDITIONAL INFORMATION.

CASE MANAGER_____

TELEPHONE NUMBER_____

MEMBER CHOICE OF PROVIDER FORM

Member:_____ Date:_____

Issues Noted	**Services Recommended**	**Provider**	Member Choice of PCP	**Frequency**	**Participant Feedback**
			MC PC		
			MC PC		
			MC PC		
			MC PC		
			MC PC		

_____ _____

Member Signature Date

_____ _____

Case Manager Signature Date

s;c;ans please fill jn hjghlighted argas *&pecif;callv* jtems *19 20 and vgur signature on line 37 Thank vgu*

PLEASE RETURN THIS PAGE ILOC) TO OUR AGENCY: ALL OTHER DOCUMENTATION MAY BE RETAINED FDR YOUR PATIENT FILE.

Georgia Department of Community Health

ELDERLY AND DISABLED WAIVER SERVICES PROGRAM LEVEL OF CARE AND PLACEMENT INSTRUMENT

Section 1 - A. Identifvina Information

1. EDWP ASSESSMENT TEAM NAME AND ADDRESS	2. Patient's Name (Last, First, Middle Initial) Client ID
	3. Home Address:
	4. Telephone Number | 5. County: 6. PSA |

7. Medicaid Number	8. Social Security Number			9. Mother's Maiden Name:	
	10. Sex	1. Age	12. Birthday	13. Race	14. Marital Status	15. Type of recommendation R Initial Assessment Reassessment

16. Referral Source _____

This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance and the Department of Community Health with necessary information including medical data.

17. Signed _____ 18. Date _____

(Patient, Spouse, Parent or other Relative or egal Representative)

8. Physician's Examination Report, Recommendation and Nursing Care Needed

19. Diagnosis on Admission to Community Care (Hospital transfer record may be attached)

1. Primary--;:::==:::::==:::::;:;;===:::;-2. Secondary--;===:::::;:;:;:;:;;:;;===:;-3. Other -.====:;;;:::::::::::::::===:;-

!CD 10 CODE !CD 10 CODE ICD 10 CODE

Yes No

20 Is Patient free of *communicable* disgase?

21. Medications (including OTC) D see attached sheet for listing

22. Diagnostic and Treatment Procedures

tNam• ———————t1-Do sage +--Rout• -f1-Fr•gu ency----1 | Type/Frequency

23. EDWP SERVICES ORDERED: ECM O TCM O PSS O PSSX O HOM O ERS O AOH I O AOH II O ALS O HOS O SNS O SEC O OTH

24. u1et	''– Hours uut of tied 1-'er uay	2ti. overall 1,,.:ond1t1on	21. Kestorat1va Potential	28. Mental and t1ehavioral status
O Regular O Diabetic 0FofTllUln O LOH Sodium 0 Tube Feeding D 01''''	D Intake D Output Q Catheter Care 0 Colostomy Care D Sterile Dressings D Suctioning Q1v O Bedfast	O Improving O Stable 0 Fluc!ualing 0 Deteriorating D Critic:il 01em11hal	Q Good O Fair Q Pao D Ouestion:ible 0None	D Agitated D Noisy D Dependent D Confused O Nonresponsive D Independent D Cooperalive D Vacillating D Anxious D Depressed O Violent D WeH Adjusted D Forgetful O W:mders D Disoriented 0Alert O Withdrawn D Jnapproprfale Re.:iction

29. Decubiti	30. Bowel	31. Bladder	32. Indicate Frequencv per Week						
			Physical Therapy	Occupahonal Therapy	Remote Therapy	Reality Orient:il:ion	Speech Therapy	BoweVBkldor Relrain	Activities Progr:im
0V00 0N0 D Infected O On Admission D Surgery Date	D Continent D Occas. Incontinent D Incontinenl Q Colostomy	O Continent D Oceas. Incontinent D ncontinent D Catheter							

33. Record Appropriate

Legend	IMPAIRMENT					ACTIVITIES OF DAILY LIVING						
1. Severe 2. Moderate 3. Mild 4. None	Sight	Hearing	Speech	limited Motion	Paralysis	1. Dependent 2. Needs Assistance 3. Independent 4. Not Applicable	Eats	Wlee! Chair	Transfers	Bath	Ambulation	Dressing
	D	D	D	D	D		D	D	D	D	D	D

34. This patient's condition _____ D could § could not be managed by provision of EDW? or

Name (Print)

35. I certify that this patient D requires § does not require the

38. Physician's _____

Home Health Services

39. Physician's

intermediate level of care provided by a nursing facility. Address

36. I certify that the attached plan of care addresses the client's needs for The Elderly and Disabled Waiver Program. <tu. Date signed by Physician <t 1. Physician's License No. ❞ • Physician's Phone/Fax

37. Physician's Signature FAX:

ASSESSMENT TEAM USE ONLY

43. Nursing Facility Level of Care D Yes 0 No 44. L.O.S 365 DAYS Certified thru ——————————

45. Signed by person certifying LOG: Title: Date Signed:

SOURCE LEVEL OF CARE AND PLACEMENT INSTRUMENT-INSTRUCTIONS

Purpose: The Level Of Care (LOC) page summarizes the client's physical, mental, social, and environmental status to help determine the client's appropriateness for SOURCE services. In addition, the LOC page represents the physician's order for all waivered services provided by SOURCE.

Who Completes Form: Initial assessments are completed by a licensed nurse (RN or LPN), case manager. The LOC is always signed by the RN. The agency medical director or client's physician participates in all assessments and reassessments by completing designating sections of the LOC page and signing the form.

When the Form is Completed: The case manager completes the LOC page at initial assessments and reassessments, and transfers from one SOURCE site to another. Include the transfer date.

Instructions:

Indicate whether this is an initial admit, discharge, or transfer and date agency would like change to occur. May write any other helpful information in the box or at top of page.

SECTION I A. **IDENTIFYING INFORMATION**

Client Information in Section I is completed from information obtained from referral source or individual (patient) being referred.

1. Enter complete name, address, telephone number, including area code, and Medicaid provider identification number of care coordination team.

2. Enter client's last name, first name, and middle initial, in that order, exactly as it appears on the Medicaid, Medicare, or social security card.
3. Enter home address of client, including street number, name of street, apartment number (if applicable), or rural route and box number, town, state and zip code.
4. Enter client's area code and telephone number.
5. Enter client's county of residence.
6. Enter client's Medicaid number exactly as it appears on the Medicaid card.
7. Enter client's nine-digit social security number.
8. Enter client's mother's maiden name.

09, 10, 11. Enter client's sex ("M" or "F"), age, and date of birth (month/day/year).

12. Enter client's race as follows:
    A = Asian/Pacific Islander H = Hispanic W = White
    B = Black NA = Native American
13. Enter client's marital status as follows:

    S = Single M = Married W = Widowed
    D = Divorced SP = Separated
14. Check (O) appropriate type of recommendation:
    1. Initial: First referral to SOURCE or re-entry into SOURCE after termination
    2. Reassessment: Clients requiring annual recertification or reassessment because of change in status.
15. Enter referral source by name and title (if applicable), or agency and type as follows:
    MD = Doctor S = Self HHA = Home health agency
    NF = Nursing facility FM = Family PCH = Personal Care Home
    HOSP = Hospital ADH = Adult Day Health

0 = Other (Identify fully)

16, 17. Client signs and dates in spaces provided. If client is unable to sign, spouse, parent, other relative, or legal/authorized representative may sign and note relationship to client after signature.

NOTE: This signature gives client's physician permission to release information to Case Manager regarding level of care determination.

SECTION 18. PHYSICIAN'S EXAMINATION REPORT AND DOCUMENTATION

Section B is completed and signed by licensed medical person completing medical report.

18. The physician or nurse practitioner enters client's primary, secondary, and other (if applicable) diagnoses. (Nurse assessor may enter client diagnoses, but through review and signature on Appendix F, the physician or nurse practitioner confirms the diagnoses)

NOTE: When physician, nurse practitioner or Medical Director completes signature, the case management team indicates ICD codes. Enter ICD codes for "primary diagnosis", "secondary diagnosis" or "third diagnosis" in the appropriate box. Case management teams secure codes from ICD code book, local hospitals or client's physician.

19. The physician or nurse practitioner or Medical Director checks "yes" box to indicate if client is free of communicable diseases; if the member has a communicable disease or it is unknown, check "no".
20. List all medications, including over-the-counter (OTC) medications and state dosage, how the medications are dispensed, frequency, and reason for medication. Attach additional sheets if necessary and reference.
21. List all diagnostic and treatment procedures the client is receiving.
22. List all waivered services ordered by case management team.
23. Enter appropriate diet for client. If "other" is checked (--1), please specify type.
24. Enter number of hours out of bed per day if client is not bedfast. Check (--/) intake if client can take fluids orally. Check (--1) output if client's bladder function is normal without catheter. Check (--1) all appropriate boxes.
25. Check (--1) appropriate box to indicate client's overall condition.
26. Check (--1) appropriate box to indicate client's restorative potential.
27. Check (--1) a// appropriate boxes to indicate client's mental and behavioral status. Document on additional sheet any behavior that indicates need for a psychological or psychiatric evaluation.
28. Check (--1) appropriate box to indicate if client has decubiti. If "Yes" is checked and surgery did occur, indicate date of surgery.
29. Check (--1) appropriate box.
30. Check (--1) appropriate box.
31. If applicable, enter number of treatment or therapy sessions per week that client receives or needs.
32. Enter appropriate numbers in boxes provided to indicate level of impairment or assistance needed.
33. Case Management team with the Medical Director (admitting physician) indicates whether client's condition could or could not be managed by provision of Home and Community Services or Home Health Services by checking (--/) appropriate box.

NOTE: If physician indicates that client's condition cannot be managed by provision of Home and Community Services and/or Home Health Services, the member will not be admitted to SOURCE and should be referred to appropriate institutional services.

34. Medical Director, admitting physician with Multidisciplinary Team certifies that client requires or does not require level of care provided by an intermediate care facility and signs on #36, confirming the AHS review and LOC determination.

35. Admitting/attending physician certifies that CarePath, plan of care addresses patient's needs for living in the community. If client's needs cannot be met with home and community-based services, the member will not be admitted to SOURCE and will be referred to appropriate services.

36. This space is provided for signature of admitting/attending physician indicating his certification that client needs can or cannot be met in a community setting. Only a physician (MD or DO) or nurse practitioner may sign the LOC page.

NOTE: Physician or nurse practitioner signs within 60' days of completion of form'. Physician or nurse practitioner's signature must be original. Signature stamps are <u>not</u> acceptable. UR will recoup payments made to the provider if there is no physician's signature. "Faxed" copies of LOC page are acceptable.

37, 38, 39, 40, 41. Enter admitting/attending physician's name, address, date of signature, licensure number, and telephone number, including area code, in spaces provided.

NOTE: The date the physician signs the form is the seivice order for SOURCE seivices to begin. UR will recoup money from the provider if date is not recorded.

42, 43, 44. REGISTERED NURSE (RN) USE ONLY

42. The registered nurse checks (.,/) the appropriate box regarding Nursing Facility Level of Care (LOC). When a level of care is denied, the nurse signs the form after the "No" item in this space. The RN does not use the customized "Approved" or "Denied" stamp.
43. LOS - Indicate time frame for certification, i.e., 3, 6, 12 months. LOS cannot exceed 12 months.
Certified Through Date - Enter the last day of the month in which the length of stay (LOS) expires.
44. Licensed person certifying level of care signs in this space, indicates title (R.N.), date of signature, and contact information.

NOTE: Date of signature must be within 60" days of date care coordinator completed assessment as indicated in Number 17. Length of stay is calculated from date shown in Number 43#. The RN completes a recertification of a level of care prior to expiration of length of stay

For SOURCE: LOS Certified Through Date = Expiration on PA
• For SOURCE "Date of Signature" for the Physician and RN is extended to 90 days

Distribution: The original is filed in the case record. Include a copy with the provider assessment/ reassessment packet

DISCHARGE PLANNING CHECKLIST

Assessment Date_____

Member's name:_____ DOB:_____ Date of Admission to Waiver: _____

	Discharge Planning	Yes	No	Comments/other
1.	Is member able to participate in discharge planning process? If no, provide rational in comments.			
2.	Is caregiver assisting with discharge planning if client is unable to assist?			Name and relationship to member:
	Backup Care			
3.	Can member safely be left alone? If yes, check appropriate time in comments.			☐ < 1hour ☐ > 2 hours, but less than 8 ☐ 1-2 hours ☐ 8 hours or more
4.	Is there an alternate plan for support in absence of the formal caregiver? List name, phone number, address, time alternate plan/support available			☐ _____ days ☐ months ☐ weeks ☐ Indefinite/flexible
5.	Is alternate support available to provide nighttime care? List name and phone number if different than number 4.			
6.	Does the member have emergency placement available in the event the home had to be evacuated quickly? List name, phone number, address.			
	Member Preferences for Care Following Discharge from Waivered Services			
7.	Family (formal support) - Name (first, last)			Care Provided (circle all that apply) ADL support IADL support
	Location of care (circle all that apply) Member's home Family's home			Other: (address if other than member's home)
8.	Nursing Home (Name and contact number)			County
9.	Community Resources {check yes/no if needed after discharge and include contact information)	Yes	No	Contact Information
	Food			
	Emergency Shelter			
	Personal Support (ADL\IADL care needs)			
	Transportation			
10.	Private Arrangements/Friends/Church/other assisting with care needs a.			Contact information (phone number)
11.	Services received and requiring a physician's order upon discharge in order to continue: (home health, rehabilitation, referrals, other) a.			Contact Information: phone number/address
	Follow Up			
12.	MD name and phone number	MD address:		

Other discharge resources/plans/instructions

Date Copy of DC Plan Given to Member _____ o Mail o Hand Deliver o Other_____

Instructions

Elderly and Disabled Program

DISCHARGE PLANNING CHECKLIST

Purpose: To provide assistance and written documentation to the EDWP client by identifying resources and developing a plan to ensure his/her health and safety in the event of disruption/loss of EDWP services.

Who Completes/When Completed:

- At initial assessment, the RN introduces the document as patt of the initial client admission packet review and requests the client to formulate his/her personal plan
- At the 30 Day Comprehensive Care Plan Review, the care coordinator reviews the document with the client and assists the client in writing his/her personal plan
- At each subsequent quarterly review, the case manager (nurse or social services) will review the plan with the client and assist in making changes as needed or appropriate

Instructions:

Enter today's date, client's name admission date to CCSP

I. Review all sections (I-IV) of the Discharge Planning Checklist for Community Care Services Program participants with the client/care giver

2. Assist the client in identifying his/her own unique plan through responses to the questions.

3. Document the care plan discharge plan section to indicate the client's discharge plan

4. Review the plan with the client/care giver at each care plan review and update when change in needs

Distribution: The original is given to client at the first face to face following assessment. A copy is filed in the client's case record.

ASSESSMENTS

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[CODE FOR LAST 3 DAYS, UNLESS OTHERWISE SPECIFIED]

a. Q 1r

Z GENDER

1.Ma!e 2.Femde

J. BRTfDATE '-'-+_, I -CD-

4. I\WillAL STA1US Yeef' Marth
1.Neverrnerried
2.Mttried
3.Patiner /Sigiificmt other
4.\NidOV\ed
5.Sepa-ate:l
6.Divcrced

5. NATIONAL NLMERIC DENTIFIER[EXAM'LE-USA]
a. Social Secuity runtier
| | | I-CD-I | | | |
b. Medicare oorrtier(or comparable railroad insurance nurOOer)
| | | | | | | | | | | | |
c. Medicaid ntnt>er

[/\bte:"+"tpendiftJ, "N"fnot a 1¥1cdhakl reciplenq
| | | | | | | | | |

6. FAOUTYAGENCYPRO\JIDER!f.Jr.EER
| | | | | | | | | |

7. CURRENTPAYr.ENTSOURCES [EXAM'LE-USA]
[Ncte: Billing Offke lo *indicrte]*
O.No 1.Yes
a.Medicaid
b.Meclicare
c. Selforfarrily paysfor full cost
d. Medicare with Medicaid co-payrnert
e. Private ilSU"ancc
f. Other per diem

B. REASON FORASSESsr.ENT
1. First assessment
2. Rcut'ne reassessment
3. Retum assessment
4. Si_gnilcant chan93 in status reassessment
5. D1Si::terge assessment, covers last 3 days ofsu'vice
6. Disd"argetradtingorly
7. Olh;r---e.g., researcn

9. ASSESSMONT REFERENCE DATE
12101 | 1-CD-
Year Morth Day

10. PERSON'S EXI'ROSSED GOALS OF CARE
Enterprfmary !!Jal in roxes at/xJttom

12.RESIJENTIAL IU\,t>IG STA1US AT TIVE OF ASSESSMONT
1. Privdehome /!f!atlmert / rented room
2. Board ard care
3. Assisted li\>irg er semincependeot li\>ing
4. Mefltd t-eath redtenca--eg., pS')>';hiatlic grcup home
5. Group home fCt' persons \i\l1h physicd ditilily
6. Setting fOrpersonswth intellectual disability
7. Pspi1air:chospitalcr unit
8. Homeless ('Aith or V\it!"out sl"elter)
9. Lorg-tenn care tldlily(nurslnghome)
1O.REfiebilitation h:ispital/mlt
11. Hospce tlcility /palliaive care unit
12..Ai::ute ca-e hospital
13.Ccnediond facility
14.0lher

13. LMNG ARRANGEMONT
a. Liues
1. More
2. Wrthspruse /pattrer cnty
3. With spouse /pattnerend o1t"er(s)
4. Wrthchild ct spruse / partner)
5. Wrth pare s) or gLardian(s)
6. Wdhsiblin s)
7. Wdholherrelatives
8. Wrthncn-relative(s)

b. Ascorll)aredto 00 DAYS AGO (or sincelast assessment), person nowliues with someooe new e.g.1moued1n With another person, ciher moued in
O.No 1.Yes

c. Person or refatiue feelsthatthe pefSOn would be better off living e!sev.llere
O.No
1. Yes, oth;lr community resideri::e
2. Yes, !nslilllicn

14.TME SINCE LAST HOSPITAL STAY
Code for most recent instance fn !AST90 DA YS
1. Nohostitalizd:lon V\rthln 9J d:lys
2. 31 lo90 days ag:i
2. 151030 00.ysag:i
3. Bto14 daysog;i
4. Jnthelast 7days
5. Nowinho ital

[Note: COrrpeat AcitrissbrlFirstAssessmert on.I;/

1. DATECASEOPENED I i s
121o| | I-CD-CD
Year Marth Day

2. EIHNICITY AND RACE[EXAM'LE-USA]
O.No 1.Yes
ETH/IC/TY
a. Hif:l)anic or Latino
RACE
b. Arrerican Indian or Alaska Hative
c. Asian
d. Black or African American

[EXAM'LE-USA]

11. POSTAL IZPCOOE OF USUAL LMNG ARRANGEMONT

e. flatiue Hat.'.Qiian or other Pacific Islander
t. wtite

3. PRI'MRYLANGUAGE EXAMP!.E-USA]
1. En9ish
2. Spmish
3. French
4. otter

4. RESDENTIALHISTORY CM'RLAST 5YEARS
Cede br allsettln.gsperoon /Ned in during 5 YEARSprior to

date caseopened[kem 81]
O.No 1.Yes

a. Long..termcarefacilfy-e. g.,rursinghome
b, Boardand care home, assisted living
c. Mental heafth residence e.g., psychlatr!cgrOl.pheme
d. Psychiatric hospital or unit

e. Settiry.1forpersons'lllith intellectual cisabilitv

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!UPDATED 1.<DS·HC 2.

interRAI.

