MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES DIVISION OF SENIOR AND DISABILITY SERVICES

GENERAL HEALTH EVALUATION & LEVEL OF CARE RECOMMENDATION

A: PARTICIPANT INFORMATION

DATE

PARTICIPANT (LAST, FIRST, MI)	DCN	DATE OF BIRTH	REGION
ADDRESS (STREET, CITY, ZIP)		COUNTY	PHONE NUMBER(S)

B: PROVIDER NURSE INFORMATION

NAME OF PROVIDER NURSE (LAST, FIRST, MI)	NAME OF PROVIDER	PROVIDER PHONE NUMBER

C: REASON FOR NURSE VISIT

☐ Participant General Health and Care Plan Evaluation (Semi-Annual Nurse Visit)

Initial Assessment for Authorization of: ☐ Advanced Personal Care ☐ Respite Care

Monthly Review for Advanced Care Plan Authorization of: ☐ Advanced Personal Care ☐ Respite Care

Six (6) Month Review for Advanced Care Plan Authorization of: ☐ Advanced Personal Care ☐ Respite Care

☐ Significant Change Explain:

☐ Request from DSDS or its designee Explain:

☐ Other Explain:

D: HEALTH CARE INFORMATION

PRIMARY HEALTH CARE PROVIDERS	ROLE	PHONE

CURRENT DIAGNOSES/CONCERNS:

RECENT HOSPITALIZATIONS, SURGERIES, OR PROCEDURES:

ANY ADDITIONAL HEALTH INFORMATION:

E: ALLERGIES AND VITAL SIGNS

Allergies:