Rev. 07/1,,,--

SECTION A. IDENTIFICATION INFORMATION

1. NAME

a) b. (Middle Initial) c. (Last) d. (Jr/Sr)

Day

SECTION B. INTAKE AND INITIAL HISTORY

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SECTI IN

1. COGI TIIE SKLLSFOR DALY DECISION MAKING

Making decishnsreg{}(d/ng tasks ofdaiJ; lfe-e,SJ.,wMnto oetvpor have mea"?twhich cbthesto wear or,;cfJ1Jfes todo

0. *lndepenoent--Dedsions* consistent, reasonable, and safe
1. *Moditi'ed independence-Som* edifficultyln newsituations only
2. *Mhiimally impaired-In* sped1ic recurring situatrons, decisions become poor or unsafe; a Jes / super\ Islon necessary at those times
3. *Moderately impaired-Decisions* consistently poor or unsafe; cues super'vision required at alltimes
4. *Se i{e_rely impaired---Never* or rarely makes deasions
5. *No discern able consciov sness, coma {Skip to Section GJ*

2. I>EMORI' / RECALL ABILITY

C-Odefor recalfcfwh:.twas leamed or known

0. Yes, manay OK 1.Metnmyprcblan
a. Short.tenn memocyOK--Seems/api:earsto recall ater 5 mirutes
b. ProcOOJral mermiy OK-Cm i:ertmn all or dmost al! stepsina mUttask sequance '11\ilhoi.t cues
c. Situational merroryOK---8olh: recogriz:esca-e9vers' nanesfaces 1requantiyenco mtered JlND knO\\I\<S!ocati cn ofpla:es reg..1lal1yvisited (bectoom, diring room, actiWy roan,tl'erapt roan)

J. PERJOOICI:ISORDERED THNKING OR AA/ARENESS

[Al::Jte:Accurate Bssessmeri: requres comer&:]tkms w.th dBff, fBmi/y orotherowho h<Ne direct kncwlectJe oftheperson's behavior over this lime]

0. Behavicr not present
1. Behavicr present, o:inslstent '11\ilh usual 'functioning
2. Beha\oiorpresert,appea>sdifferert ton usual 'functioring (e.g., newonset *or* '11\0rsening; different l'rom a feW\'\eEksago)

a. Easilycistracted-e.g., epsodes of dffio.Jty payirg ettertion; ssiretracked
b. EpisoOOsof c:isorganized speech-e.g., speech is ncnsenslcat, lrrelevant, er rruibling 1rctn sut:jectto stbject; !osestrein ofthoug-rt
c. Mental fooction varies over the cotrseoftheday-e.g., sometimes l:etter, sometimes '11\C/Se

4. ACLITE CHANGE INfI/ENTAL STATUS FROMPERSONS

USUAL FUNCTK)N IG

to Bmusc, atered envir

MMUNICATION AND VISION

QNo 1.Yes

5. CHANGE NDEQSJON MAKNG AS COMFI\RED 1090 Dm'SAGO(ORSNCE LAST ASSESSMENT)

o.rmr:ravej 2.Dediled
1.No chm 8.Un:ertein

1. MAKNG SELF UNDERSTOOD (E>IJresSCXl)

Expressing intbnnrJtbn content-lx; th verb11and non-i;etbal

1. *Understood-E:.presses* Ideas viliho.rt difficulty
2. *U.sv olly IInderstood-OifflcIlty* finding'll\\Or'ds or lhishilgthcugfi:sBUT lfgventtne, little or no pretnplfngreglired
3. *Often* 1Jnderstood-DIffcultyfinding'll\ords or lirishing1hou;ihts ft.ND µom,ingusually reqt.ired
4. *Somet»nes* 1JnOerstood:.....,Ljjlity1slimited to makirg o:in:rete requests
4. *Rarely or never understood*

2. ABLIIY TO UNDERSTAND OTHERS (Conµeheim)

UnderdrJndin9 vetbalinfonnatbn content(hcwer rJt/e, wlti tierJriny rJppli2nce nomirJ/¥ used)

o. *Undentatds--C!ee*< ronprel'enskn
1. *I.kus/¥* undrustands41isses sone pat /Intent *of* message BUT o:imi::r&ierrls most o:inversd:icn
2. *aten undentds-M lsses* some pffi /Intert of message BUT '11\ilh rei:etilion or e:xplanaticn can ollen compreherrl o:nversation
3. *Sometintu* umfetstandt-Resporrlsadequatelyto simple, cirect o:mmunl::a1lon oriy
4. *Ran?¥ or twver unde1staud$*

3. HEARNG

Abflfy to herJr (ivlhherJlin!) epplience normalJ; tJsed)

1. *Adequafu-N o* dlffcLlly inronnal cmversaticn, soda! Interactlcn, listeningto TV
2. *Mnima/ dfffically-DiffcLlly In* some erMrcnmerts (e.g. '11\ten person speakssotly or ismore 1han lStee1 2 meters a'll\a

2 *Severe cliffii::uRy-Difficuttylnell sttuatlros* (e.g., st:eaker hastetalk lcudly ors1'3ak ve1y sloWy, or person reports lhat fil speechismumtled)
4. *No heanitg*

4. \IISION

Abilfy to see in adequrJte lt;ht(Nih!J/iisonvlh ottier visuBl rJpp/JBnce notmBll/ used)

0. Adequate:-Sees1ire dd:eil, ilducfng regUar r:rnt in neapers /books
1. *Mrtimaldifficulty-Seeslarge print,* h.rl:nd

4 regu!a- ptint innaP?rs /books
Nbderate difficuRy....:...t.imited 'lisbl1 rot Eble to see ne'll\6Paper heamnes, but can ldertify cbjects
3. *Severo dlm::uJlv-Ot;jeet* ideotifca1ion in Q.Je:siion, bLt eyes e:ppearlo 'bllowobjects; sees roly light, o:ilors, she-pes

No vis

1. NDICATORS OF POSSIBLE DEPRESSED, ANXIOOS, OR SAD MOOD

Cede forjndlcarors obsctved in last 3 dys, HrespecWe of the assumedcse[Nr.te: wtieneverpossible, askperson]

O.Not present
1.PreSent but nde>:hltiled in last 3 cays
2. E>:hibted on 1-2oflast 3 cbys
3. E:dibiled deilyin last 3 days

a. Made negatiue statemerts-e.g., *" Nr.thing matters; VlkwldrtJtller be derJd,' WliBt's ttie use; RelJ(et h<Nit'(J li1edsohf{}; Letmedkl'*
b. Persistent anger \\lith self or others--e.g., easily amoyed, arger at care received
c. Expressions, incluc:ing non....,erbal, of what appear to be rnrealistic fears--e.g., Bar of being abancbned, being let acne, belrg Vlflh o1hers; intense fear of specific otjects or sttuet1cns
d. Repe(IOue healhcorrpJaints-e.g., persi&entlyseeks meC!ical attertlon, incesS:ent o:ncern Wth b:idyf..mctlcns
e. RepetitNe anxious clairi:s/concems(non-heaf1h relat-e.g. perslstentry seeks attention /reassurance regudirgsd"edUes, meas, lairrlry, dctl ng, releticnsfips
1. Sad, pained, or 'INOrriedfacial expressions-e.g., futro\\ed brow, constant frovuiing
g. Crying, tearfulness
h. Recurrent statemertsthat SDII"lething teribleisaboli to cie,nave a

to happen-e.g., believes he or ste is OOoLt hea1 atack
I. Withctawil from activities *cl'* ri:erest-e.g. long.stanci ingactivtties, teing wth tunify' /friends
j. Reduced social ita-actions
k. Expression incluclj non....,efbal of alack ct pleasure inlife(anhedonia)-e.g., *IOOnt enP.f an,thf!r; Bfl more"*

SELF-REPORTED MOOD

o. Not in last 3 cays
1. Nct in last 3 days, bi..t often 1eelsth:lt WIY
2. ln1-2 ot!asf.3 Mys
3. Dailyintre last 3 days
8. Person could not (11\0Ud net) resporrl

Ask: "Intire .bst3 days,ltmv often ltwe you felt.••"

a. *little inlett* orpleasu1 irt things you nonnal¥ *en.JOY'l..*
b. *Anxbm, rosthss, orur1easy?*
c. *Sad, deprBSse<fi or hokss?*

3. BEHAVKIRSfM'TOMS

Code ti:Jr ind.'CrJtors obseNed, irmspectNe ofthe rJssutned CQIJse

1. Not Presert
2. Presi:nt but nde>:hittted in last 3 mys
3. E>:hittted on 1-2of last 3 d3ys
4. E:dibitedde41yin st 3 days

a. Wandering-Moved wth norational pupose, seem!rgly obli\oiousto needs or sahly
b. Verbal abuse-e.g., otl'ers \'\ere threatened, saeamed at, cursed at
c. Physical abuse-e.g., ethers V\erehit, shoved, scracred, sexually abused
d. socialy inappropriate or c:isruptivebehaui or-e.g.,mareD d!:stur;tive soi..nds er noises, oc:reamed oi.t, smearedorthrevv food or Bees,hoarded, rummaged 1htou£ti other's telongngs D
e. Inappropriatep1.Elic sexual behavior orpl.Eic dsrobing
f. Resistscare-e.g., tdcing mecfcations/irjections,flDL assistmc:e, eat!rg

GI interRAI!

interRAI Home Care HC ©

SECTION E. PSYCHOSOCIAL WELL-BEING

1. SOCIAL FfiATlONSHPS
[/\Ote: IM'leneverpossfb,le, ask petoonJ
1. Never
2. Mere"than30 days a!})
2.8to30daysa;io
3.4 to 7 days a9)
4.ln!a& 3 cays
8.Unltll? to determire

a. rn1r: i:tion i1social acti11itiesoflortJ-stancing
b. Xkitm a lollJ-stancingsocial relatioo orfarrily
c, other i1teraction \Mth long.standng social relation or familymenDer-ea., teleph:lre, e-mal
d, Corllict or anget"'NlhfamilyorfriendS
e. f earfl.J of a farrily merrDer or close acipairtance
f, Heglected, abused, orrristreated

2. LONELY
SrJys or in<h:ates that he I she feels lone!;
O.No 1.Yes

3. CHANGE IN SOCIAL ACIMTIES N LAST !IODAYS
(ORSUICE LAST ASSESSM:HTFLESS lHAtl 00 DAYS AGO)
Decline in levelof padfcipatk'Jn in social, rol(Jious, occuprJtk'Jnal or olherprofcrred actililes
IF THGiLCL!NE, pffSOn d&ressed byttis act
1. Dedine,rot distressed
2. Dedine,di&res:sed

4. LENGlHOF ThE ALONE 01.RtlG TIE 00(MORNNG Atll AFTEPNOON)
O.Lessthan1 four
1.12 hwrs
2. Mct"ettan 2 h:lurs b.it !es:sihan 8hours
3.8hoL.rS or more

*severe perOOnalillness· death orsevere illnessolcl.J&. f,illl:ly_*
member/friend; loss ofhome; m;ipr l:Jss *ofincomelasse/s;vtimo a ctime such* rJs *rotbery or aSSQut;* l:Jss *ofdriling ense/car*
O.No 1.Yes

1. IADl SELF PERFORMANCE Atll CAPAOlY
Co:Je for P£RFORM4NCE in routine act;1ilesatound lhe ft'Jme orinlhecommlJ!) dt.V'irfj the IAST3 IVIYS
*Coie for C4f!I CJ7Y basedon presumed abilfytocrJfi'fOUt ;;ctil-*fy as *independeri!;f aspossibh. This will require "epecu!.l/.Jtlnf* fy *the assessor.*
0. */Jidt;pendent--N ohelp,* setup, or stflervision
1. *Setvp hefp onlJ*
2. *Svpervision--Oversight* feting
3. *Limited assistance-Hel p* on s::ome oo:asions
4. *£;.tensive* assistance---HelP.ttroo;ihc:ul task, but petonns50% or more Oftask on owi
5. *Maximal* assistance----Helpthrcugh:lut task, tut petionnsless:than BJ% oftask on owi
6. *7otal a'e;;:lem1ence---Full* perlonnence by ott.ers ciL.rirg aitire pe1iod
8. *ActfvitJ did not* occur-Duingentire period
[DO NOT USE TH!S CCOE INS:ORING CACITYJ

PERFORMANCE CAPACITY

a. Meal preparation---Howmeelsare r:repared(e.g., plenring meels, assen bing ing-OOierrtS, o:okirg, sett1rg oL.t food and utensils)
b. Ordinaryhousework---Howordi nary \'\Ork arond tt.e tuuse Js perhnne:l (ef!., ddng dishes, dusting, meldng bed,tidng 4'.', lauidry)
c. Managingfinances--Howbitlsarepaid,d'ed:bock Js belanced,'h:lusetold exuenses are budgeted, crectt card oci:ourt ismcnltcred
d. ManagirXJ rredications---Howmedcdlonsare mena;ied (e.g., rememberirgtotake medicires, cpenirg bcttles,teldng o:t"rect drug dos:ag3s, gving irjections, ai:p!ngointmerts)
e. Phone use---Hovvteleptone calls 1Jfe made or received (Vl«hassistive de1,ices such as large numbers ontelef'.hore, amplilio:tion as neecbd)
t. stairs--Howfutl ight of &airs ismanag::d (12-14 stairs)
g. Shoppi1o--Howshoppingis erhrmed br food end hruseh:lli3"1tan s (e.g., seleaing Items,pa)ingmorey) • .EXCWDE TRllNSPOOTATICN

-=rlo'Ira.'-.,ort 8.,-Howtrave1s bypLll llctransp:ir.a'll (naliigaling svstem ,pa)'lng fare)or dtiliing self Qnduaı!rg t\!ngmlt ofhcuse, iilto ard wt:of vehides) OJ

2. ADl SELF-PERFORMANCE
CMskier alt epkt:Jdcs over 3-<:!ay perhd.
*fall epioo*S'1te petf01med at the same bve/ w;reAOL tMt J::vet fany episo:JesstJevel6, arx!* ethers *J:ssdcpendcri,* xore *ADL asa* 5. *a.tier.vise,fccm on the ttuee mostdependeri epfoodes[or aH*

epiSIX!es lperformedfewerfh:in 3 times]. f"rmddependeri ephodi: is *1,score AOL as1. f mt, St:oreADL* RS *least dependent of those epioodes in rmge 2-5.*
1. *Ina't;pendeni---No* physical assistance, :set4), or supervision inanyepisode
2. *Inliependent,sewp /Jefp only-Mcie* cr de\oice pro\>ideycj or placed 'fl1ll"in reach, no f'.hysicel assistance cr supetv1son inanyep1sode
3. *Svperv!Sion-Overslght* /cling
4. *limirea' assistance-Guided* mareuvaing oflimbs, physicalguidan:::e \Aflhoutt Efcirg VIEight
4. Emnsiveassistance-WeigH-bearingsuppott (lrdudi ng lifting limbs) by 1helper Vlhere person still petionns50% or mere of subtasks
5. *A1aximal* alJsistance-Welgli-bearingsuppott(irduding litinglimbs) by 2+ helpers-CR-Weight-bearing suppat fcr morethan 50% of stiltasks
6. *7otadependence-Full* p:itiotman::e byothera dwing al epdes
8. *Acti viry did not occur dvring entire period*

a. Bathing-Ho'Ntakes a 1.111-l:ody ooth / sh::iVIEt'. lndtrles ho'Ntransfers inmd out oftub *or* shoV\er ftND howeach pai.ofbody lsb:itted: atms, 4)per md ICMer legs, chest, ab:lcm palneel area EXCLLDE VVASHINGOF Bll.CK ANDH.lllr;:: D
b, Personal tygieoe---Howmarages persora! hyg'ene, irdudhgcomting h6'r, hushirgteeth, sta\>irg, ai:p!rg mff(e.i.Jp, V'llsHng arudrying fa::e and f'ands EXCLUDE BATHS ftNDSl-OlAERS D
c. Dressing upperbody-Howctesses-ard urdresses (street dottes unrervi.ear) above the Vlei&, lndtrlIng prostheses, cr\hctics, fasteners, pullovers, etc. D
d. Dressi lower body---Howctesses ard urdresses (street dothes, underV\ear) tom the Vlei& doVln induding prosl.heses, otlh:lllcs, b311s, p:1nts, skirts, shoes, f:lsteners, etc. D
e. Walmg-HoVW1elksbetV1een locatlonson same1loor IndOCt'S D
f. Locomotion---Ho'fl.moves l:etV1een locat:Jonson same (Vlelking *or* '#leel!rg). ltin'#!eelchair, self.sufliciency once in chcir 11008
g. Transfertoilet---HowmCNes en md offtcilet or o mmore
h. Toiletuse-Howusesthetoilet roan (cr commore, bedpan, utincl),demsesselfallertollet use crlnconlinert epioode(s),D charges pad, mana;ies ostom y orcdheter, acjusts cbtres- EXCLUDE TRftNSFERCN DOFF TOLET
i. Bedrrobility---Howma..iesto end tom lng r.osition,tuns from side to side, ard r.osilions bcdy V'hile In be::l D
J. EOO:ng-Howed:s ard drinks (rerdless of skill). Induces intakeofnwrishmentby ctt.ermems (eg.,ti.be Bedlng, tctal p«enteral n.rtrition) D

3. LOCOMOTION 1\111\LKING
a. Primary mode of locomotion
1. Walking, no assislive devi:e
2. Walking, uses assistive cb\>ice-eg.,care,w:ilker, autch, pushing Vlheelctair D
3. V\11'1eelchai r,srooter
4. Bedbwnd

b. Timed 4-meter (13 foot) walk
[Lay olla straighturbdiuctedcot..rse. Hwe personstend instill pJsitic:n, feet just touding start lineJ
Tlwn $aiJ: "Mien Itel/you begf11 to walk ata nonttal pa:e *6vitil caneAvallrnr T* used1 *This fs not ate$tof how f{ntyou can wmt <. Stop when It.el/you to$top. It this clew?"* Assessor may demcnstratetest.
7hensay: "Begin to walk now" start stopwrtch (or o:in counlsecords)Vlhen lirst foot falls.Endcouit If'hen bot fa!s bey"Ord 4-meter mak.
71ten$ay: "Youmay$top now"
Enter tirne Inseo:nds, upto 3J se:onds.
30. 30 or more re:oncls lo Voalk 4-meters
77. stop[.Bd beDre test complete
88. Refuredtodo the te::t
99. Notteste..l-e.g., does not IMilk onol/\n OJ

c. Distance 'Nllked--Farlhest distance 'Milked aonetime \"Jlhott :sitting dO\'\nlnthe LAST3DAYS(Wlhrupporl as needed)
O.Dldnct \l'llilk
1.Jessthan 15feet (urder SmelEfs)
2.15-149 eel(5-49meters)
3.1SIJ.239 Ee{ (50.S9 meters)
4.300+ Eel (101'.»- meters)
5.1f2mileormore (1+ kilaneters)

d. Distance wheeled self-Farthest dstence Wleeled self at ore time htt-e LAST 3 DAYS Ondudes Indeperdent use at motorized Wleelchelr)
0.Wheeled l:ty' ott-ers
1.Used motorized V\heelch:l!r lsrooter
2.Wheeled self !esslhl!'fl 15feet (Lnder 5 meters)
3.Wheeled self15-149 Eet(549 meters)
4.Wheefed self1 SJ-289feet (50-93 meters)
5.V\lheeled self300+ feet (100+meters)
a. Did net use \'\heelchair

4. ACTMIY LEI.R
a. Total hoursof erciseor physical activity in LAST3 DAI/S-eg.,wilk!ng
0. None
1. Lesstmn 1ho.ir
2. 1-2 hours
3.34hours
4. Morett"an4 hours

b. Inthe LAST3 OAVS, number of days v.enl out of the house or building In which he/she resides (ru matter howshotl the period)
0. Nodwsout
1. Did nct goout inla:st 3 days, bU uruallygoesoulr:Nff a 3-day f.erlcd
2.1-2days
3. 3days

5. PHYSICAL FUNCTKJN MPROl.!OtlENT POTENTIAL
O.No 1.Yes
a. PersonbeUeveshe/she iscapable ofirq:iroued performance in physical fooct1on
b. Care professional believespersonlscapable d irqroued performance in psical function

6. CHANGE IN ADL STAIUS AS COll'PARED TO OODAYS AGO, ORSl'lCE LAST ASSESStlENT F LESSTHAN OODAYS AGO
0. Improved
1. No d;engo
2. Dedined
3. Unc:e1tan

7. DRMNG

a. Dro11ecar (Vehicle) inthe LAST90 DAYS
O.No 1.Yes
b. lfd'ovein LAST OODAVS, assessor isa\o\Qrethat

someone hassuggested that person Units OR stops cti\'lirg
O.No, or does not drive

SECTION H. CONTINENCE

1. BLADDER CONTINENCE

0. *Contfnent-Ccmete* o:ntrd ! DOES NOT USE arl)'m:eys ofcathet.er or ofher urinary oo ledionde\.ice
1. *Control witll any catheter or ostomy overst3 days*
2. *Infreq ventJ Incontinent-Not* in:onnent o\ltr last 3d, bi.J: does have Incontinert eplrodes
3. *Occasionally* incontli1ent-Les.s1han daly
4. *freqv rmtly* mcontinem-Daily,but sane cortrolpresenl
5. /llcontinent-Noccntrolpresent

8. *Did nor* occvr---No uire culp;l: from bla:ldEr" in last 3 days

2. URtlARY COl.LECTiarnruCE (Exclule l1xfsbritfs)
o. Nore
1. Concbm catheter
2. JrdV\Elling CEthE:ter
3. Cysb:tslcmy, hostcmy,ureteros!omy

3. 800\EL CONTirENCE
0. Conbitent-Compttecontro!;DCESNOTUSEanytypeof ostcmy de\tice
1. *ContJolwitlt ostomy-Ccnlrol* \l"ith ostomy daliice over last 3 days
2. *ktftfH/lHUtfJ/ i1tconbent--Not* in:ontinent CNer !ast 3 da.bi.J: does have incootinfflt epiro:les
3. *Occ8$ional* incontinent--lessth:in dai!y
4. *Ftru(llenfJ/* mcontinent-Daily,btt rome o:rrtrd p-eoort
5. *lttcontine1tt--No* cootrol presert

8. *Did trot occur-No* 00\'\ef movement inlhe!ast3 d

4. PADS OR BRIEFS WORN
0.No 1. Yes

SECTION I. DISEASE DIAGNOSES

Disease code
0. Nct presert
1. Primarydagnosis.t:l!agiosestorcurert stay
2. Diagnosis preSEflt, recei\'tirg octive treatmert
3. Diagmsispresent,mmitored bi.J: *m* a:tivetreetmert

1. DISEASE DIAGNOSES
NJJSCULOSKEl.EfAL
a. HipfracturedlJing last 30 days(or sincelast assessment if less than 30 dilys) D
b. other fracture dtrirglast 30 days(or sincelast assessment if less than 30 days) D
NEUROLOGICAL
c. Alzheirrers disease
d. Dementia ether than Alzheimers disease
e. Herriplegia
f. M.lltiplesclerosis
g. Paraplegia
h. Parkinson'sdisease
l. Quactiplegia
J. stroke/ CVA
CARD/AC OR PULJi/DNARY
k. Coronaiy heart disease
l. Chroric obstructiuepulmonary dsease §
m. Corgestiue heart failure
PSYCHV1mtc
n. AnMiety
o. Bipolar disorder
p. Depression
q. Schizophrenia
llFEC110NS
r. Pneumonia B
s. Urinary tract irtection in last30 days
<YrfER
t. Cencer B
u. Diabetesmellfuis

2. OTl-ER DISEASE DIAGNOSES

	Diagnosis	Disease Code	ICD code
d.			
e.			
f.			

(Note: Add additional lines as necessary for other disease diagnoses)

SECTION J. HEALTH CONDITIONS

1. FALLS
0. No f:lll !nlsd 9J days
1. No kll in last 20 d9.ys, i:ottel 31.ffi days a9) D
2. One ftll inlad 30 days
3. T'AO or mcre tatlslnlast 30 days

2. FECElff FALLS
(Skp flad.as.sessedmoreth<1nYJdaysag:JortfhisistN&assessmen
O.No
1. Yes D
[l::iarlc] Nd applical::ie (1r:st assessment, ormorethm 30 days since lad assessmffllt)

3. PROBLEMFREQUENCY
Code ff:Jrprence in /ti.st 3dtiys
0. Not presert
1. Present but net exhi!.:it:ed rn last 3 days
2. E>:hbited ((']1o1lad 3days
3. E>:hbited co 2 oflad 3days
4.E:<tibiteddEilyi n l:lst 3 days

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interRAI Home Care (HC)©

BALANCE

a. Difficult orunableto moueselfto standingposition Unassisted D

b Difficult ormabletotumself arooodandfacethe D

·opposite direction Men standing

c. Dizziness

d. Unsteaq,tgait

CARE ·•C OR """ NARY

e. Chest pain

f, Diffict.Jtyclearing ai"v.Bysecreti ons

PSYCHIATRIC

g, Abnormal Utoughtprocess---eg., boseningof eisso:iations, b!c.d\ing,fli!fit of ld::as,tmgeritiahty, dro.imstartiSrty

h. Oelusions--fixed ttlse l::eliefs

I. Hallucinations-False sensay r.erceplions

NEUROLOGJCAL

J. Aph asaa

GISTATIB

k. Acidreflux-RegurgitaticnofOOd from stomachtoth'oot

t. Constipation---No bo-Ae!movanentin3 d:iys or dffloJI pass;ge of hardstool

m.Diarrhea

n. Vorriting

SLEEP PROBIENB

o. DiffictJtyfalling asleep orstaying asl waJGng lfl too earl)r, restressness; non-reStful sleep

p Too much sleep-Excessiveamoortof sleeplhct

·lrlefaeswlh petscn's namel fun:tion'ng n

vu,..._,

q. Aspiration

r. fever

s. GI or GU bleedng

t. Hy{jme---Unusuatypocr h'fdene, urkemi:t, disfei,ele:f

u. Peripheral edema

4. DYSPNEA (Sha'tnesscibrea'.h)

0. Absence ofsptom
1. Absent at rest, but P'esent lflhen perlonned rnoderfte activities
2. Absent at rest, but present Vlt"'en perlonnect nonnal dEty-to-day adiyities
3. Present arest

5. FATIGUE

Inetiiltyto cornpld:e rormal daiy a:tivties-e.g., .llDls,IPDLs

0. *Nolte*
1. Mnimal--Oimini&led energyl:.ut conpld:esronna dEty-to-day adi'tities
2. *Nbdenrte--Owto* ctrn!risfedenerw, UN.Aa.E TO FlNEH ncrmdday.to-day a:tl'vities
3. Sevete-Oi.etoclrniristederiel'!J1, UN.Aa.E TO START SOME ncnna! cay.to.day a:ti'vities
4. *Utt8ble to commence any normalday-to-day 81:.tivitffls--Oi_e* to ctmhisfed erergy

6. PAINSYM'TOMS

(f.bte:Al.w1ystJsJl the perron tJlxxJtpain froq,;ency, intent;}, andcontrol Obse1Vepel'!l:Jn tJnd ask others who are in r:on-toctwlh theperoon,]

a. Frequency withwtich pen;on cof!lllains or sho C\litfence *Cipain*Oncluding{Jirnacing,teeth clenching, moaning, Wthdrawal when touched, or other non-uefbal signs suggesting pain)

O. No paln
1. Presa"ltbutnct e00111:itectlntast 3 cays
2. E*ii itedon12of fast 3 c3ys
3. E)f"ibi!ed d:iilyln last 3 clys

b. Intensity ofhighest leuel of pain present

0. No ,in
1. Mid
2. Mcderde
3. Severe
4. Times lflhen pain!shcrrible or excrud&ing

c. cens;st"°m"'Ofpan

0. No!Elln
1. Slnge eb!soOO: cluing last 3days
2. lntetrnittent
3. Constart

d, Breal<f:tn>ugh pain-Timesh LAST 3DAYS \"\hen i:erson experienced S1.Jdden, acute 1lare-ups of pain D

0. No 1.Yes

e. Par. corm:it-PJ:lecpacy of ctrrent therapelllcregimento o:mtrolpein(tom perscn'spointof'lie

o. Nois:sueof ptin
1. Painintensty occeptabletopersmj notreetmerrt re\imen er d1arge in regimen requred D
2. CCntll:llededed!.atdybytherapell Jcreginen
3. Ca-drolled V'hentheretieuticreglmen filfo\"00, butnotal"l\eysfollol/\edasorcfered
4. Therapart!cregimen til!oV1ed, bi..t paincorrtrol rut

S. c r.eu!icregimenbe!rg'bllow;dforpai pain notadeq.iatelyccrrtrotled

7. INSTABILITY Of CONDlllONS

a. Concitions J diseasesmakeco.!Jliti'!e, AOL, fl'.lDOd or behavior patterns mstable (fluctuatirg, precanous, or deteriorating) D

b. Experiencing an actie episode, ora flareup of a recurrent or chronic problem B

c. End-stage disease, 6 orfe\.Wrmonthsto liue

B. SELF-REPORTED ..i:.ALlH

Mk: "ktgeueral, how wooklyoor«eyourhe811.h?"

0. E>!dlert
1. Geed D
2. Ffir
3. a · P°"'t ot(.'d ct) d
· OJ n WJ... n resprn

9. TOBACCO PlID ALCOHOL

a. Smokestobacco daily

0. No D
1.Notln!ast3days,b.Jt lsusualy actaly smokff
2.Yes

b. Ak:ohol-H!£tiest rumber ofctlnksin my'single Sttin!J'in lA.ST 14DAYS

0. Nore D
3 5 ,....

1. HEIGHT AND \"\EIGHT PNCHES AND POUNDS-COUNTRY SPECFIC]

Record (tJ.) height in inches and (bJ weM inpo1Jnds.. Base weg;M onmod rocent meawre in lAST30 D:!.\'S;_

a. HT (inl ITJ b. WT (lb.) | | |

2. NIJTRJTKJNALISSUES

O.No 1.Yes

a. Weigti:loss cX5% ormorein LAST30DAVS,or10% ormorein LAST180DAYS D

b. oewa-ated or BUH /Cre ratio>25 {Ratio, co..1ntry specilicJ D

c. Fil.lid intakelessthan 11')00 cc per day(lessthan four 8 oz c""'s/day) D

ct. Fil.lid outptt ceeds iflll i D

3. IOOOE Of NUIRITIONAL INTAKE

1. Notma/-Sw:i.llO'M a\l t"ypeS of foods .
2. *Nbdified inOOper1deltt-e.g.,* liq.lid !ssir:ped, tdes limited sdid 'bod, reed fer modlicatcn may be t.nknoW'l
2. *Reqoit dif t modiffcalion toswallow solidfood-* eg., mectenic8 de! (eg., p.iree, mlnce:l,etc.) or cn\y al:le to ingest speci1c feeds D
3. *Requi111s modifkation toswalbw liquids-e.g.,* tti eredliqllds
4. *Cansw8/low onl<Jputeedsolids -AND-thickened li<pids*
5. *CIJmbined ora/ andparentera/ orfube Wedlug*
6. *Nasog:ls"tr'k tllbe Weding on>/*
7. *Abdomin8/Weding* tzJbe-eg.,PEGti..be
8. *Pare11t.eralfeedi11g* oundudesallts; !Jf pet-enlera!feedings, ru:h astcta p«enleral n.dri!ion(TPN)
9. Actiufydid net occtr--OLrhg entire p;ricd

6) interRAI!

interRAl Home' -Gare'--He-d'--

4. DENTAL ORAL
0.No 1. Yes
a. wears a denture (remouabl eprristhesis)
b. Has broken, fragmented, bose, or other. <llise non-intactnattralteeUl
c. Repcxts hauing dry mouth
d. Reports difficulty chewing

N

1 MOST SEllEPE PfESSURE ll.CER
0.No pressure urcer
1./Jnyarea of persistert skin redness
2. Pattial loss of skin byers
3. Deep craletS in the Sdn
4. Breffis in skin exp:ising musde er bore
5. Not codeable, e .,necroticesi:her predominart

2 PfOCIRPfESSIffULCER
O.No 1.Yes

3 PRESENCE OF SKtl ULCER OTIER THAN PRESSlff ll.CER-e.g., *venoustJkcr, <:uteriefuher, mi<edvenous-att.en';;fulcer, diatetic foot tJfcer*
O.No 1.Yes

4. rMJCRSKIN PROOLEMS-e.g., /cskms, *2ndor 3rd de9(ee bums, heafHlg sutyicaf wwnds*
O.No 1.Yes

5. SKNTEARS OR.CUTS-- *ether than swgery*
O.No 1.Yes

6. OTIER SKIN CONOmONSOR CHANGES tiSKtl *CONDITOO-e.g., trtJises, r:Jshes, lching, motffif(J, tierpes zoder, intertro, eczema*
O.No 1.Yes

7. FOOT PROBLEMS-e.g., *b1mfDns; hammertoes; ove1loppif(J toes; st1uctural problems, infections; ulcers*
0. No tot prd::lems
1. Fcotprct:.ilems, no!imitdbninV\dki rg
2. Fodprotlerns limit V\dkirg
3. Foot f:t'cblems pre\1€flt kirg
4. Foot problems, cbesrot IAf'llk for dherreasons

SECT NS

1 UST OF ALL flEOICATIONS

List all Bcfive presc, Pthns, and ony non-piescribed (wer the court.er) meWclithnstakenin tlie LAST3 DIIYS

INcte: Use computerized recotdsf fXJSSib.'e; *tu1ndenteronlj when tJboolelJ necessal';I}*

For each drug recorct
a. flame
b. Dose-Aposiliverumber suchas OS,5, 1SJ,300.
[Note: Never wite a zero byitselfater a decimal)X1int (X mg). P!I/Æ"ISUse a zero betcre a decimal point (O.X mg)]
c. Unit-CoOO ushg the fotlCMiri.;-i list
gtts (Dreps) nfq (.Mili-eq..iivelert) Pttfs
(1Tl (Grmi) mg {.Mill£r.fim) % (Percent)
L (Liters) ml !Mlliliter) Unls
mcg (.Micrcgran) oz (Oun::e) OIH (Other)
d. Route *t:L* administntion-Code ushg the foUCN\irg list
PO (.BymoUricre4) REC (Rectal) ET (Ertera TuOO)
SL (Stillng..ia) TOP (fopca) TD (fransrennal)
MQrtramuroJ!ar) Ii(Irheiatictn) E'd: @ye)
IV Qnlravenous) HAS (Nas:S) OTH (Other)
SW-Q (Subculmeous)
e. Freq-Cod:: the nunber oftimesperday, vi.eek, ormorthtf'e medication !sa:fmlristered using tf'e tilloWng list
Q1H veiyhour) 50 (Stimes dcily)
Q2H vel'f 2oursl Q2D revery cther day)
Q3H Ue vety 3 ours Q3D very3days)
Q4H E Yel 4 ours We
QSH [f vel'f 6 ours 'Nol times \o\eeklyl
Q8H (EvetyBhOurs Wl timesl/\eekly
Daiv iJN 4 times IJ\eekly
BE!T jf OOdtimel &/II Stimes V1eekly
BIO 1imese:bify) &/II times\o\eek!y
(indu esevery12hrs) 1M 1orthly) h)
TIO C3timestl'tilY) 2M Wceevel'f mcnt
QD (4timese:biIy) OTH Other)
f. PRN
O.No 1.Yes

g. Comptier-ertered chlg code g.ATCa-HOC code

	a.Harre	b.Oose	c.Urit	d.Route	e.freq.	f,PRt	
1.							
2.							
3.							
4.							
'.							

[NOT!:: Md additkin:al lines, :asf'/ecess:ary, br dher drugstahef'l/ [Abbfevifltionsare D:iunfly Spectlc for Unl, Route, Freq.Jeno;}

Z ALLERGY TO ANY DRUG
0. No known drug allergies 1. Yes D

3. ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN
0. Always adherent
1. Adherent 80% of time or more
2. Adherent less than 80% of time, including failure to purchase prescribed medications
8. No medications prescribed

SECTION N. TREATMENT AND PROCEDURES

1 PPEllENTION
O.No 1.Yes
a. Blood pressure measured in LAST YEM
b. Colonoscopy testin LAST5YEARS
c. Dental examin LAST YEAR
d. E}e exam in LAST YEAR
e. Heari1g examin LAST2 YEARS
1. Influenza uaccine in LAST YEAR
g. Mammiogram or breast exam in LAST 2 VEARS (for women)
h. PoE1Jrmumt uaccilein LAST5 YEARS orafterage65

2. TPEAlMENTS AND PPDGRAI/ISRECEMOO ORSCIEDLLED ti THE LAST 3 DAYS (OR SfICE LASTASSESSfIENTF LESS1HAN3DAYS)
O. Net ordered .AND dd rot oa::ur
1. Ordered, ndimpemerted
2. 12 of last 3 days
3. Dailyin bst.3 days

TREATNENTS
a. Chemotherapy
b. Diahfsis
c. Infecli.:£ control-
i%1r.Jcn·
ci. IV me<ication
e. Oxygentherapy
f. Radiation
g. Suctioning
h. Tracheostor1¥ care
J. Transfusion
J. Ventilator or respirator
1. Sched.Jledtoileting program
m. Palliatiuecarepro17Bm
n. Ttllling/repositioning program

8 D D D D B

3. FORMAL CARE
D<!IS(A)ax!Tct1ri11utes(B)of""inlast7d<!IS
ExrentofCi9reh etimett ifi CAST YDAYS (CYsfogela:ita:sersmgr1 cx -edm'risiro,if/ess Inoc 7 dtdys) Invobir1?:
a. Harre health aides
b. Home nurse
c. Homemaking sesvices
d. Meals
e. Ptysical therapy
f. Occupationaltheraw
g. Sh-language patholoW and audiolow services
h. Psycholotjcal theraw (W aiv licensed mental health professional)

interRAI Home Care (HC)©

4. HOSPITAL USE, EflERGENCYROOM USE, PHYSIOAN VISIT
Code for number of timesduring the LAST90 DAYS (or since lad assessment if LESS THIIN90 DAYS)
a. Inpatient acliehospital ....nth ouemigtt stay
b. Emergency room visit (not counting ooernigtt st...)
c. Physician visit (or authorized assistant or practitioner)

5. PHYSICALLYFE ED-Llinbs *restrained, used bedrails, redffJlned ID cf/air when s.tting*
O.No 1.Yes

SECTION O. RESPONSIBILITY

1. LEGAL GUARDIAN [EXAMPLE-USA]
0.No 1. Yes

SECTION P. SOCIAL SUPPORTS

1. I\'\OKEYNFORMALHELPERS
a. Relationstip to person
1. Chlld orchild-lnaw
2. Spcuse
3. Partner/signifcant other
4. Perent lgtardien
: reletive
7. Ftierd
8. Nei$.t\l:or
9. No 1hfcnna helper
b. Lives wth person
O.No
1. Yes,6morthsorless
2. Yes,moretl'an6mo;lhs
B. No 1rlorma!helper
Helper 1 2
1-klpu 1 2
AREAS OFINFORNIIL HELP DURI'./G LAST3 DAYS I+.lp!r 1 2
O.No 1.Yes a. No Infcrmal helper
c. IAOL help
d. ADL hefp

2. INFORMALHELPERSTAIUS
O.No 1 Yes
a. Informal helperts) is IJ'lableto continuen caring actiuiies-e.g.,dedire in mathofl"f!lper md<esil difliOJltto o:irtlnr..e
b. Primary informal helper expresses feelings of distress, anger, or depression
c. Familyor closefriends ort feeling ouerWlelmed by person'S illness

3. HOURS OF INFORMAL CARE AND ACTI\£ MONITORI>IG DIRNG LAST3DAYS
For instr.1Jmpnts/r:ndpersonal activities of dail/ rving inthe LAST 3 DAYS, indnete the total
number of/Jo1Jrs ofhe,P recelled from ellfamilj, friends, end neiJhbors

4. STRONG AND SUPPORTI\£ RELATIONSHIPVHH
1. Yes
O.No

SECTION Q. ENVIRONMENTAL ASSESSMENT

1. HOfIE ENI.ROI.MENT
Cr.x!eforeny cfblhwing thdrtlflke home emironment hBZ<NdOlJS or IJfinhal:itable (iftemporan'ljin insb't1.tion, b:Jse assessment on home vis.t)
O.No 1.Yes
a. Disrepair cithehome-e.g., hazffcbus dutter, iradeq.iet.e or rolgliirg in living roan, sleePng room, kitd"en,toilet, orndors; hdesh 1oor, led<!ng plr:es
b. Salid Condition-e.g.,e:dremdy dirty, inEstet!on byrd:s orbUJS
c. Inadate heoting «cooling-e.g.,toohct!nsummff, too o:ild inVImter
d. Lack tipersonal safety-e.g. , feff ofvicience,safety
p-dleming:iirgtomalboxor'viSil1ngnellfJbots,heaw traffic instreet
e. Limited accessto home or rooms in home-e.g., difficulty ert«"irg er lea'virg fume,l..nalleto dimb stars, difliOJlty mmeuwirg wtHn roans, no railingsaltluulfJ needed

2. =''S N A'PIIRT fIENT OR HouSERE.eNG NeRED ACCESSIJLE FORPERSONSWTH DISABUTIES
O.No 1. Yes
1OUTSIIE ENVROI.MENT
a.No 1. Yes
a. Auaiabilty at mcy assistance--eg., telephcne, aterm resi;onse system
b. Accessibilityto grocey store wthout assistance
c. Auailabiity dhorre deliueryof groceries

4 FINANCES
Because of limited funds, during the last 30 days made trade offs among purchasing any of the following: adequate food, shelter, clothing; prescnbed medications; sufficient home heat or cooling; necessary heath care
0.No 1. Yes

SECTION R. DISCHARGE POTENTIAL AND OVERALL STATUS

1. ONE OR MORE CARE GOALS MET IN THE LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)
0. No 1. Yes
2. OVERALL SELF-SUFFICIENCY HAS CHANGED SIGNIFICANTLY AS COMPARED TO STATUS OF 90 DAYS AGO (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)
0. Improved [Skip to Section S]
1. No change [Skip to Section S]
2. Deteriorated
CODE FOLLOWING THREE ITEMS IF "DETERIORATI IN LAST 90 DAYS - OTHERWISE SKIP TO SECTION S

3. NUMIEROF 10AIX.AREASINVIHICHPERSON W\S NDEPENDENT PRKJR TO DETERIORATKIN
4. NIMIEROF 8 IADLPEIHRMANCE IIREASN \i\IHCH PERSONWASNDEPENDE NTPRIOR TO DETERIORATKIN
5. TlfIE OF ONSET OF THE PREOP!TATING EVENT OR PROBLEMRELATED TO DETERIORATKIN
O.\f\Athh last 7 days
1.8to14 OOysag:i
2. 15to30 d9ys ag:i
3. 311060 days agi
4. Mereihan60 de ago
ent

SECTION S. DISCHARGE

[I\tJte: C-OmpleteSecthn SiltDix/JRrge on)J]
1. LASTDAY OF STAY
12101 1 -rn-rn
Year Morth Day

2. RESIIENTIAL ILIWIG STAIUS ATTr.E OF ASSESSfIENT
1. Ptivdehome /ef)artmert/rentedroom
2. Board ard care
3. Assisted IMrg er seminrepident 11\>ing
4. Mentel f'eaUi resirencs-e.g., psychiatric grcup home
5. Group home tcr persons Wlh ph:i$c6 disatmty
6. Setting forpersonsV\<th intellectual disability
7. Psycti1atrichospilal er unit
8. Homeless (\fIlhor Wlluut sf'elter)
9. Lorg-tenn care tidlity(nursing home)
1O.Relii:tililation tnspilal /mil
11.HosPce tidlitP.allifiive care unit
12.Arutecffehospiial
15. Decease;{

. SIGNAJURE OF PERSON COORDNATNGCOM'LETNG HE ASSESSfIENT
1.Signature (sign on above line)
2. Date assessrrert signed as COITJIfete
12101 1 1 -rn-rn
Year Marth D

Rev. 04/11 Note: Remember when assessing LOC with the Multi Data Set - Home Care (MDS-HC) that the target population for SOURCE are physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance in the performance of the activities of daily living (ADLs) and instrumental activities of daily living (IADLs); these individuals must meet the Definition for Intermediate Nursing Home LEVEL OF CARE.)

MEDICATION LIST

Client Name:				Date:	
Med Name	Dosage	Route	Freguency	Indication	Physician

	• Problems identified that need reported to the MD?

Intermediate care services may be provided to an indivictual with a stable medical condition requiring intermittent skilled nursing services under the direction of a licensed physician (Column A- Medical Status) AND a mental or functional impairment that would prevent self-execution of the required nursing care (Column B- Mental Status and Column C- Functional Status).

Special attention should be given where psychiatric treatment is involved. A patient is not considered appropriate for intennediatecare services when the primary diagnosis or the primary needs of the patient are psychiatric rather than medical. This individual must also have medical care needs that meet the criteria for intermediatecare facility placement. Insome cases a patient suffering from mental illness may need thetype of services which constitute intem1ediatecare because the mental condition is secondary to another more acute medical disorder.

REQUIREMENTS: TWO CONDITIONs MUST EXIST FROM COLUMN A (Medical Status) AND ONE FROM COLUMN B (Mental Status) OR COLUMN C (Functional Status) WITH THE EXCEPTION OF #5 IN COLUMN C.

Column A
Medical Status

1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician.
   Ila-u, Ua-f, N2a-k=l,2,or3

In addition to the criteria listed immediately above, the patients specific medical condition must require any of the following plus one item in Column B or Column C.

2. Nutritional management;which may includetherapeutic dietsor maintenance or hydration status.
   K2a-d=l or an issue
   K3(1-9)=5,6,7,or 8 is selected
   N2d=2 or3

3. Maintenance and preventative skin care and treatment of skin conditions, such as cuts, abrasions, or healing decubiti.
   L1=2,3,4,5 L3:L4:L5=1/yes
   L7=2 or 3 N2=k (wound care/present)

4. Catheter care such as catheter change and irrigation.
   Hl=l H2= 2 or 3

5. Therapy services such as oxygen therapy, physical therapy, speech therapy. occupational therapy (3 times per week or less).
   N3b, 3e, 3f, 3g =Present
   N2a-k=Present/l,2,3

6. Restorative nursing services such as range of motion exercises and bowel and bladder training.
   N3e and N21= Present

7. Monitoring of vital signs and laboratory studies or weights.
   Nla=l N2a,b,d, and i = Present
   N3b= Present K2a=Present

8. Management and administration of medicationsincluding injections.
   G 1d 1-6 (performance)
   N2a, N2d, N2i = Present
   Mld=IM(intramu scular), IV (intravenous), Sub-Q (Subcutaneousor ET (Enteral Tube)
   M3=1 or 2 is selected

Column B
Mental Status

The mental status must be such that the cognitive loss is more than occasional forgetfulness.

1. Documented short or long-term memory deficits with etiologic diagnosis. Cognitive loss addressed on MOS/ care plan for continued placement.
   C2a, b, or c = 1

2. Documented moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making. Cognitive loss addressed on MOS/ care plan for continued placement.
   Cl= 3,4 5 C5=2

3. Problem behavior, i.e. wandering, verbal abuse, physically and/or socially disrupti ve or inappropriat e behavior requiring appropriate supervision or intervention.
   E3a-f =1,2 or 3

4. Undetermined cogniti ve pallerns which cannot be assessed by a mental status exam, for example, due to aphasia.

J3j=2,3, or 4 ---llj; Ile; lld=l,2,3---12a-f*
Possible Diagnoses:severeseizuredo,TBI,ABI,Anoxic brain injury

Client Name_____

Completed by_____

Date of Visit'-_____

RN Approving LOC_____

Date of LOC_____

Column C
Functional Status

One of the following conditions must exist (with the exception of #5).

1. Transfer and locomotion perfonnance of the residentrequireslimited/extensiveassistanceby staff through help of one person physical assist.
   G2g, G2f=3,4,5,or 6 G8b=2 or3
   G3c, G3d = 0 J3a; J3b = 1,2,3,4
   **If J3a-b is circled (CI), is this compensated by walker, cane, slower movements, or use of furniture? *YIN* Ifso, this is NOT enough for NH level.

2. Assistance with feeding. Continuous stand-by supervision, encouragement, or cueing required and set up of meals.
   G2j= 3,4,5,or 6

3. Requires direct assistance of another person to maintain continence.
   G2g; G2h=3,4,5 or6

4. Documented communication deficits in making self und erstood or understanding others. Deficits must be addressed in medical record with etiologic diagnosis addressed on MDS/ careplan for continued placement.
   Dl; D2= 3 or 4

5. Direct stand-by supervision or cueing with one person physical assistance from staff to complete dressing and personal hygiene. (If this is the only evaluation of care identified, another deficit in functional status is required.)
   G2a;G2b,G2c;G2d=3,4,5or6

INSTRUCTIONS/GUIDE for Determination of ILOC

Intermediate Level of Care Criteria: SOURCE Applications

The target population for SOURCE are physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance in the performance of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs); these individuals must meet the Definition for Intermediate Nursing Home LEVEL OF CARE and all other eligibility requirements listed in 801.3. The Intermediate Level of Care Criteria is recommended by the Site's Registered Nurse, using assessment information reported via the MDS-HC assessment, case notes, physician notes, history & physical, and other assessment tools. The R.N. circles all relevant items from Column A, B & C to support the level of care. If additional notes such as related diagnoses are required, such information is noted on the document.

Specific criteria as below:

I. **Medical Status: Must satisfy Question #1 and any one of #2 through #8**

SOURCE LOC CRITERIA	PRIMARY LOC APPLICATIONS
1. "Has at least one chronic condition . . ."	Examples: HTN, diabetes, heart disease, pulmonary disease, Alzheimer's, spinal cord injury, CVA, arthritis, etc.
2. Nutritional management . . ."	Medical record reflects status as underweight or morbidly obese; need for therapeutic diet d/t exacerbation chronic condition (HTN, diabetes, skin condition, etc.); dialysis patients (hydration); others at risk of dehydration.
3. "Maintenance and preventive skin care . . ."	Diabetics; SRC members spending significant time in wheelchair or bed; existing wound care/skin issues or history of; members with incontinence
4. "Catheter care . . ."	Self-explanatory
5. "Therapy services . . ."	Self-explanatory
6. "Restorative nursing services . . ."	Self-explanatory
7. "Monitoring of key clinical indicators, laboratory studies or weights . . ."	Diagnosis requiring ongoing monitoring of clinical indicators: hypertension, pulmonary disease, diabetes, cardiovascular disease, etc. (key clinical indicators

	include but are not limited to blood pressure, pulse, respiration, temperature, weight, blood sugar for diabetics); medications indicating ongoing laboratory studies (Coumadin, Dilantin, Tegretol, Digoxin, Phenobarbitol, liver profiles, certain cholesterol medications, etc.); CHF and dialysis patients for monitoring of weight.
8. "Management and administration of medications…"	SRC members needing assistance with management OR administration of medications (d/t cognitive or physical impairments). May be paid care or informal support providing assistance.

II. Cognitive Status that includes cognitive loss. Must Satisfy one of #1 through #4

(NOTE: ALWAYS INVOLVES COGNITIVE LOSS WITH ETIOLOGIC DIAGNOSIS NOT RELATED TO A DEVELOPMENTAL DISABILITY OR MENTAL ILLNESS FOR SOURCE WAIVER ELIGIBILITY)

SOURCE LOC CRITERIA	PRIMARY LOC APPLICATIONS
1. "Documented short or long-term memory deficits…"	Linked to a diagnosis (CVA, TBI, dementia, Alzheimer's, etc.) documented in medical record; review MMSE score.
2. "Documented moderately or severely impaired cognitive skills…"	Same as above. Allow for eccentricities.
3. "Problem behavior…"	Self-explanatory. Allow for eccentricities.
4. "Undetermined cognitive patterns which cannot be assessed by a mental status exam…"	Rarely used. Aphasia listed as example.

OR

III. Functional Status: Must satisfy one of #1 through #4 (with the exception of #5)

{NOTE: ALWAYS INVOLVES IMPAIRMENT WITH ETIOLOGIC DIAGNOSIS NOT RELATED TO A DEVELOPMENTAL DISABILITY OR MENTAL ILLNESS FOR SOURCE WAIVER ELIGIBILITY)

SOURCE LOC CRITERIA	PRIMARY LOC APPLICATIONS
1. "Transfer and locomotion performance requires limited/extensive assistance . . ."	"One person physical assist" is key indicator. Not someone who lives alone with no support (paid or informal) in place or planned. "Locomotion" viewed as primarily in home.
2. "Assistance with feeding."	May be due to significant physical or cognitive impairment. Cueing and set-up help required together (i.e., not just an IADL issue).
3. "Direct assistance . . .to maintain continence."	"Assistance of another person" is key indicator (i.e., not just using incontinence products). May be due to physical (transfers, etc.) or cognitive impairments.
4. "Documented communication deficits . . ."	Deficits must be addressed in medical record with etiologic diagnosis addressed on MDS/care plan for continued placement.
5. "Assistance . . . dressing/personal hygiene"	Self-explanatory. See "another deficit" requirement described.

RN will complete this form and attach to packet uploaded to AHS. Each section will be completed by the RN by circling the section of the MOS beside each item in each Column. For instance, if the MOS indicates that the member requires moderate assistance with ambulation, then circle the 3 or 4 by G2g under Column C number 1. On the blank line indicate the diagnosis that causes the level of impairment. Each item that is circled should match the scoring on the MOS.

RN Review and Signature Form

MDS-HC Participants
SOURCE Program

Participant	Agency	Relationship to Applicant	Date

RN Who Reviewed MOS HC for Consistency & Completeness: (Printed)	RN signature	Date:

Appendix T needs to be signed and dated by R.N. SOP is within 10 business days of completion of the MDS-HC and uploaded with packet to AHS

Elderly and Disabled Waiver Program (EDWP)
Physicians Evaluation

SECTION I-IDENTIFICATION (To Be Completed by Submitting Agency)

Date:	Patient Name:
Agency Name:	Sex:Male or female
Address,Phone, & Fax	DOB:

NOTICE TO PHYSICIAN:This member has requested home and community-based services from the EDWP (Elderly and Disabled Adults Waiver). In order to qualify a person must have a severe to moderate physical impairment and/or memory impairment that requires the assistance of another individual to perform their normaldaily activities such as bathing,grooming,eating, and toileting.

Please complete the information below to document the patient's current condition and functional status.

Active and Important Diagnosis(es)n related to physicalimpairment or physiologic/neurologic problem (Please attach problem list)

Height __ft. _in;Weight ___

Medical	Mental Status	Functional Status
Does the patient require monitoring of a medical condition by a licensed MD? Yes/No	Is there documentation noting short or long-term memory deficits with etiologic diagnosis? Yes/No	Does the patient require extensive assistance with transfers and locomotion performance through help or one-person physical assist? Yes/No (If this is compensated by walker,cane,slower movements or use of furniture, this is NOT enough for the nursing home level of care requirement.)
Does patient require nutritional management? Yes/No ● Therapeutic diet -yes/no ● Hydration Maintenance -yes-no	Is there documentation noting moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making? Yes/No	Does the patient require assistance with feeding such as: continuous stand-by supervision, encouragement or cueing, and set-up help of meals? Yes/No
Does the patient require maintenance and preventive skin care? Yes/No ● treatment of skin conditions, such as cuts, abrasions or healing decubiti? Yes/No	Does the patient exhibit a problem with behavior, i.e. wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring supervision or intervention? Yes/No	Does the patient require direct assistance of another person to maintain continence? Yes/No
Does the patient have a catheter care that requires a catheter change and irrigation? Yes/No	Does the patient have undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia? Yes/No	Are there communication deficits in making self-understood or understanding others? Yes/No
Is the patient currently receiving therapy services such as? ● oxygen therapy: Yes/No ● physicaltherapy: Yes/No ● speech therapy: Yes/No ● occupational therapy:Yes/No	Note: Etiologies not covered inSOURCE or CCSP are those due to a mentalhealth (i.e. Schizophrenia, mental retardation,developmental delay etc.). Cognitive loss (i.e. traumatic brain injury,dementia,etc.) is covered by SOURCE or CCSP	Does the patient require direct stand-by supervision or cueing with one-person physical assistance from staff to complete dressing and personal hygiene? Yes/No
Does the patient require restorative nursing services such as range of motion exercises? Yes/No Does the patient Bowel and bladder training? Yes/No		Graded Strength Scale of 1-5/5:)Muscle Flicker,but no movement 2)Severe Weakness (no movement against gravity) 3)Moderate Weakness (movement against gravity but not resistance) 4)Mild Weakness (move against resistance) S)Normal Strength Upper Extremities: Right | Left Lower Extremities: Right | Left
Does the patient require monitoring of vital signs and laboratory studies or weights? Yes/No		
Does the patient's medicalcondition require management and administration of medications including injections? Yes/No. Is skilled nursing required for medication administration and management? Yes/No		

Comments:

Print Physician Name/Title | Physician Signatures/Title | Phone Number | Date

Mini-Mental State Examination (MMSE)

Patient's Name: ———————————————————— Date:_____

Instructions: Ask the questions in the order listed. Score one point for each correct response within each question or activity.

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials:
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-0-W)
3		"Earlier I told you the names of three things. Can you tell me what those **were?"**
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		TOTAL

(Adapted from Rovner & Folstein, 1987)

Source: www.medicine.uiowa.edu/igec/toolstcognitive/MMSE.pdf Provided by NHCOF. 0106-410

Instructions for administration and scoring of the MMSE

Orientation (10 points!):

- Ask for the date. Then specifically ask for parts omitted (e.g., "Can you also tell me what season it is?"). One point for each correct answer.
- Ask in turn, "Can you tell me the name of this hospital (town, county, etc.)?" One point for each correct answer.

Registration (3 points!:

- Say the names of three unrelated objects clearly and slowly, allowing approximately one second for each. After you have said all three, ask the patient to repeat them. The number of objects the patient names correctly upon the first repetition determines the score (0-3). If the patient does not repeat all three objects the first time, continue saying the names until the patient is able to repeat all three items, up to six trials. Record the number of trials it takes for the patient to learn the words. If the patient does not eventually learn all three, recall cannot be meaningfully tested.
- After completing this task, tell the patient, "Try to remember the words, as I will ask for them in a little while."

Attention and Calculation (5 points):

- Ask the patient to begin with 100 and count backward by sevens. Stop after five subtractions (93, 86, 79, 72, 65). Score the total number of correct answers.
- If the patient cannot or will not perform the subtraction task, ask the patient to spell the word "world" backwards. The score is the number of letters in correct order (e.g., dlrow=5, dlorw=3).

Recall (3 points):

- Ask the patient if he or she can recall the three words you previously asked him or her to remember. Score the total number of correct answers (0-3).

Language and Praxis (9 points):

- Naming: Show the patient a wrist watch and ask the patient what it is. Repeat with a pencil. Score one point for each correct naming (0-2).
- Repetition: Ask the patient to repeat the sentence after you ("No ifs, ands, or buts."). Allow only one trial. Score O or 1.
- 3-Stage Command: Give the patient a piece of blank paper and say, "Take this paper in your right hand, fold it in half, and put it on the floor." Score one point for each part of the command correctly executed.
- Reading: On a blank piece of paper print the sentence, "Close your eyes," in letters large enough for the patient to see clearly. Ask the patient to read the sentence and do what it says. Score one point only if the patient actually closes his or her eyes. This is not a test of memory, so you may prompt the patient to "do what it says" after the patient reads the sentence.
- Writing: Give the patient a blank piece of paper and ask him or her to write a sentence for you. Do not dictate a sentence; it should be written spontaneously. The sentence must contain a subject and a verb and make sense. Correct grammar and punctuation are not necessary.
- Copying: Show the patient the picture of two intersecting pentagons and ask the patient to copy the figure exactly as it is. All ten angles must be present and two must intersect to score one point. Ignore tremor and rotation.

(Folstein, Folstein & McHugh, 1975)

Source: www.medicine.uiowa.edu/igec/toots/cognitive/MMSE.pdf Provided by NHCQF, 0106-410

Interpretation of the MMSE

Method	Score	Interpretation
Single Cutoff	<24	Abnormal
Range	<21	Increased odds of dementia
	>25	Decreased odds of dementia
Education	21	Abnormal for 8th grade education
	<23	Abnormal for high school education
	<24	Abnormal for college education
Severity	24-30	No cognitive impairment
	18-23	Mild cognitive impairment
	0-17	Severe cognitive impairment

Sources:

- Crum RM, Anthony JC, Bassett SS, Folstein MF. Population-based norms for the mini-mental state examination by age and educational level. *JAMA.* 1993;269(18):2386-2391.
- Folstein MF, Folstein SE, McHugh PR. "Mini-mental state": a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res.* 1975;12:189-198.
- Rovner BW, Folstein MF. Mini-mental state exam in clinical practice. *Hosp Pract.* 1987;22(1A):99, 103, 106, 110.
- Tombaugh TN, Mcintyre NJ. The mini-mental state examination: a comprehensive review. *J Am Geriatr Soc.* 1992;40(9):922-935.

VAMC
SLUMS Examination

Questions about this assessment tool? E-m.aill a!tin;@sln.edu..

Nam Age

Ispatient alert? Level of education _____

_f 1 0 1. What day of the Wffk is it?

11 0 2. \Vihat is the year?

11 0 3. W!bat state are we in'>

.i. Ple.ase remember these five o je.cts. I will ask ou what they are later.

Apple Pen Tie Hoose Car

5. You have $100 and you go to the stol't' and buy a dozen apples for $3 and a tricyde for $2-0.

0 How much did you spend?

13 8 How much do you haw left?

6. Please name as manv animals as you C1.D in one minute.

_13 0 0-4 animals O 5-9 anim.a]s 9 10-14 animals e t s+ animals

/.S 7. What were the five objeds I asked you to reme-mbe-r? 1 point for each correct

8. I am going to give yon a se-ries of numbers and would like you to gj1e them to me bach.""Wards. For ell.Dlple, if I say .i2, you would say 24.

fl. (i) 87 0 649 0 8537

9. This is a clock fuc.e. Pluse put in the hour markers and the time at ten minutes to eleven o'clock.

8 Hour markers okay

_f 4 8

fl. 0 io :i ::=..xmth.m..gi.. D6.D

0 '\Vhich of the abon figures is largest?

11. I am going to tell yon a story. Please listen carefully because aftenvarcls, I'm going to ask you some questionsabout it.

Jillwas a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. Shemarried him and had tluee children.. They lived in Chicago. Shethen stopped wo:d:and stayed at home to bring upherc.bildren. When they were teenagers, she went back to wodc She and Jack lived happily ever after.

8 What was the female's name?

8 Wh.atnortdid shedo?

18 8 When did she go back to work.?

8 Wnat statr- did she fu;e in?

TOTAL SCORE

Department of Veterans Af fairs

SAi r LOI HS
ll:"JYE RSITY
SCORJ:';C..

Ihca ScaooL Eouc		LEss THAN lbGa ScaooL l:DuCATIOl'i'
27-30	Normal	
2.1-16	MNCD*	*20-U*
1-2-0	Dr-men.Cia	1-19

* Mild Nnrocognitive Disorder

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for Detecting Mild Cognitive Impairment and Dementia is more sensitive than the Mini-Mental Status Examination (MMSE) - A pilot study. J am Geriatri Psych (in press).

VAMC Saint Louis University Mental Status Examination Form Details

Who Can Complete the Fonn:Sociali Seniices,Refledions/Passages Program Coordinalol's, licensed Nurses, MDs,NPs,OTs,PTs,Residence Servisors and Other Quaified Healthcare Professional Mio have been traiied {andretrained annually) by viewing fhe VA-produced DVD (available uponrequestto tumosan@slu..edu).

Purpose of the Fonn: Toscreen incfividuals to look for 1hepresence of cognitive deficils, and lo identify changes in cognition over lime.

Instructions for Use:

1. Complete resident demographics althetop of the page.

2. We remmmend that putthedate andthe name ofthe evaluator onthe bottom of 1hepage aswell (see #19)_

3. Acministration should be conducted *privately* ar!G in lhe examinee'sprimary language_ Be prepared with the items u needtooomplete the exam. You will need a watdt with a second hand on it.

4_ Record the numbeir of years the patient attended school. ff the patient obtained an Associates, Badtelor's, Master's orOoctorale degree,notethe degree acttievedilstof actual years ofschool alien.

5. Oetennine if the patient is alert *Do* not answer •yes• or •no•, bu.t indicate level of alertness.. Alert indicates that the individual is fully awake and al>le to tows. Ofher plots Wldude: drowsy, confused, distradible, inattentive , preoca.ipied.

6. Beginby asking the patient the following:
"Doyoo have anytrouble with your memory?" "May laskyoo some questions about your memory?"
Then proceed with the exam questions.

]_ Read the questions aloud clearfy and *sbwly* to 1he examinee . It is not usually necessary to speak loudly but it is necessary to speak slowly_

8. Begin by asking 1he patient SC>mething similarto 1he following:
"Doyoo have anytrouble with yoor memory?" "May laskyou some questions about *your* memory?"
'Td like to see how good your memory is by asking yoo some questions."You may need to reassure patients by tel6ng them that this is not a test that they can faa but meJ"ely a toolmuch like a thennometer that takes temperature is a tool.What this does is checb for the amount of memoty they have_
Then begii to adminisfet·1he exam questions.

9. Scorethe questions asindicated on the examination.

10. On question IM,read the statement as listed on the exam. Ask the patient to repeat eadt of the five objects (Apple, Pen, Tie, House, Car) thal you recite to make sure that the patient heard and understood Mlat *you* said. Repeat them as many times as it takes i>r the patienl to repeat them back to you corredly_

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "V" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little Interest or pleasure In doing things	a		2	3
2. Feeling down, depressed, or hopeless	a	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	a	1	2	3
4. Feeling tired or having little energy	a		2	3
5. Poor appetite or overeating	0		2	3
6, Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? or the opposite - being so fidgety or restless that you have been moving around a Jot more than usual	0		2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	a		2	3

FOR OFFICE CODING __O__ + + + **=Total Score:**

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
D	D	D	D

Developed by Ors. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educab:onal grant from Pfizer Inc. No permission required to reproduce, translate, display or dlstlibute.

Determine Your Nutritional Health

The Warning Signs of poor nutritional health are often overlooked. Use this checklist to find out if you or someone you know is at nutritional risk.

Read the statements below. Add up the numbers in the "YES" column for those that apply for you.

	YES
I have an illness or condition that made me change the kind and / or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables, or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 2 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and / or feed myself.	2
Total	

Total your Nutritional Score: If it's-

0-2	GOOD! Recheck your nutritional score as needed if signs of decline
3-5	You are at Moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Check your score again as needed if signs of decline
6 or more	You are at high nutritional risk Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk to them about any problems you may have. Ask for help to improve your nutritional health.

Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition. Tum to thepage to learn more about the Warning Signs of poor nutritional health.

The Nutrition Checklist is based on the Warning Signs described below. Use the word DETERMINE to remind you of the Warning Signs.

Disease

Any disease, illness or chronic condition which causes you to change the way you eat, or makes it hard for you to eat, puts your nutritional health at risk. Four out of five adults have chronic diseases that are affected by diet. Confusion or memory loss that keeps getting worse is estimated to affect one out of five or more older adults. This can make it hard to remember what, when or if you've eaten. Feeling sad or depressed, which happens to about one in eight older adults, can cause big changes in appetite, digestion, energy level, weight and well-being.

Eating Poorly

Eating too little and eating too much both lead to poor health. Eating the same foods day after day or not eating fruits and vegetables, and milk products daily will also cause poor nutritional health. One in five adults skip meals daily. Only 13% of adults eat the minimum amount of fruits and vegetables needed. One in four older adults drink too much alcohol. Many health problems become worse if you drink more than one or two alcoholic beverages per day.

Tooth Loss/Mouth Pain

A healthy mouth, teeth and gums are needed to eat. Missing, loose, or rotten teeth or dentures which don't fit well or cause mouth sores make it hard to eat.

Economic Hardship

As many as 40% of older Americans have incomes of less than $6,000 per year. Having less -- or chosing to spend less -- than $25-30 per week for food makes it very hard to get the foods you need to stay healthy.

Reduced Social Contact

One-third of all older people live alone. Being with people daily has a positive effect on morale, well-being and eating.

Multiple Medicines

Many older Americans must take medicines for health problems. Almost half of older Americans take multiple medicines daily. Growing old may change the way we respond to drugs. The more medicines you take, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and others. Vitamins or minerals when taken in large doses act like drugs and can cause harm. Alert your doctor to everything you take.

Involuntary Weight Loss/Gain

Losing or gaining a lot of weight when you are not trying to do so is an important warning sign that must not be ignored. Being overweight also increases your chance of poor health.

Needs Assistance to Self Care

Although most older people are able to eat, one of every five have trouble walking, shopping, buying and cooking food, especially as they get older.

Etder Years Above Age 80

Most older people lead full and productive lives. But as age increases, risk of frailty and health problems increase. Checking your nutritional health regularly makes good sense.

Reprinted with permission from the Nutrition Screening Initiative, a project of the American Academy of Family Physicians, the American Dietetic Association and the National Council on the Aging, Inc., and funded in part by a grant from Ross Products Division, Abbott Laboratories.

Instructions

Elderly and Disabled Waiver Program

NUTRITIONAL SCREENING INITIATIVE (NSI) NUTRITIONAL HEALTH CHECKLIST

Purpose: The purpose of the NSI Checklist is to identify individuals who are at high risk of nutritional problems or who have poor nutritional status.

Who Completes/ When Completed: The Nurse/care coordinator completes the NSI in Harmony at initial assessment and reassessments. Should the client's condition or situation change, the care coordinator, completes the NSI, as needed, between reassessments.

NOTE: Referral sources include but are not limited to physicians, dietitians or other health professionals, social services, oral health, mental health, nutrition education, supp01t or counseling services.

Instructions:

For each of the ten statements, read and circle the appropriate number in the "Yes" column which describes each client/ client representative response. Total the numbers circled to identify the client's nutritional score.

Based on the total score, make the appropriate referrals, if indicated, as suggested in the reference - Nutrition Interventions Manual for Professionals Caring for Older Americans Executive Summary 1992. Document all activity relative to the NSI checklist referral, such as follow-up and outcome results. Complete the NSI checklist as needed.

Distribution: A copy is filed in the client's case record along with documentation regarding any deviation from normal, specific instructions or referral information.

DIRECTIONS FOR ALLIANT UPLOADS

FAQs

SOURCE program admission now includes AHS review for initial admission assessment, 6 month reassessment, and a designated number of annual reviews.

Information on their services and how to access their services is now available to Providers via the Provider Workspace/Education and Training link.

To access the training resources referenced in the SOURCE Webinar, please follow these instructions:

Open the web portal at www.mmis.georgia.gov

Log in using your assigned credentials to open the *Secure Home* Page

Click the ***Prior Authorization*** link

Click ***Provider Workspace*** from the drop list

Go to the bottom of the workspace page, and under the Help & Contact Us section, click ***Education and Training Material and Links***

Help & Contact Us

Education & Training Material and Links - Use this link to access workshops webinars user manuals and other resources.

Contact Us or Search My Correspondence - Use this link to contact review nurse staff behind the scenes of MMIS portal

If AHS gives a final denial to the member it is the responsibility of the SOURCE Case Management Agency to follow up with the member per section 901 under Procedures/ Medicaid Eligibility: Screening staff will access the GAMMIS website to confirm a potential member's eligibility status. For persons not eligible for SOURCE or not interested in joining the program, appropriate referrals to other services or organizations will be made (including referral to the Social Security Administration if the person screened may be eligible for SSI). See also Policy No. 1405, Right to Appeal.

2nd level Reviews:

The 2nd level review option is only for members who have an evaluation denial from AHS

- The member receives this information in their denial letter and will have 30 business days to provide new information to AHS through their Case Management agency.
- Please do not use the contact us system. Use the Reconsideration Link only (page 39 of the Provider Workspace User Manual).
- If the member provides new information in the 30 days, they will either be accepted by AHS for LOC, or they will receive a 2nd and final denial letter.
- If the member does not give new information, no new denial letter will be issued from AHS. The member continues to have the right to ask for an appeal within 30 days from issuance of the original denial letter

OPTIONAL FORM

SOURCE ASSESSMENT ADDENDUM

Member:_____ Date: _____

1. Home Assessment:

List people who live in the home:

Name/Relationship	Age	Work: FT, PT, Night	Status: Permanent, Temporary, Intermittent	School: Yes or No

Is there usually someone with you at night? Y_____ N_____

Do you have someone who could stay with you if you were sick? Y_____ N_____

If yes, provide name and contact information: _____

_____

Plans for evacuation or disaster: _____

_____

2. Physical Environment:

Features:	Yes	No	Features:	Yes	No
Electrical hazards			Space heater(s)		
Stove/refrigerator on premises			Telephone		
Signs of careless smoking			Smoke detectors		
Washer/dryer on premises			Running water		
Other fire hazards			Indoor toilets		
Pets (specify)			Adequate ventilation		
Satisfied with living situation			Planning to move		

Comments: _____

_____

_____

3. Medications:

Pharmacy name and telephone number: _____

How do you get your medications? _____

OPTIONAL FORM

SOURCE ASSESSMENT ADDENDUM

Member:_____ Date: _____

4. Psychosocial:

In the past year have there been any significant changes in your life, such as:

	Yes	No		Yes	No
Illness/injury			Change in marital status		
Change in job, residence			Victim of crime or Exploitation		
Losses or deaths			Other (specify)		

5. Advance Directives:

Do you have a signed Advance Directive? Yes_____No ____
If yes, where is the copy kept?_____
Does the family know of the Advance Directive? Yes_____No____

6. Proxy Decision Makers:

Name:_____Relationship: _____
___ Telephone: _____
Type: guardian ____ payee ___ power of attorney_

7. Financial Information:

Monthly Income $_____
Social Security_____
SSI _____
Other
Checking Account? Yes_____No
Savings Accounts? Yes_____No
Who manages money for member?_____

8. Nutrition:

Has your doctor told you to eat a special diet? _____

Are you compliant with your diet order? Yes_____No ____

Do you use alcohol? Yes_____No_____; tobacco? Yes_____No_____; or recreation drugs? Yes_____No

If yes, what drugs?_____

9. Home Monitoring:

If applicable, in addition to your doctor, who is responsible for monitoring_BS_____BP ____weight?_____others assisting_____

OPTIONAL FORM

SOURCE ASSESSMENT ADDENDUM

How often?_____

Member: _____ Date:_____

Member: _____ Date: _____

List any monitoring equipment and supplies you have (blood pressure cuff, One-Touch type machine, scales, etc.)

_____

10. Lab-work:

Do you currently require any ongoing/ab-work/diagnostics or other medical procedures (blood machine, scales, etc)?

_____

Procedure_____Frequency _____

Reason _____Provider _____

11. IADLJAOL:

Instrumental Activities of Daily Living

Category:	**WHO helps and WHEN? (include ALL assistance - family/friends AND formal services)**
Telephone	
Shopping	
Food preparation	**Breakfast/Lunch/Supper**
Housekeeping	
Laundry	
Mode of Transportation	
Medications	
Finances	

OPTIONAL FORM

SOURCE ASSESSMENT ADDENDUM

Member:_____ Date:_____

Basic Activities of Daily Living - If assistance is required:

Category	WHO helps and WHEN? (ALL informal AND paid suooort)
Bed mobility:	
Transfer:	
Locomotion:	
Dressing:	
Eating:	
Toilet use:	
Personal hygiene:	
Bathing:	
Continence:	

Are existing caregivers willing/able to continue providing assistance at current levels? Yes _____No Comments:_____

_____

12. Physician Information

Doctor's Name_____Phone No. ( )_____

Reason _____

Doctor's Name_____Phone No. ( ) _____

Reason_____

OPTIONAL FORM

SOURCE ASSESSMENT ADDENDUM

Member:_____ Date: _____

13. **Medical Treatment**

Do you currently receive any of the followinQ medical treatments? (If ves, list who provider and teleohone number.\

Treatments:	Provider/Telephone Number:
Pressure sore treatment	
Wound or other skin care treatment	
Skilled therapy (PO/OT/speech)	
Colostomy/ostomy care	
Oxygen	
Other	

14. Other Programs

Cross reference with other programs:

15. Education

What is the highest grade completed in school? ——————————————

16. Special Equipment

_Bed Rail _Hospital Bed _Incontinence pads
_Catheter _High toilet seat _Glasses

_Brace (back) _Prosthesis_____ _Cane/walker

OPTIONAL FORM

SOURCE ASSESSMENT ADDENDUM

_Blood glucose monitor _Adaptive eating equipment _Grab bars
_Bathing equipment _Bedside commode _Other vision
_Lift (manual/electric) _____ Wheelchair (manual/electric) _Dentures
_Other _____

_____ _____

Care Manager Signature _____ Date _____

EDWP Modified Reassessment

Section A. Identification Date of Visit
Member Name:_____DOB Medicaid number
Place of Assessment: 0 Home 0 Hospital 0 Nursing Home 0 ALS/PCH 0 other

Section B. Reason for evaluation
O Discharged from Nursing Facility O Discharge from institutional stay (mental health) O Internal Transfer
O External Transfer O Change in function (cognitive or physical) O Other _____

Section C. Diagnoses (if applicable, include diagnosis relevant to nursing facility or institutional stay and/or change in function)
1. _____ 2. _____ 3. _____

Section C. Carepath Goals

Community	Service Recommended	Provider	Frequency/Units
Nutrition/Weight	Ordered diet:_____ 0 Weight gain (90 days) D Weight Loss (90 days)		
Skin Care	O No skin breakdown O Decubitus ulcer/stage and location _____ O Other wound/ulcer (specify) and location _____ O Wound care provider and frequency		
Clinical Indicators	D Self-monitoring 0 BP O Blood sugar 0 Weight 0 Other _____ O Assisted monitoring 0 Dialysis 0 Chemotherapy/radiation O Oxygen Nursing Facility admit date discharge date		
Medication	O Self-monitoring 0 Compliant 0 Noncompliant O Needs assistance D Medication list updated		
ADL/IADL Performance (S-Self; INF-informal support; PSS)	____bathing_dressing_____eating_____transferring_____toileting_____walking _____managing finances_____errands_____meal prep_____laundry_____shopping transportation		
Transfers	O cane O walker O wheelchair 0 bedbound O other _____ O fall in 30 days O fall in 90 days O fall with injury in 90 days _____		
Problem Behavior	0 Alzheimer's O Dementia O mental health 0 substance abuse O depression O Other _____		
Informal Support/Caregiver	O indicators present for caregiver burnout 0 adequate caregiver support/name _____		
Other - Continence, Housing, Hospice, other	O UTI/other urinary related infection 0 Urinary Incontinence O Bowel Incontinence O Request to move O Dual enrollment hospice/provider		

Additional information (i.e. home health, PT, OT, ST, etc.)

_____

_____

_____

Member signature _____ Date _____
LPN/RN Signature _____ Date _____
Supervisor Signature _____ Date _____

CARE PATHS

Carepath

Member Medicaid # Date:_____

SOURCE Service Prior Authorization Number_____

SOURCE Service Dates to ——————————

Service Options Using Resources In Community Environments

CAREPATH

Circle what the patient has:

1) a documented cognitive problem (with cognitive loss)-
2) a documented physical problem

Disease (s) that require DM Letter *to* PCP? _____

SOURCE Case Manager Signature Date._____

SOURCE Case Mgmt Sprvsr Signature Date_____

SOURCE Medical Director_____ Signature Date _____

Care Path additions: Document Reason for Care Path changes and signatures as needed below for members who have Care Path changes but don't require a full reevaluation.

Carepath

Member Medicaid # Date.

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Member resides in community, maintaining maximum control possible over daily schedule and decisions. Incident reports are discussed with appropriate parties and process improvement that will assist member to reside safely are documented and put into action. GOALS: A. Member/caregiver contributes to the design and implementation of community-based services plan. Key member **responsibilities:** • Accept services as planned with **manager;** • Provide accurate information on health **status and service delivery; and** • **Maintain scheduled contact with case manager.** B. Member keeps scheduled medical appointments. C. Support services are delivered in a manner satisfactory to SOURCE members, informal caregivers and Case Managers. **Key provider performance areas:** • Reliability of service • Competency and compatibility of	Stabilize chronic conditions and promptly treat episodic/acute illness through long-term management by a Practitioner /Case Manager team. The team will monitor risk factors for institutionalization, responding with medical and support services provided at the time, setting and intensity of greatest effectiveness. PCP: Case Mgr. **Practitioner *role:*** **Evaluate and treat episodic /acute illness** **Manage chronic disease, including:** **Risk factor modification/monitoring of key clinical indicators** **Coordination of ancillary services** **Education for members/informal caregivers** **Medication review and management** **Communicate with Case Manager as needed** **Review support service plans** **Refer/coordinate/authorize specialist visits, hospitalizations and ancillary services** **Promote wellness, including immunizations, health screenings, etc.** *SOURCE Case Manager role:* **Maintain contact with member, for ongoing evaluation:** **Monthly by phone or visit {minimum)** **Quarterly by visit {minimum) PRN as needed** **Educate members on patient responsibilities** **Encourage/assist member in keeping all medical appointments** **Communicate with PCP twice a year using the ECM Disease Management Physician letter;** **Encourage/assist member in obtaining routine immunizations, preventive screenings, diagnostic studies and lab work** **Coordinate with informal caregivers and paid providers of support services** **Educate or facilitate education on chronic conditions** **Educate member on Emergency Preparedness** **Assist members in ALL issues jeopardizing health status or community residence**	GOALS: 1'review period (_}_j_): A. _met _not met B. _met _not met C. _met _**not met** **Incident Reports?** 2''' review period (_j_J _): A. __met __**not met** B. _met _**not met** C. _met _not met **Incident Reports?** _____ 3"review period (_j_j_): A. _met _**not met** B. _met _**not met** C. __met __**not met** Incident Reports? 4^{10} review period (_}_j_): A. _met _not met B. __met __**not met** C. __met __not met

staffing; • **Responsiveness to member concerns and issues; and** • **Coordination with Case Manager.**	NOTES:	Incident Reports?
	(Providers and units/schedules listed on Member Version)	

Carepath

Member Medicaid # Date

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
A member's diet will be balanced and appropriate for maintaining a healthy body mass and for dietary management of chronic conditions GOALS: A. SOURCE member's body mass supports **functional independence and does not pose a** critical health risk OR progress is made toward this goal (PCP, ADH or other report). B. Meals are generally balanced and follow appropriate diet recommended by PCP **(observed by Case Manager or provider, self-** **or caregiver report).**	MEMBER EDUCATION: _Practitioner or staff _SOURCE educational material _other MEAL PREPARATION: _self-care (total) **_assistance by informal caregiver(s)** _SFC _ home delivered meals _ALS (alternative living service) ___ PSS aide (includes G-tube) MEAL PREPARATION SCHEDULE: (Indicate SELF, INF, HOM,PSS or ALS): Mon_____B_____L_____S Thurs_____B_____L_____S Tues_____B L S Fri_____B L S Wed_____B_____L_____S Sat_____B_____L_____ S Sun_____B L S NOTES:	GOALS: **1st review period (_)_)_):** A. _met __not met B. _met _ not met **znd review period (_)_)_):** A. _met **not met** __ B. _met **_not met** **3rd review period (_)_)_):** A. _met _not met B. _met **_not met** **4th review period (_)_)_):** A. _met **_not met** B. _met **_not met**

(Providers and units/schedules listed on Member Version)

Carepath

Member Medicaid# Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Member's skin will be maintained in healthy condition, **avoiding breakdowns and decubiti.** GOALS: **Member has no skin breakdowns or decubiti requiring** clinical intervention/wound care.	MEMBER/CAREGIVER EDUCATION: __ **Practitioner staff** __ SOURCE educational material _other MONITOR SKIN for integrity: __ PCP **_self-care** **_informal caregiver** _SFC _ADH _specialist _PSS aide/PSS RN every 62 days _ALS _skilled nursing provider:	GOALS: 1'review period (_}_j_): _met _not met 2''' review period (_}_J_): __met __**not met** 3"review period (_}_j_): __met _not met 4th review period (_}_j_): __met __**not met**
	Dates of Service: **Assistance required:** _turning/repositi oning (see page_____) _continence (see page___) _nutrition (see page_____) NOTES: _____ _____ _____ (Providers and units/schedules listed on Member Version)	

Carepath

Member Medicaid # Date

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Key clinical indicators and lab values will regularly fall within parameters acceptable to PCP or treatingspecialist. NOTE: Key clinical indicators and lab values deemed applicable are determined and monitored for each member by the PCP, accordingto the member's diagnosis and current medical condition. The CM role is to assist the member in carrying out PCP orders, to facilitate achieving this goal. **The PCP will advise on any additional monitoring required for each member.** Additional monitoring required, if applicable: _blood glucose _blood pressure **_weight {as indicator of illness, for CHF patients, etc.)** _labs _other __LMP **last menses for women of child bearing age**	MEMBER/CAREGIVER EDUCATION: _Practitioner/staff _SOURCE educational material _other MONITOR CLINICAL INDICATORS: _PCP (OV) ADDITIONAL MONITORING REQUIRED: _self-care _ASSISTANCE REQUIRED _**informal caregiver** _ADH _PSS aide _ALS _RN provider: _SFC _other _____ _____ NOTES:_____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (_/_/_): __met __not met 2nd review period (_/_/_): __met _**not met** 3rd review period (_/_/_): __met _not met 4th review period (_/_/_): __ met _**not met**

Carepath

Member Medicaid# Date:

KEY MEMBER OUTCOMES	PLAN/RESPONSI BLE PARTY	QUARTERLY REVIEWS
Member/caregiver understands and adheres to medication regimen (self- or caregiver report, physician/RN report or observation by Case Manager). **Incident Reports around medications are** discussed with appropriate responsible parties.	MEMBER/CAREGIVER EDUCATION: _Practitioner/staff _SOURCE educational material _other MEDICATION ADMINISTRATION/MANAGEMENT: _self-care _**informal caregiver** _ADH/DHC _SFC _ALS _PSS aides (cueing) _RN provider Dates of Service: OBTAINING MEDICATIONS: _self-care _**informal caregiver** _pharmacy delivery _____ _other PHARMACY: _____ NOTES: _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__j__J__J: __met __not met Incident Reports? _____ 2nd review period (___j___}_): _met _not met **Incident Reports?** _____ 3rd review period (___j___}_): __met _not met Incident Report? ____ 4th review period (___j__J__J: __met ___not met Incident Reports? ___

Carepath

Member Medicaid # Date:

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Regular performance of ADLs and IADLs **is not interrupted due to cognitive or functional impairments.** GOALS: No observations by Case Managers or reports from mbr. /caregiver/other providers identifying problems with ADLs, IADLs and/or patient safety. Incident Reports are discussed with appropriate parties (exclude falls).	_ASSISTANCE REQUIRED: (S;SELF; INF;informal support; PSS;PSS aide; HDM;home delivered meals; ALS;alternative living service): _____ bathing dressing eating **transferring** _____ **toileting/continence** turning/repositioning _____ **errands** **chores** **financial mgt.** meal prep. _____ _informal caregiver{s) _SFC _home delivered meals _ADH _ALS _ERS **_incontinence Carepath** _PSS aide Total hours/week:_____ **Indicate no. of hours:** Monday_____AM_PM Thursday_____AM_____PM Tuesday_____AM.PM Friday_____AM_____PM Wednesday_____AM_____PM Saturday_____AM ____ _____PM Sunday_____AM_____PM NOTES: _____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1' review period (_}_}_J: _met __not met 2''' review period (_}_J_): __met __not met 3" review period {_}_j_): __met __**not met** 4th review period (_}_j_): __met __**not met**

Carepath

Member Medicaid # Date:

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Problem behavior will not place the Member at risk of social isolation, neglect or physical injury to themselves or others. **Diagnosis:** **_depression substance abuse** **_bi-polar disorder _schizophrenia** _Alzheimer's **_ other dementia** _other	ROUTINE AND PRN MONITORING AND EVALUATION by Practitioner for signs of changes in mental status MEMBER/CAREGIVER EDUCATION: **_Practitioner** _other_____ _ongoing management of condition by mental health professional provider: schedule _supervision by informal caregiver(s): _supervision by SFC **_ALS for supervision and monitoring** **_PSS aides for supervision and monitoring** **_day program for supervision and monitoring of mental status**	GOALS: 1'review period (_j_j_): A. _met **_not met** B. _met _not met C. _met _not met **Incident Reports?** _____ zod review period LJ_j_): A. _met _not met B. _met **_not met** C. _met **_not met** **Incident Reports?** _____ 3'd review period (_j_j_): A. _met **_not met** B. _met _not met C. _met _not met Incident Reports? 4th review period (_j_j_): A. _met **_not met** B. _met _not met **C. _met _not met** Incident Reports?_____
GOALS: A. Residential arrangements remain stable. B. Mental health conditions or cognitive impairment will be adequately managed by informal or paid caregivers. Indicators of inadequately managed behavior include: • **hospitalization for condition** • **discussion of potential institutionalization** • **increased level of caregiver stress** • physical danger to self or others posed by behavior • discharge from a program or service due to behavior Examples of problem or symptomatic behavior: **wandering impaired memory substance abuse** profoundly impaired judgment physical aggression **suicide attempts or threats** C. Incident Reports around behavior are discussed with appropriate parties and process improvement that will assist member to reside safely are documented and put into **action.**	when or if informal support is unavailable **provider:** schedule: M T W Th F NOTES: (Providers and units/schedules listed on Member Version)	

Carepath

Member Medicaid # Date:

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS :
Transfers and mobility will occur safely. GOALS: Member has no falls due to unsuccessful attempts **to transfer.** **Incident reports around falls are discussed with** responsible parties.	MEMBER/CAREGIVER EDUCATION: _Practitioner/staff _SOURCE educational material _**PCP is notified. Member gait, balance assessed, medication reviewed.** _other ASSISTANCE REQUIRED: _informal caregiver{s) to provide assistance with transfers and mobility: _____ _SFC _PSS aide for assistance if/when informal support is unavailable _ALS _ADH program for assistance if/when informal support is unavailable _Adaptive equipment as indicated, with training as required (specify): _____ _Home modifications as indicated (specify): NOTES: Providers and units/schedules listed on Member Version)	Goals: **1st review period (__)__)__):** _met _**not met** **Incident Report?** 2nd review period (__)__)__): _met _**not met** Incident Report? 3rd review period (__)__)__): _met _not met Incident Report? **4th review period (__)__)__):** _met _not met **Incident Report?**

Carepath

Member_____ Medicaid# Date:

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Informal caregivers will maintain a supportive role in the continued community residence of the SOURCE member. GOALS: No reports or other indicators of caregiver exhaustion (self-**report, observed by case manager, etc.).**	_Ongoing SOURCE case management/support service plan _Referral to support group _In-home respite Extended Personal Support (EPS) schedule: _Out-of-home respite **provider:** schedule: _ADH for respite purposes for informal caregiver NOTES:_____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (_}_J_): _met _not met 2nd review period (_}_J_): __met _not met 3rd review period (_J_J_J: __met __not met 4th review period (_}_J_): _met _not met

Carepath

Member Medicaid # Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
GOALS: Member's discharge planning needs will be assessed on the day of admission with continued assessment occurring quarterly.	CM will assess discharge planning needs of member/responsible party including preparation for education and/or referral needs for ordered services.	**GOALS:** 1st review period (___J___)____): _met _not met 2nd review period (___J___J_): _met _not met 3rd review period (___J___J_): _met _ not met 4th review period (___J___J____): _ met _not met

Carepath

Member **Medicaid #_____ Date:**

		1st review period (____}___}__): met not met 2nd review period (____}___}__): met _ not met 3rd review period (____}___}__): met _ not met 4th review period (____}___}__): met _ not met

MEMBER VERSION

Member: _____ Medicaid Number: _____ Date: _____

Welcome to SOURCE

Our goals are helping you:

Stay as healthy as possible

AND

Continue living in your own home.

Your SOURCE Case Manager:

_____

SOURCE 24-hour Phone: _____

Your Doctor:

_____ Phone: _____

Preferred hospital (name, location)

_____

For Emergencies, please dial 911

Hurricane, Tornado, or other Natural Disaster evacuation and/or support plan (local shelter, family/friend support, other):

_____

_____

_____

_____

_____

Good Nutrition

Proper Meals

_____

_____

Healthy Skin

Checking skin for problems _____

_____

Keeping It Under Control

___ Blood Pressure _____ Blood Sugar

_____ Weight ___ Unsafe Behavior

Monitoring each: YOUR DOCTOR

Others: _____

_____

No: _____

_____

Member signature: **Date**_____

Case **Manager signature:** **Date**_____

MEMBER VERSION

Member: _____ Medicaid Number: _____ Date: _____

Taking Medicines Properly

Current medications: Contact your case manager or doctor's office.

Drug Store: _____

Picking up medicines:

Help with taking medicines:

Getting Up, Down and Around Safely

Equipment _____

Help from another person

Taking Care of My Home and Myself

Cleaning

Errands _____

Laundry

Bathing

Dressing

Other support

Current SOURCE Support Services

_____

_____

_____

_____

_____

Notes: _____

_____

_____

_____

* Refer to Discharge Planning Checklist for available resources following discharge from waivered services

Incontinence Carepath

	PLAN/RESPONSIBLE	FUNDING	QUARTERLY REVIEWS
Member's incontinence will be managed to promote skin integrity and adequate personal hygiene. GOALS: A. Member has no skin breakdowns or decubiti requiring clinical intervention/wound care B. Member maintains acceptable personal hygiene (no perceptible odor, etc., and no reports by Member or caregiver/provider/PCP). C. Member has no infections/complications OR frequency of infections decreased for persons with catheter.	_paper continence products supplier:____Member/informal caregiver _Community Benefits _assistance by informal caregiver _ assistance by PSS aide provider: schedule: catheterization in-and-out _assistance by informal caregiver assistance by LPN/RN provider. schedule: _in-dwelling _assistance by informal caregiver/SFC _assistance by RN/LPN provider: schedule: _external _assistance by informal caregiver		MEASURES: 1st review period (/ /):_ A. A. _met _not met B. _met _not met C _met _not met 2nd review period (/ /) fl_ met _not met B. _met _not met C. _met _not met 3'd review period (___/ /):

	_assistance by PSS aide provider: schedule: _SFC _ostomy _Member/caregiver education _SOURCE PCP _SOURCE RN _self-care Assistance required: _assistance by informal caregiver _assistance by PSS aide provider: schedule: _assistance by LPN/RN provider: schedule: _Assistance by SFC		A. _met _not met B. _met _not met C. _met _notmet 4 review period (/ /): A. _met _not met B. _met _not met C. _met _not met

CARE PATH VARIANCE REPORT

Carepath Variance Report

SOURCE Member: _____

Year/Quarter:_____ **Date:** _____

Comm _Skin Clin Meds _I/ADLs

_Trans/MOB

Nutr'n Behavior _Inf Support Incontinence

Corrective Action Taken:

Year/Quarter –Date: – —

Comm _Skin _Clin Meds _I/ADLs

Trans/MOB

_Nutr'n _Behavior _Inf Support Incontinence

Corrective Action Taken:

CARE PATH VARIANCE REPORT

Year/Quarter _____ Date: _____

_Comm _Skin Clin Meds _I/ADLs

_Trans/MOB

Nutr'n _Behavior _Inf Support _Incontinence

Corrective Action Taken:

Year/Quarter _____ Date: _____

__ Comm _Skin Clin Meds _I/ADLs

Trans/MOB

Nutr'n _Behavior _Inf Support _Incontinence

Corrective Action Taken:

DOCUMENTATION

SOURCE MONTHLY CONTACT SHEET

Use this form for Case Management Monthly Contact Sheet. May use this form or Quarterly Alternate for quarterly reviews. Review these areas with member or members caregiver each month. See section 1302

Member Name_____DOB_____ PCP:. ___

Services Receiving_____

Significant Diagnosis:_____

Column A PROCESS — See Policy 1302	Column B 1st znd 3rd 4th (circle quarter) QUARTERLY OBJECTIVES Circle Variances	Column C MONITORING/CASENOTES ../: if GM goals met. CN: see case notes. NA: **not** applicable
Monthly Contacts (Minimum) Circle Specifics below:	Ihave Reviewed with the member: Community services:	*Quality Service Level provided? Complaints?*
	Medical Appts and Dates: J PCP or D Specialist	Document reason and outcome of appti.e. new diagnosis, meds, referrals etc. or NO APPTs
	Emergency Room Visit or Hospitalizations	*Document number, reason, outcome if any of these occurred*
Month 1 DATE — Month 2 DATE — Other ___	Diet and Nutrition Goals:	*Weight stable, feeding problems, following diet*
	Skin Integrity Goals:	*Details for any skin openings or decubiti: ie stable, worsening, new*
	Clinical Goals	*Is blood pressure, blood sugar or other within goa/7*
	ADL/IADL Goals	*Any disruptions in AOL or /AOL maintenance?*
Home Visit or Phone or Other_____	Transfer and Mobility Goals	*Any falls or concerns with Transfers or Mobility?*
_____Copies of Advance Directives received, if applicable	Behavioral Goals:	*Any problem behaviors?*
	Care Giver Supp°t'.J Goal s	*Informal caragivers maintained in member's life?*
Any Variances Yes No Document # of Variances (In Quarter)	Incontinence Goals: J Ostomy or Catheter	*Incontinence issues including supplies*
	Medications (update list from chart)	*Adherence issue? Problems?*
Disease Management Tracking Log Reviewed Yes No N/A	Disease Management (DM) (Does member Have or Need DMI	*Is Intervention needed? What will be done?*
Any Sentinels this month/Quarter? Yes No # of Sentinels	Notes *(include resolution of last month's variances, if any, teaching done on* OM):	
	Appropriate follow up actions/ interventions needed:	

SOURCE MONTHLY CONTACT SHEET

CM Signature and Date	Member Signature and Date (if face to face)
CM Supervisor Signature and Date (quarterly)	

Tips for Monthly Contact Sheet

Tips for completing for Monthly Reviews

Before calling member: fill out Column A, Review chart for any phone calls, notes, variances, critical indicents, service problems. Make notes of any follow up information you may need from the member. Pull most recent medication record. Move back and forth between columns B and C while speaking with member.

Complete section D with thoughtful review on conversation with member taking into consideration variances/ sentinels. Review non-urgent issues including new medications during Case Management supervisory review. Escalate problems to PCP if needed. Urgent matters should be discussed and handled per individual agency guidelines.

Tips for completing for Quarterly Reviews:

Before visiting member fill out Column A. Review member's chart for any phone calls, notes, variances, critical incidents, service problems. Make notes of any follow up information you may need from the member. Review Carepath and use columns B and C for short summaries. Take copy of Medication Record to confirm with member.

Complete section D with thoughtful review on conversation with member taking into consideration variances/ sentinels. Review non-urgent issues including new medications during Case Management supervisory review. Escalate problems to PCP conferences as needed. Urgent matters should be discussed and handled per individual agency guidelines

Per Policy: **Case Managers and Carepaths are at the core of concurrent review in SOURCE. To reach the program's stated goals, Case Managers initiate and facilitate communication with SOURCE members/caregivers, Medical Directors, program supervisors, Primary Care Providers if needed and if applicable, service providers. Carepaths provide guidance and formal structure for the concurrent review process.**

SOURCE QUARTERLY ALTERNATE /ANNUAL CONTACT SHEET

Document on this form before and during Carepath review with member. See Policy 1302.

Member's

Name:_____ Level:_ PCP:_____

_____

Date of Birth: _____ Significant Diagnosis:_____

PROCESS	1'2nd3rd4 QUARTERLY/ ANNUAL OBJECTIVES ...J: if GM Poals met. Circle Variance, NA: not annlicablc	MONITORING/CASE NOTES (Date and CM Signature required each contact)
Quarterly Review OR	_____COMM _NUTR'N __SKIN	
Annua1 Ke· evaluation	CLIN __MEDS _1/ADL BEH __TRANS __INFSUPP ('-I= goals met, circle variances)	See member chart for additional information on:
Phone, Face to Face Other _	No. of Emergency Room visits: No. of Hospitalizations: Critical Incidents this quarter? Yes No Or Number of Sentinels this yeat#	Copies of Advance Directives received, ifapplicable

If so, information given/ reviewed with patient: OR

Is skilled nursing, RN or PCP care, or other intervention needed for OM and will be recommended at team meeting? Yes No

(Circle appropriate intervention if needed)

Notes/Additional Follow-up acUons indicated by this review:_____

_____

D. Confirm/ List medications for Annual Visit:

Name	Dosage	Who ordered?	Member Compliant?	Notes

D. For Annual Evaluation: Member Stated Goals for year: _____

Member Signature and Date

Case Management Signature and Date

Case Management Supervisor Signature (quarterly) Date

SOURCE QUARTERLY ALTERNATE /ANNUAL CONTACT SHEET

Tips for Quarterly Contact Sheet

Quarterly Contact Sheet can be used instead of Monthly Contact for quarterly visits. Always use for Annual contact with members

Quarterly visits:

Before speaking with member, Fill out Column labeled *Process* and Pull/ copy a recent medication list. .Review chart for any phone calls, notes, variances, critical Incidents, service problems. Pull Carepath to review with member. Make notes of any information you may need from the member.

Complete quarterly objectives with member while reviewing Carepath. Complete monitoring notes with thoughtful review with member taking into consideration variances/ sentinels. Review non-urgent issues including new medications during Case Management supervisory review. Escalate problems to PCP conferences as needed. Urgent matters should be discussed and handled per individual agency guidelines.

Note: Case Managers and Carepaths are at the core of concurrent review in SOURCE. To reach the program's stated goals, Case Managers initiate and facilitate communication with SOURCE members/caregivers, Medical Directors, program supervisors, Primary Care Providers if needed and if applicable, service providers. Carepaths provide guidance and formal structure for the concurrent review process.

Annual visits:

See guidelines above for quarterly visits and also complete the areas marked

LEGAL MEDICAL RECORD STANDARDS

FOR SOURCE PURPOSE

To establish guidelines for the contents, maintenance, and confidentiality of patient Medical Records that meet basic legal standards. To give guidance on electronic!paper documentation with more hybrid medical records evolving.

All documentation and entries in the Medical Record, both paper and electronic, must be identified with the patient's full name, and another unique identifier. Each page of a double-sided or multi-page forms must be marked with member identification, since single pages may be photocopied, faxed or imaged and separated from the whole.

Documentation requires the signature and professional title of staff, and the date of documentation..

Each Medical Record shall contain sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

Maintenance and Legibility of Record

All Medical Records, regardless of form or format, must be maintained intheir entirety, and no document or entry may be deleted from the record, unless that recording was incorrectly assigned to the wrong member.

Handwritten entries should be made with permanent black or blue ink. This is to ensure the quality of electronic scanning, photocopying and faxing of the document. All entries in the medical record must be legible to individuals other than the author.

Corrections and Amendments to Records

When an error is made in a medical record entry, the original entry must not be obliterated, and the inaccurate information should still be accessible.

The correction must indicate the reason for the correction, and the correction entry must be dated and signed by the person making the revision. Examples of reasons for incorrect entries may include "wrong patient," etc. The
contents of Medical Records must not otherwise be edited, altered, or removed.

Copy and Paste Guidelines

Copying for re-use of data: A clinician may copy and paste entries as long as care is taken to ensure that the information actually applies to the current patient condition and visit, that applicable changes are made to variable data, and that any new information is recorded.

Enhanced Case Management Disease Management Physician letter

Date _____

Dear Dr. (Physician name)

Based on criteria within the Elderly and Disabled Waiver, (client's name) , (DOB) mm/dd/vvvv, qualifies for Enhanced Case Management services. Criteria includes but is not limited to the presence of a chronic medical condition which requires med ical oversight and long term care services to assist with performance of ADL/IADL care needs.

The Member entered the program on (date of initial assessment) and is receiving the following Home and Community Based Services within a plan of care.

D Personal Suppo ll Service _____

D Skilled Nursing Services _____

D Alternative Living Service _____

D Adult Day Health _____

D Home Delivered Meals _____

D Home Delivered Services . _____

D Out of Home Respite _____ D Emergency Response System

0Structured Family Caregiving D See attached Plan of Care (member version)

Observations noted durincr the recent home visit(s) Date of Last Home Visit include:

0Cognitive/Behavior issues/changes _____

O Nutritional Proble1ns _____

D Clinical Problems/Treatments _____

D Skin Problems _____ D Falls/Mobility _____

D Caregiver Concerns _____ D Other (i.e. preventative care, requests for referrals, DME, etc.)

_____ 0 See attached 1nedication list for medications observed in the home during the last hon1e visit.

Please contact me if you have questions.
Case Manager's Name
Case Manager Phone Number (ext)
Mailing Address
Zip Code
For more inforn1ation on The Elderly and Disabled Waiver and other Georgia \Vaivers, please visit our website at https:/I111edicaid.georgia.gov/\vaiver-prograins

Date Sent _____ fax: # _____ Mail (address) _____

Hand Delivered: Name of Recipient/title _____

Instructions

Enhanced Case Management Disease Management Physician letter

Purpose: This form is used as a communication tool to the Member's Primary Care Physician to notify of entrance and ongoing placement of a client in the Enhanced Case Management

Who Complete/Wizen Completed: Complete at initial assessment and every six months thereafter.

I11structio11s:

I. Complete all applicable sections.
   - Date -Date letter is mailed to physician
   - Date member entered the program (date of initial assessment)

2. Be sure all information is included is relevant to the client's medical care.
   - PSS – include frequency and units (2 hours/3 times week
   - SNS – include skill and frequency (med management LPN lxwk)
   - ALS - include name of facility
   - ADH – include name of facility and frequency (Adult Day 4 half days per week)
   - HDM - 7 meals weekly
   - HDS -PT 3 times week x 2 weeks
   - OOH Respite – include facility, frequency, units (TC Healthcare 2nd Saturday and Sunday of the month every 2 months)
   - ERS

3. Document date of last home visit and observations of the following:
   - Cognition - oriented, ale11, presence/absence of behaviors
   - Nutrition – diet followed in the home, compliance, tube feeding, other
   - Clinical problems/treatments – refer to abnormals or noncompliance with home monitoring for blood pressure, blood sugar, weight; note dialysis, chemotherapy, radiation, Home Health; surgery in the last 3 months, when applicable include edema, pain, member concerns
   - Skin problems – rash, burns, skin tears, surgical incisions, ulcers, wound care, other
   - Falls/mobility - changes in mobility, falls in last 3 months, injury
   - Caregiver concems
   - Other – include need for referrals (hospice, home health, therapy, other) and DME requests.
4. Attach medication list from home visit (med ication reconciliation)
5. Submit via mail, email, fax or hand delivery to the Member's Primary Care Physician
   - File original/copy (depending on submission type) in Member file/upload to the electronic data system formal notes if applicable.
6. The form is not intended for return by the Physician but may do so if needed.

Date Sent_____fax: #_____Mail (address)_____

Hand Delivered: Name of Recipient/title ——————————————————————

FORMS USED IN COURSE OF BUSINESS

SOURCE's
Member WAIVER TRANSFER FORM (Non-Electronic)

SOURCE Program Member's:

1. LOC Authorization Number:_____ Expiration Date:_____

2. Member Name

_____ DOB:_____
(Last, First, M.I.)

Soc. Sec. No._____ Medicaid#_____

3. Other Contact Information: _____

4. Member transfer from fAgene.y A); Information::

Agency Name: _____ Provider ID# _____

County _____

Care coordinator/ CM / Contact person _____

Email_____ Telephone (_:_____

Current Waiver type (CCSP/SOURCE/NOW-COMP/ICWP) Last service date_____

Member's address _____

County_____ State_____ Zip _____

5. **Member transfer to. fAgene.w B\)ll'mforrmatii'omi**

Agency Name: _____ Provider ID# _____

County _____

Care coordinator/ CM / Contact person

_____

Email_____ Telephone (_:_____

Waiver type (CCSP/SOURCE/NOW-COMP/ICWP) (circle) _____

Member's address _____

County_____ State_____ Zip _____

Telephone (_____

SOURCE MEMBER TRANSFERS

Instructions:

Purpose: The member transfer form is used to transfer case records and to notify AHS of transfer.

Who Completes/When Completed

Transferring Agency A:

The current case manager/care coordinator completes the member transfer form. It accompanies the original case record of the last year of seivice to the receiving agency.

Original agency is responsible for providing one year of copied records to the receiving agency (Agency B).

Receiving Agency B: This receiving agency uses those records for historical reference and picks up monthly contacts, seivice, and care path reviews from the previous dates and related standards of promptness. An RN review and case note is required within 10 days in the case of a change of address that impacts caregiver availability, environmental issues related to seivice delivery, or needs of the member.

Sending to AHS:

Transfer from Agency A:

The AHS review nurse will receive the transfer form via Contact Us message - use Current Agency's (Agency A) Level of Care Prior Authorization request number to pull up the Contact Us note. As long as the transfer form is filled out in its entirety (with the addition of the receiving agency's email address), only the current Agency A needs to perform this task. Agency A should include documentation of the transfer such as a CCNF in CCSP or a MIF *I* Z discharge letter from SOURCE.

Transfer to Agency B:

IF there are transfer issues that still need to be addressed, it may make sense for the "transferred to" agency B to attach the transfer form again with clarifying information to AHS via contact us as outlined above.

Instructions:

SOURCE MEMBER TRANSFERS

1. Enter the current LOG Prior Authorization Number and Expiration Date of the LOG PA issued by AHS

2. Enter member's name (last name, first, and middle initial) and Date of Birth. Enter member's social security number.

   Enter member's Medicaid number.

3. Other contact infonnation that may be helpful can be entered here such as a note or a family contact.

4. **Member transfer from Agency A Information:**

(Current member's (Agency A) Information

Enter name of current agency and provider ID

Enter name of care coordinator, Case Manager or Contact person's email address, name, and phone.

Enter the Last Day Agency A will give service to the client. AHS will end the LOG PA for agency A on this date. The service PA should end on this date.

Enter or circle the Member's current Waiver type for Agency A

Enter member's Contact infonnation when with Agency A. Include: Address, City, County, State, Zip code Enter

Member's Phone number when with Agency A

5. **Member transfer to Agency B Information**
(Receiving Agency (Agency B) Information)

Enter agency name and provider ID of agency B, the agency the member is transferring to.

Enter Agency B contact information: email address, name, and direct phone number of the contact person who is responsible for coordinating the transfer to the new agency or new site.

Circle or write in the new Agency B's Waiver Type (CCSP/SOURCE/NOW/COMP/ICWP) If the

member has a new address or new phone number, enter here.

A copy is maintained in the transferring WAIVER agency file.

SOURCE Referral Form

SOURCE Member _____ Date _____
Social Security No._____ Medicaid No._____
Address_____ Phone No._____
_____ Medicare No._____
_____
Diagnosis Code _____
SOURCE **Service Prior Authorization Number** _____
Service Prior Authorization Effective Date _____ Expiration Date _____
Directions to home_____
Primary Contact and Relationship_____
Primary Contact Phone Number _____
Primary Contact Address _____
Services Requested:
Adult Day Health_____
Provider _____Frequency_____
Level 1 Full Day_____ Level II Full Day_____
Level 1 Partial Day_____ Level II Partial Day_____
Physical Therapy_____
Speech Therapy_____

Alternative Living Service_____ Provider_____
Group Model_____ Family Model_____
Respite Services_____
Provider _____Frequency_____
Out of Home Respite (12 hours) _____
Out of Home Respite (8 hours maximum, 3 hours minimum)_____

Structured Family Caregiving _____
Provider _____

Member Medicaid Number _____
Personal Support Services (PSS) _____Extended Personal Support Services (EPS)_____
Provider
_____
PSS Frequency_____
EPS Frequency _____
Emergency Response System_____

Provider_____

Installment_____ Monitoring Monthly_____

Home Delivered Meals_____

Provider _____ Frequency _____

Comments: _____

Medicaid Home Health (75 units of service)_____

Provider _____

Skilled Nursing Visit_____
Physical Therapy Visit_____
Occupational Therapy Visit_____
Medical Social Services_____
Home Health Aide_____

Level of Care is approved through _____

Services to Begin: _____

Member is under administrative review. Please continue services until: _____

Comments:

SOURCE Site _____

Case Manager Signature/Title_____

Date_____

Case Management Agency Monthly Report

1. Agency Name: _____ 2. Report Month: _____

3. Submitted by: _____ 4. Today's Date/Year: _____

Provide member counts for the report month as follows:

5. Previous Month Total Members: _____
6. Members Admitted during report month: _____
7. Members Discharged during report month: _____
8. Current Active Members: _____

Ba. Unduplicated Members with yearly "Flu Shot" _____

Sb Total members who received "flu shot" (add Sa + any members from previous months as applicable. _____

9. Unduplicated total _____
10. Reason(s) Discharged (include number for each)·

Nursing Facility: _____

_ Deceased: _____
Moved out of Service Area: _____
Hospice: _____
Member Choice: _____
Non-Compliance: _____
Lost SSI/Related Eligibility: _____
Lost Level Of Care _____
Other (specify): _____

Wait List Data:

11. Total Number on the Wait List: _____
12. Wait List Report by DON·R Score:

DON-R Score	# Members on WL	DON-R Score	# Members on WL

Programmatic report is due to: Department of Community Health, Division of Medicaid, SOURCE Program Specialist no later than the 15" of the month following the report month. EPCMM agencies with multiple locations will complete one programmatic report.

EDWP NOTIFICATION FORM

1. Mark (X) indicate the reason for sending: (CC to Provider D Provider to CC D)

   D Initial D Change D Complaint/Concern D Transfer D Discharge D Other_____

2. To: ———————————— Date: ——————————

3. From: ———————————— Telephone: ——————————

4. Client Name: ——————————— (Source D CCSP D) Medicaid #: ———————————

   D Mark if new address Client Address: ————————————————————

   City:_____Zip:_____County:_____ Telephone: ———————

5. SERVICES:

   D PSS D PSSX D CD PSS D SFC
   D ERS
   D ALS
   O ADH O HALF, 0FULL 0LEVEL I, O LEVEL II
   D HDM
   D SNS D RN, D LPN
   D HDS
   O 0HR
   COMMENTS:_____

6. Date your RN/Staff completed initial evaluation with client: *(Must be RN for ALS, ADH and PSS/XI*
   D Services were accepted D Services were not accepted – REASON: ———————————

7. Date services began: ———————————

8. Service Issues: (Check below and clarify in #14)

Request service increase	D	Request service decrease	D
Failure to pay cost share	D	Fall/Incident	D
Client termination	D	Requested provider change	D
Health/Safety Issue	D	Request for information	D
Client out of home	D	Other	D

9. Discharge (briefly describe actions leading up to need for discharge process): ———————

10. Date discharge (30-day) letter sent_____ Actual discharge date_____ Last day of service_____

11. Are services continuing through 30-day notice? D Yes D No *Please enter final units below*

FINAL UNITS	PSS	PSSX	CD PSS	SFC	ADH	ERS
	_____HDM	ALS	RN	LPN	OHR	

12. INITIAL OR CURRENT SERVICES IN THE HOME: ——————

13. FREQUENCY CHANGES REQUESTED: ————————————————————

14. Complaint/Concern/Other_____

15. ER/Hospital/Rehab visit- (Name/Date/Reason if known) _____

16. Sender name or signature:_____ Title:_____ Date:_____ Email:_____

17. Recipient name or signature:_____ Title:_____ Date:_____ Email:_____

18. Recipient response: _____

Revised 11/19

Instructions for SOURCE monthly report:

The purpose of the report is to keep track of how many active members your SOURCE site currently serves (members locked into your site), how many unduplicated members the Site has served to date, track the reason why members discharge from the program, and track the number of members in process to receive service.

Instructions:

1. **Agency Name**

   Insert the SOURCE case agency name here.

2. **Report month.**

   The month the data gathered and submitted for the report. Member information gathered in April would equal an April Report Month.

3. **Submitted by**

   Who is responsible for this data or who compiled the report.

4. **Today's Date and Year**

   The date the report is submitted.

5. **Previous month total**

   Represents the current number of members active on the previous month report.

6. **Members Admitted during report month**

   Number of new members who became locked into your site during the month. (This includes anyone locked in during the report month who were retro locked back to a previous month.)

7. **Members Discharged during report month**

   If you sent in a discharge and OCH closed the span.

8. **Current Active Members**

   Active members equal #5 + #6 - #7. (Number of members locked into your site as of the last day of the report month)

Ba. Members unduplicated who received influenza vaccine the month of the report in that SFY.

Bb. All members who received influenza vaccine for this season. Season starts July of the calendar year to June 3Qth of next calendar year.

Rev. 1/12

9. Unduplicated total equals #5 (previous month total) + #6 (members admitted during report month)

10. Reason(s) Discharged (include number for each

Self-explanatory Numbers must equal number discharged.

Wait List Data (WL)

11. Total Number on Wait List:

Anyone screened during the report month and any members pending lock in from previous months. If score is less than 15, there is no need to put on the waiting list.

12. Wait List Report by DON-R Score

The agency may devise a span of scores to group member data on this list or report by individual score.

EDWP Provider Case Conference and Complaint Resolution

Member Name: _____ **Member DOB**: _____ **Member Medicaid ID:** _____

Date of Conference: _____ **Conference Requested By:** PROV CM MBR CGR OTHER _____

Case Management Agency: _____ **Provider Name:** _____

Case Management Provider ID: _____ **Provider ID:** _____

Conference type: Phone Face to Face Electronic Other **Follow-up Date (as needed):** _____

Participants: (include name/relationship to member) **Date Resolved:** _____ (date or pending)

_____ _____

_____ _____

_____ _____

_____ _____

_____

Reason(s) for Conference (include all that apply) Re-brokering of Provider Home Environment

Service Order Issues Provider Complaints Case Manager Complaints Caregiver/Family Complaints

Client Complaints Other (specify) _____

Action/Responsible Party (include all that apply)

Action	**Responsible Party**	**Due Date**
Provider Re-broker	_____	_____
Aide Reassignment	_____	_____
Change Service Frequency (related to complaint)	_____	_____
Documentation (refer to summary)	_____	_____
Community/other referrals	_____	_____
Notify PCP/Schedule appointment	_____	_____
Submit DCH Web Based Incident Report	_____	_____
APS/HFR/Police Report	_____	_____
DCH Referral/Consult	_____	_____

Other (specify) _____ _____

_____

_____ _____

_____

Brief Summary of conference information, reason, resolution (who, what, when, where, how):

_____

_____

_____

_____

_____

_____

_____

Instructions:

Purpose: The EDWP Provider Case Conference and Complaint Resolution form will be utilized by Case Management to document the exchange of information for service delivery/provider performance issues, dissatisfaction, and other areas requiring resolution. Follow up should occur after reports are received by phone, face to face, or written communication between:

- Case Management and member
- Case Management and provider
- Case Management and member's family and/or caregiver
- Case Management, and member/caregiver, and providers

1. Details of complaints/concerns requiring resolution will be documented on the form as well as attempts to resolve **within three (3) business days** of notification including:
    a. Schedule conference with participants named (not signatures) in the complaint/concern (Case Manager, Provider, Member, Caregiver, other) – feedback may be obtained in separate contacts
    b. Conduct conference by phone, face to face, or other mutually agreed method of communication (written, electronic, etc.); feedback will be received and documented including all parties involved (separately or concurrently)
    c. Reasons for conference may include all but are not limited to:
        i. Re-brokering of Provider – before re-brokering ALS, ADH, PSS/EPS, SFC, Case Management will document member choice and/or attempts to resolve dissatisfaction on the EDWP Provider Case Conference and Complaint Resolution form. Member can choose not to participate. The purpose of the conference is to address dissatisfaction, resolve outstanding issues, and prevent billing overlap.
        ii. Home Environment – pests, hygiene, home repairs with potential for injury to member, other
        iii. Service Order Issues – member complaint related to current service order (not enough/too much, additional care needed/not identified in task list **and** resulting in or has potential for member decline, member noncompliance (chronic) with services ordered in Care Path. (Changes in a member's overall condition resulting in revisions to service frequency/units or adding/removing a service will be included in the Modified Reassessment and do not require a case conference.)
        iv. Provider Complaint – failure to provide timely documentation (packet not received **prior to expiration of current LOC**, EDWP notifications not returned **within 3 business days** of sending, Service Prior Authorization needs outstanding **5 business days** of notice, other)
        v. Case Manager Complaint – failure to provide timely documentation (DCH incident reports, EDWP notifications not returned **within 3 business days** of sending decline); lack of communication (member/provider), other
        vi. Caregiver/Family Complaint – aid behavior (phone use, hygiene, timeliness , communication with Case Management/Provider, tasks not completed according to Care Path), requests to change Case Manager/aid assignment, other
        vii. Client Complaint – same as above
        viii. Other (specify)
    d. When applicable, DCH Incident Reports (initial and follow up) may include the EDWP Provider Case Conference and Complaint Resolution form.

e. Case Management will document action needed, responsible party, and due date as indicated to resolve complaints.
f. When applicable, Case Management will follow up with participants no later than the month following the report to evaluate resolution and document date of resolution.
g. Case Management will document a brief summary of the conference and if applicable, request a written statement from other participants.
h. The EDWP Provider Case Conference and Complaint Resolution form will be filed in the member's chart.

Standards of Promptness Guidelines

Standard of Promptness for Care Coordination

IfACTIVITY IS	THEN STANDARD OF PROMPTNESS !SWITHIN .
Responding to telephone inquiry regarding SOURCE admission	3 business days after telephone inauirv
SCREENING	
Screening a referral	3 business davs after teleohone inauirv
Notifying client referral source of client denial/ineligibility determination at screenina	Within 3 business days after decision of non- eliaibilitv
INITIAL ASSESSMENT	
Nurse completion of face to face assessment for new admissions	within 15 business days of notification of slot availability
RN review of the assessment	10 business days following the assessment visit
Sending assessment /reassessment package to AHS for LOG review	Immediately following RN Review
REASSESSMENT	
Start Reassessment Process and Send Reassessment package to AHS for LOG review	At least 90 days before expiration of the current Level of Care reassessment must be started.
RN review of the assessment	10 business days following the assessment visit
Medical Director/PCP signature confirming LOG	Within 90 days of the member signature on LOG or 10 business days after a member's appeal has been granted by the judge and LOS extended by Alliant
Completing reassessments when requested by: Utilization Review analyst DCH Legal Services Office Administrative Law Judge	5 business days after reassessment request
Brokering services for new client	Within 5 business days of SOURCE admission or confirmation of lock in
Telephone follow-up with a client after service brokered to assess service compliance, client satisfaction	10 business days after service initiation
Sending member a Participation Form and Member Care Path	5 business days after service initiation

Standards of Promptness

IF ACTIVITY IS (cont'd.)	THEN STANDARD OF PROMPTNESS IS WITHIN (cont'd.)
Sending referral packet to provider	Before service provider begins services
Completing and returning Member Information Form (MIF) to provider	3 business days after receipt from provider
Telephone contact with member	Monthly
Face to Face Care Path review	Quarterly
Provider meeting for the coordination of care (Applies to all ALS, ADH, and PSS providers)	Quarterly Note: may be conducted face to face, telephone or electronically
Transfer of client record when client moves to another SOURCE site with the same provider (copy of records is acceptable)	5 business days after notification of transfer
Submitting Monthly Statistical Reports to OCH	By the 15lli of the month following the month subject to report
Involuntary Discharge	
Complete and provide a copy of the discharge plan with specific resources to the member	No later than 15 days following a SOURCE involuntarily discharge (day of notification by AHS or date the CM agency issued letter to member)
Follow up call or visit to member and or family to confirm understands information on discharge and discharge planning resources	7 to 10 work days after discharge plan is given

NOTICE OF DENIAL, TERMINATION or REDUCTION in SOURCE Services

To _____ SSN xxx-xxx-_____ Date:_____

Your participation in the SOURCE Program has been given careful consideration. In accordance with the Code of Federal Regulation, 42 CFR 441.301(b) (i) (ii) and 441.302(c) (2), the following determination has been made:

J 2. Decision to **Reduce Services:** you have been determined to require fewer services because _____

OR

J 3. Decision to **Terminate or Deny Services:** You **do not meet** the **eligibility** requirements as found in the Elderly and Disabled 1915-c Home and Community Based Services Medicaid Waiver as outlined in Section 701 in the Georgia Department of Community Health Manual, Part II Policies and Procedures for Service Options Using Resources in Community Environments (SOURCE).

You do not meet the eligibility requirements because (check as many as apply)

J a) You don't Receive full Medicaid (this excludes SLMB, QMB, or QI Medicaid)/ or full Medicaid under SSI or Public Law categories
Contact your local DFCS and ask if you are eligible for waiver Medicaid

J b) You did not have SSL You must contact Social Security at 1-800-772-1213

J c) You are an excluded member of Medicaid because you are, at the time of application or enrollment you are:
- J A Member with retroactive eligibility only or presumptive eligibility
- J A Member in an institution, including skilled nursing facilities, hospital swing bed units, in patient hospice, intermediate care facilities for people with developmental disabilities, or correctional institutions in the Georgia Families program
- J A Child enrolled in the Medical Services Program administered by the Georgia Division of Public Health (Children's Medical Services) or receiving services under Title V (CMS funding)
- J A Member in another waiver program (CCSP, Independent Care Waiver, the NOW and COMP Waiver Programs or the Georgia Pediatric Program (GAPP)
- J A Child whose care is coordinated under the PRTF program
- J A member of a federally- recognized Indian Tribe

J d) You did not Meet the 1915-c Waiver target population guidelines see- section 801.3 of the SOURCE manual: Your primary diagnosis or your primary needs are psychiatric or related to a developmental disability rather than medical needs

NOTICE OF DENIAL, TERMINATION or REDUCTION in SOURCE Services

APPENDIX Z (continued)

To _____

J Your cost of medically necessary services that can be provided by SOURCE is higher than me 1v1ea1ca1a cosr or nursing rac1111y care

J g) You are not cooperative with enrollment in SOURCE (Member did not (have/do/ complete/ refuses etc.)_____

J h) You don't live in / or have moved from a SOURCE Enhanced Case Management's designated service area

I ***i)*** **Vn11 rlnn't huP. thP r.::iri;::ihitity, \Mith ;::ic:;it::inr.P frnm ()l lRr.l= ::inrl/nr infnrm::il r::in:iciuQrc:.** ***nf*** safely residing in the community (with consideration for a recipient's right to take calculated risks in how and where he or she lives)

J' Ii r'uu are an appiicani wi10 has aii needs rnei oy your inionmai suppon

J k) You failed to meet requirements at initial screening:

J Your DON-R (determination of need-revised) score was too low to meet admission requirements

J You don't have unmet needs__

J\ f"\fhnr
'J v .,1

_____

If you disagree with this decision, you may request a fair hearing. You have thirty days (30) **from the date of this letter to request a hearing in writing.**

Department of Community Health
Legal ervices ection
2 Peachtree Street, NW 40th Floor
Atlanta, GA 30303-3159

4. Call your SOURCE Case Manager or Care Agency if you do not understand this letter. Call:

_____

Name of Case Manager/Other Agency I""llUllt:::

NOTICE OF DENIAL, TERMINATION or REDUCTION in SOURCE Services

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COMMUNITY ILEAILTH

NOTICE OF YOUR RIGHT TO A HEARING

You have the right to a hearing regarding this decision. To have a hearing, you must ask for one **in writing.** Your request for a hearing, along with **a copy of the adverse action letter,** must be *received* within **thirty (30) days** of the date of the letter. Please mail your request for a hearing to:

Department of Community Health
Legal Services Section
Two Peachtree Street, NW-40tti Floor
Atlanta, Georgia 30303-3159

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the heari ng, you may speak for yourself or let a friend or family member to speak for you. You also may ask a lawyer to represent you. You may be able to obtain legal help at no cost. If you desire an attorney to help you, you may call one of the following telephone numbers:

1. **Georgia Legal Services Program**
   1-800-498-9469
   (Statewide legal services, EXCEPT for the counties served by Atlanta Legal Aid)

2. **Georgia Advocacy Office**
   1-800-537-2329
   (Statewide advocacy for persons with disabilities or mental illness)

3. **Atlanta Legal Aid**
   404-377-0701 (Dekalb/Gwinnett Counties)
   770-528-2565 (Cobb County)
   404-524-5811 (Fulton County)
   404-669-0233 (So. Fulton/Clayton County)
   678-376=4545 (Gwinnett County)

4. **State Ombudsman Office**
   1-888-454-5826
   (Nursing Home or Personal Care Home)

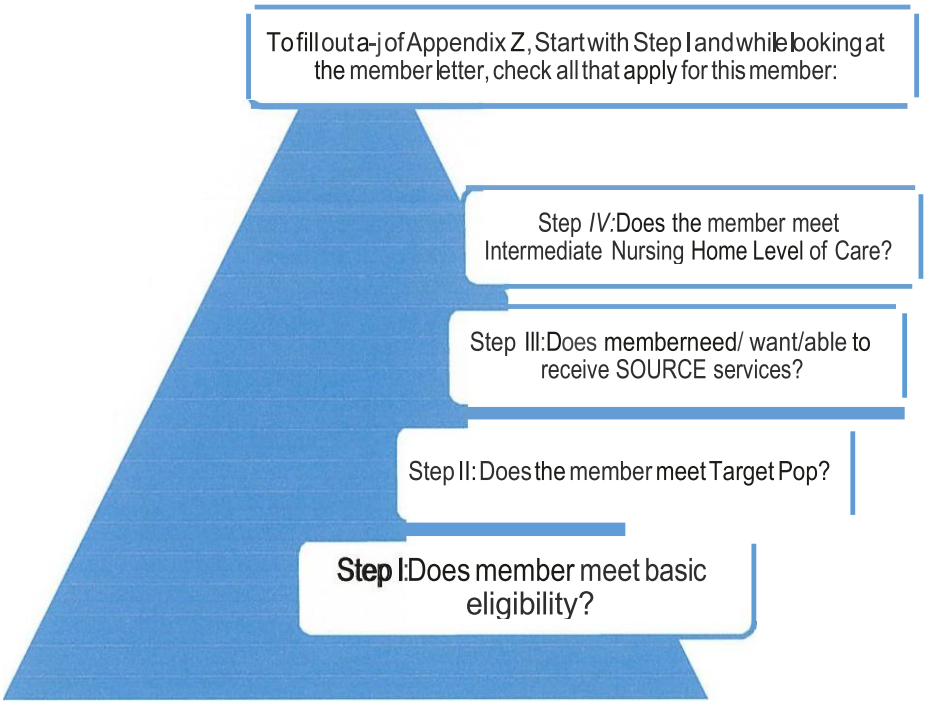
NOTICE OF DENIAL, TERMINATION or REDUCTION in SOURCE Services

Instructions for agency completion of Appendix Z

Agency Use ONLY

Appendix Z is a mandatory foml that must be used as formatted by OCH.

1. Fill in member's name, last 4 digits of Social security number, and date
2. Check this option if you are reducing services. Write in the reason for the reduction in services.
   i. Then: Skip to #4 and give the member contact infomlation
3. Check this option if denying or temlinating services. Then see pyramid to complete a-j.
4. Always complete #4.
5. Indicate whether Appendix I is enclosed (must be table fomlat)



I. Basic eligibility choices:

Check a-c if any of these apply for the member:

a) You do not receive full **Medicaid or Full Medicaid** under SSI or Public Law categories
b) You did not have SSI. You must contact Social Security at 1-800-772-1213
c) You are an excluded member of Medicaid (check why the member is excluded)

II. Target population choice:

Did the member not meet criteria for SOURCE because they are not the target population for this waiver-Le.:

Go to and check #d if the member is under age 65 years and their primary diagnoses that are causing problems is mental illness or mental retardation.

NOTICE OF DENIAL, TERMINATION or REDUCTION in SOURCE Services

Step III Other choices:

Check f-1 if any of these applies to the member.

Note: Detail the reason for non-compliance if #g is selected, be specific.

Note: Fill in the details for I if any other reasons apply.

Step IV Intermediate Nursing Home level of care:

All denials for not meeting Intermediate Nursing Home Level of care, come from the decision made by Alliant Health Solutions. That information is mailed to the member directly from Alliant Health Solutions. Follow up with the member regarding their decision to appeal the decision or not. Assist as needed with the denial.

FORMS NEEDED FOR HEARING REQUESTS

Rev.
07/19

Checklist for SOURCE Request for Hearing

Case Management Agency: please provide the following forms to OCH upon notification of a hearing request:

If AHS gave LOC denial:

Discharge Planning information:

Case Management form for Discharge planning
Case Notes that document discharge planning support
Recent Physician visits or ER visits
If member has unknown cognitive deficits work with attorneys to resolve

If Agency issued Denial

Reduction in service, Termination and Denial

Discharge Planning Information (as listed above)

Administrative Hearing Information (as a cover sheet

Annual Case management notes and 1-3 Quarterly Case management notes

RN Review and Signature Form

Annual physical examination from PCP and/or appropriate "H&P" (history and physical) notes from 1-2 most recent visits with PCP

Recent Physician visits or ER visits

Any specialty physician visit notes from the last 3 months(If available)

If member has unknown cognitive deficits work with attorneys to resolve

BILLING

SOURCE Billing

SOURCE Reimbursed Services

Adult Day Health

Personal Support (PSS)

Extended Personal Support

Alternative Living Services (ALS)

Home Delivered Meals (HDM)

Home Delivered Services (HDS)

Emergency Response Services (ERS)

Structured Family Caregiver

Nursing Visits

Case Management

Provider Billing

The DXC is the third-party administrator for Georgia's Medicaid and PeachCare for Kids programs.

Providers will enter claims via the web at http://mmis.georgia.gov

Customer Interaction Center: 1-800-766-4456

Customer Service Representative Availability: Barn- 7pm Monday thru Friday

Interactive Voice Response System Availability: 24 hrs day, 7 days a week

Written Correspondence: HP, P.O. Box 105200, Tucker, GA 30085-5200

General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is.* The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers.

Also, the National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid.**

The following resources are available for more information:

- Access the department's DCH-i newsletter and FAQs at http://dch.georgia.gov/publications

- Search to see if a provider is enrolled at https://www.mmis.georgia.gov/portal/default.aspx

  Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and provider's last name.

- Access a provider listing at https://www.mmis.georgia.gov/portal/PubAccess.Provider%201nformation/Provider%20Notices/tabld/53/Default.aspx

  Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

*For COS 930 this would be the NPI of the provider who signs the Appendix F

SOURCE National Codes and Rates

Updated 7/1/2019

Old Code	Description	National Code	Description	Modifier	Rate
Y3801	Home Delivered Services; Nursing Visit	T1030	Nursing care, in home, by registered nurse	TD	Provider Specific (51" unit of service)
Y3802	Home Delivered Services; Physical Therapy	S9131	Physical therapy, in home, per diem		Provider Specific (51st unit of service)
	Home Delivered Services; Speech Therapy	S9128	Speech therapy, in the home, per diem		Provider Specific (51st unit of service)
	Home Delivered Services; Occupational Therapy	S9129	Occupational therapy, in the home, per diem		Provider Specific (51st unit of service)
	Home Delivered Services; Medical Social Services	S9127	Social work visit, in the home, per diem		Provider Specific (51st unit of service)
¥J300	Home Delivered Services; Home Health Aide	T1021	Home health aide or certified nurse assistant, per visit		Provider Specific (51st unit of service)
Y3725	Adult Day Health Level I Full Day	S5102	Day care services, adult, per diem		$55.62 per day minimum 5 hours
Y3726	Adult day Health Level I Partial Day	S5101	Day care services, adult, per half day		$33.37 per day minimum 3 hours
Y3740	Adult Day Health; Physical Therapy	S9131	Physical therapy in the home, per diem; services delivered under an outpatient physical therapy plan of care	GP	$44.15 per visit
Y3750	Adult Day Health; Speech Therapy	S9128	Speech therapy, in the home, per diem; services delivered under	GN	$44.15 per visit

SOURCE National Codes and Rates

			an outpatient speech therapy plan of care		
	Adult Day Health; Occupational Therapy	S9129	Occupational therapy, in the home, per diem; services delivered under an outpatient occupational therapy plan	GO	$44.15 per visit
	Adult Day Health Level II Full Day	S5102	Day care Services, adult, per diem: intermediate level of care	TF	$69.53 per day
¥3828	Adult Day Health Level II Partial Day	S5101	Day care services, adult, per half day; intermediate level of care	TF	$41.73 per day
	Alternative Living Services - Group Model	T1020	Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant); Group Setting	HQ	$50.00 per day
Y3625	Alternative Living Services - Family Model	T1020	Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant); Individualized service	TT	$50.00 per day (payment to the individual model home must be no less than $15.25 per day)

SOURCE National Codes and Rates

			provided to more than patient in same setting		
Y3600	Out of Home Respite (12 hours)	S5151	Unskilled respite care, not hospice, per diem; intermediate level of care	TF	$42.57 per night minimum 12 hours
Y3715	Out of Home Respite (hourly)	S5150	Unskilled respite care, not hospice, per 15 minutes		$3.00 per unit, 32 units (8 hours) maximum, 12 units minimum (3 hours)
Y3832	Personal Support Service	T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)		$5.07 per 15 minutes units. 15 minutes equal 1 unit.
Y3840	Extended Personal Support	T1019	Personal care services. Per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified	TF	$4.51 per 15 minutes equal 1 unit. (Not to exceed 48 units a day) Not to exceed 720 units/ Month (360 hours/15 days)

SOURCE National Codes and Rates

			nurse assistant) intermediate level of care		
Y3823	Emergency Response Monitoring (Monthly)	S5161	Emergency response system; service fee, per month (excludes installation and testing)		$36.69 per month
Y3824	Emergency Response Monitoring (Weekly)	T2025	Emergency response system; waiver services; not otherwise specified (NOS)	U9	$9.17 per week
Y3825	Emergency Response Installment	S5160	Emergency response system; installation and testing		Up to $110.10 one installment
	Home Delivered Meals	S5170	Home Delivered Meals		$6.74 per meal maximum 21 per week
Y3850	Skilled Nursing Services RN	T1030	Nursing care, in the home by a registered nurse per diem		$65.00 per visit/ only one visit per day maximum
	Skilled Nursing Services LPN	T1031	Nursing care in home, by licensed practical nurse per diem		$50.00 per visit
	SOURCE CM fee	T2022		SE	$192.27 per month
	Structured Family Caregiver	T1020		UK	$90.20 per day, Stipend payment to the live-in amily caregiver must be at least $54.12 per day (eff 7/2019

INFORMATION

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Georgia's Medicaid Waiver Programs

Services at a Glance

Elderly & Disabled Waiver Program *CCSP & SOURCE Programs*	Independent Care Waiver Program *ICWP*	New Options Waiver Program *NOW*	Comprehensive Supports Waiver Program *COMP*
	Counseling	Behavior Support Services	Behavior Support Services
	Behavior Management	Behavior Support Consultation	Behavior Support Consultation
Home Delivered Meals			
	Environmental Modification	Environmental Accessibility Adaptation	Environmental Accessibility Adaptation
	Vehicle Adaptation	Vehicle Adaptation	Vehicle Adaptation
	Specialized Medical Equipment and Supplies	*Specialized Medical Equipment	*Specialized Medical Equipment
		*Specialized Medical Supplies	*Specialized Medical Supplies
		Transportation Services	Transportation Services
Fiscal Intermediary Service	Fiscal Intermediary Service	Fiscal Support Service	Fiscal Support Service
		Community Guide Services	Community Guide Services
		Individual Directed Goods and Services	Individual Directed Goods and Services
		Natural Support Training	Natural Support Training
Care Coordination (traditional)	Case Management (traditional)	Support Coordination (traditional)	Support Coordination (traditional)
Enhanced Case Management	Enhanced Case Management	Intensive Support Coordination	Intensive Support Coordination

*All services designated by an asterisk are provided to adults age 21 and over. Similar non-waiver services are available through the Medicaid State Plan. *Note: afl ICWP members must be age 21 or over at admission so no asterisk required.*

**All ICWP services provide specific procedure codes for TBI services and services for members with physical disabilities.

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Georgia's Medicaid Waiver Programs

Services at a Glance

Elderly & Disabled Waiver Program *CCSP & SOURCE Programs*	Independent Care Waiver Program ***ICWP*	New Options Waiver Program *NOW*	Comprehensive Supports Waiver Program *COMP*
Personal Support Services	Personal Support Services - Level 1	Community Living Support	Community Living Support
Extended Personal Support	Personal Support Services - Level 2	Extended CLS	Extended CLS
		Shared CLS {2 or 3-person model)	Shared CLS (2 or 3-person model)
Respite Services - In-home	Respite Care	In-home Respite Services	In-home Respite Services
		Additional Residential Staffing	Additional Residential Staffing
Respite Services – Out-of-home	Respite Service – Full Day	Out-of-home Respite Services	Out-of-home Respite Services
Alternative Living Services	Alternative Living Services		Community Residential Services
Adult Day Health Services	Adult Day Health Services	Community Access Services	Community Access Services
		Prevocational Services	Prevocational Services
		Supported Employment	Supported Employment
*Nursing Services per visit	Nursing Services per visit	*Nursing Services per hour	*Nursing Services per hour
*Physical Therapy {following home health exhaustion)	Nursing Services per hour	*Physical Therapy	*Physical Therapy
*Occupational Therapy {following home health exhaustion)		*Occupational Therapy	*Occupational Therapy
*Speech Therapy {following home health exhaustion)		*Speech Therapy	*Speech Language Therapy
Emergency Response System & Monitoring		*Nutrition Services	*Nutrition Services

Personal Emergency Response System & Monitoring

Georgia Advance Directive for Health Care

By: _____ Date of Birth: _____

(Print Name) *(Month/Day/Year)*

This advance directive for health care has *four parts:*

PART ONE-Health Care Agent. *This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose* is *called a health care agent. You may* also *have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.*

PART TWO-Treatment Preferences. *This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others* close *to you about your treatment preferences.*

PART THREE-Guardianship. *This part allows you to nominate a person to be your guardian should one ever be needed.*

PART FOUR-Effectiveness and Signatures. *This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.*

You may fill out any or all of the first three parts fisted above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as *your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it* is *needed. Review this completed form periodically to make* sure *it still reflects your preferences. If your preferences change, complete a new advance directive for health care.*

Using this form of advance directive for health care is *compleiely optional. Other forms of advance directives for health care may be used in Georgia.*

You may revoke this completed form at any time. This completed form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.

PART ONE-Health Care Agent

PART ONE will be effective even if PART TWO is *not completed. A physician or health care provider who* is *directly involved in your health care may not* serve as *your health care agent. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse* as *your health care agent. If you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.*

1. Health Care Agent

I select the following person as my health care agent to make health care decisions for me:

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

2. Back-Up Health Care Agent

This section is optional. PART ONE will be effective even if this section is left blank.

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

3. General Powers of Health Care Agent

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent's authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or **service;**
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that under Georgia law:

- My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and
- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, **sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.**

4. Guidance for Health Care Agent

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health **care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances** and treatment options.

5. Powers of Health Care Agent After Death

(A) AUTOPSY

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

_____ *(Initials)* My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) ORGAN DONATION AND DONATION OF BODY

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless Ihave limited my health care agent's power by initialing below.

Initial each statement that you want to apply.

_____ *(Initials}* My health care agent will not have the power to make a disposition of my body for use in a medical study program.

_____ *(Initials)* My health care agent will not have the power to donate any of my organs.

(C) FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

_____ *(Initials)* Iwant the following person to make decisions about the final disposition of my body:

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

Iwish for my body to be:

_____ *(Initials}* Buried

OR

_____ *(Initials)* Cremated

PART TWO-Treatment Preferences

PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO wiff be effective even if PART ONE is *not completed. ff you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. ff you have selected a health care agent in PART ONE, then your health care agent wif/ have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.*

6. Conditions

PART TWO will be effective if Iam in any of the following conditions:

Initial each condition in which you want PART TWO to be effective.

_____ *(Initials)* A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

_____ *(Initials}* A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

7. Treatment Preferences

State your treatment preference by initialing (A}, (B}, or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) _____ *(Initials)* Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

OR

(B) _____ *(Initials)* Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

OR

(C) _____ *{Initials}* I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:

Initial each statement that you want to apply to option (C).

_____ *(Initials}* If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

_____ *(Initials)* If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

_____ *{Initials}* If I need assistance to breathe, I want to have a ventilator used.

_____ *(Initials)* If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

8. Additional Statements

This section is *optional. PART TWO will be effective even if this section* is *left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE}, or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.*

_____

_____

_____

9. In Case of Pregnancy

PART TWO will be effective even if this section is left blank.

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_____ *(Initials)* I want PART TWO to be carried out if my fetus is not viable.

PART THREE-Guardianship

10. Guardianship

PART THREE is optional. This advance directive tor health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.

State your preference by initialing (A) or (8). Choose (A) only if you have also completed PART ONE.

(A)_____ *(Initials)* I nominate the person serving as my health care agent under PART ONE to serve as my guardian.

OR

(B)_____ *(Initials)* I nominate the following person to serve as my guardian:

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

PART FOUR-Effectiveness and Signatures

This advance directive for health *care* will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

_____ *(Initials)* This advance directive for health care will become effective on or upon _____ and will terminate on or upon _____.

You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both witnesses must be of sound mind and must be at feast 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:

- *Cannot be a person who was selected to be your health care agent or back-up health care agent in PART ONE;*

- *Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or*
- *Cannot be a person who is directly involved in your health care.*

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

_____

(Signature of Declarant) *(Date)*

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

_____

(Signature of First Witness) *(Date)*

Print Name: _____ Address: _____

_____

(Signature of Second Witness) *(Date)*

Print Name: _____ Address: _____

This form does not need to be notarized.

The minimal requirements for an applicant to qualify for a nursing facility level of care: LEVEL OF CARE CRITERIA

I. Intermediate care services may be provided to an individual with a stable medical condition requiring intermittent skilled nursing services under the direction of a licensed physician (Column A Medical Status) AND a mental or functional impairment that would prevent self-execution of the required nursing care (Column B and C Mental Status, Functional Status).

2. Special attention should be given to cases where psychiatric treatment is involved. A patient is not considered appropriate for intermediate care services when the primary diagnosis or the primary needs of the patient are psychiatric rather than medical. **This individual must also have medical care needs that meet the criteria for intermediate care facility placement.** In some cases, a patient suffering from mental illness may need the type of services which constitute intermediate care because the mental condition is secondary to another more acute medical disorder.

3. **Requirements:** Number one (I) and one other condition from 2-8, must exist from **Column A** (medical status), one from **Column B** (mental status) or **C** (functional status) with the exception of #5, **Column C.**

COLUMN A	**COLUMN B**	**COLUMN C**
Medical Status	*Mental Status*	*Functional Status*
I. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician. **In addition to the criteria listed immediately above, the patient's specific medical condition must require any of the following (2-8) plus one item from Column B or C** 2. Nutritional management; which may include therapeutic diets or maintenance of hydration status. 3. Maintenance and preventive skin care and treatment of skin conditions, such as cuts, abrasions, or healing decubiti.	**Mental Status** The mental status must be such that the cognitive loss is more than occasional forgetfulness. I. Documented short or long-term memory deficits with etiologic diagnosis. Cognitive loss addressed on MOS/care plan for continued placement. 2. Documented moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making. Cognitive loss addressed on MOS/care plan for continued placement.	I. Transfer and locomotion performance of resident requires limited/extensive assistance by staff through help or one-person physical assist. 2. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and set-up help of meals. 3. Requires direct assistance of another person to maintain continence. 4. Documented communication deficits in making self-understood or understanding others.

4. Catheter care such as catheter change and irrigation. 5. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy (less than five (5) times weekly). 6. Restorative nursing services such as range of motion exercises and bowel and bladder training. 7. Monitoring of vital signs and laboratory studies or weights. 8. Management and administration of medications including ini ections.	3. Problem behavior, i.e., wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention. 4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia.	Deficits must be addressed in medical record with etiologic diagnosis address on MOS/care plan for continued placement. 5. Direct stand-by supervision or cueing with one-person physical assistance from staff to complete dressing and personal hygiene. **(If this is the only evalnation of care identified, another deficit in functional status is required).**

Level of care criteria are based on definitions and guidelines derived from the Federal regulations and are used to assist assessors in evaluating clinical information submitted.

Georgia Department of Community Health Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

MEDICAID'S PRIVACY COMMITMENT TO YOU

We at the Georgia Department of Community Health (DCH) understand that medical information about you and your family is personal. We are committed to protecting your information. This notice tells you how DCH may use and disclose medical information about you. It tells you your rights and Medicaid's requirements about your information.

The privacy practices described in this notice were effective June 2, 2003.

By law, Medicaid must use and disclose your personal medical information to provide information:

- To you or to someone who has the legal right to act for you
- To the Secretary of the U.S. Department of Health and Human Services, if necessary, to make sure your privacy is protected
- When required by law

YOUR MEDICAL INFORMATION RIGHTS

- You have the following rights regarding the medical information that DCH has about you.
- You have the right to see and obtain a copy of your personal medical information held by Medicaid. An exception is information that is needed for a legal action relating to DCH.
- You have the right to ask DCH to correct your personal medical information if you believe that it is wrong or incomplete. DCH may deny your request under certain circumstances.
- You have the right to request a listing of disclosures that DCH has made of your personal medical information. The listing would not include disclosures to you or your personal representative, or for payment for your health care, or for Medicaid administration.
- You have the right to request additional restrictions on certain uses or disclosures of your health information. DCH is not legally required to agree with your request.
- You have the right to request that DCH communicates with you about your health in a way or at a location that will help you keep your information confidential.
- You have the right to be notified following a breach of unsecured protected health information.
- You have the right to receive a paper copy of this notice. You may get another copy of this notice from DCH by calling 770-325-2331. You may obtain a copy from the DCH Web site, http://dch.georgia.gov/hipaa-privacy-notices

PRIVACY LAW'S REQUIREMENTS

DCH is required by law to:

- Maintain the privacy of your personal medical information
- Give you this notice of DCH legal duties and privacy practices regarding the medical information that DCH has about you
- Follow the terms of this notice
- Not use or disclose any medical information about you without your written authorization, except for the reasons given in this notice. You may take away your authorization at any time, in writing, except for the information that DCH disclosed before you stopped your authorization.
- In an emergency, DCH may disclose information only if the disclosure is in your best interest.

- DCH must notify you as soon as possible of that emergency disclosure.
- Never disclose psychotherapy notes, use and disclose protected health information for marketing purposes, and/or make any disclosures that constitute a sale of protected health information without your written authorization to do so.

In the future, DCH may change its privacy practices. If there is a material change in its privacy practices, DCH will provide a new notice to you. DCH will post the new notice on its Web site at http://dch.georgia.gov/hipaa-privacy-notices

HOW DCH USES AND DISCLOSES HEALTH CARE INFORMATION

Medicaid provides some services through contracts with other agencies and private companies. For example, your county Department of Family and Children Services determines Medicaid eligibility. When services are contracted, Medicaid may disclose some or all of your information to the other agency or company so that they can perform the job Medicaid has asked them to do. To protect your information, Medicaid requires the other agency or company to safeguard your information in accordance with the law.

The following categories describe ways that Medicaid uses and discloses your health information. For each category, we will explain what we mean and give an example.

For Payment: Medicaid may use and disclose information about you so that we can pay for the health services that you received. For example, when you receive a Medicaid service, your health care provider sends a claim to the Medicaid fiscal agent for payment. The claim includes information that identifies you, as well as your diagnoses and treatments.

For Medical Treatment: Medicaid may use or disclose information about you to ensure that you receive necessary medical treatment and services. For example, Medicaid may send you appointment reminders for Health Check services.

To Operate the Medicaid Program: Medicaid may use or disclose information about you to run the Medicaid program and ensure that you receive quality care. For example, Medicaid may contract with a company that reviews hospital records to check on the quality of care that you received and the outcome of your care.

To Conduct Outreach, Enrollment, Care Coordination, and Case Management: Medicaid may share your information with other government agencies that may provide public benefits or services to you. For example, Medicaid may share your information with a Medicaid Care Management Organization (CMO) for case management.

To Keep You Informed: Medicaid may mail you information about your health. Examples are information about managing a disease that you have, information about your managed care choices, and appointment reminders for your children's Health Check services. Equal Opportunity Employer Health Information Technology | Healthcare Facility Regulation | Medical Assistance Plans | State Health Benefit Plan

For Overseeing Health Care Providers: Medicaid may disclose information about you to the government agencies that license and inspect medical facilities such as hospitals.

For Research: Information about you may be disclosed for a research project that has been approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information. The research must be for the purpose of helping the Medicaid program.

For the Health Information Exchange: Medicaid, as a payer of Medicaid claims, is a member of the Georgia Health Information Network, Inc. ("GaHIN"). GaHIN is the statewide health information exchange network through which Medicaid, its member affiliates, and other members and their member affiliates, securely share and access medical information in accordance with applicable state and federal laws and regulations. This exchange of information allows Medicaid Providers to provide you with access to better treatment and coordination of healthcare services. GaHIN has established Network Operating Policies and Technical Requirements, which members and member affiliates of the GaHIN must meet, to ensure the confidentiality and integrity of data.

As Required by Law: Medicaid will disclose information about you when required by law.

FOR MORE INFORMATION OR TO REPORT A PRIVACY PROBLEM

If you believe your privacy rights have been violated:

- You may file a complaint with Medicaid by calling the Member Inquiry Unit at 770-325-2331 (in the Atlanta area) or 1-866-211-0950 (outside the Atlanta area).
- You may file a complaint with the Georgia Medicaid agency by writing to :

Georgia Department of Community Health
Privacy Officer, Office of General Counsel
2 Peachtree St., NW – 40th Floor
Atlanta, GA 30303-3159

You may also file a complaint with the Health and Human Services' Office for Civil Rights by writing to:

U.S. Department of Health & Human Services
Office for Civil Rights, Region IV
61 Forsyth Street SW, Suite 3B70
Atlanta, GA 30303-8909

There will be no retaliation for filing a complaint

If you have questions about your health or your health care services, you should contact your health care provider (physician, pharmacy, hospital or others).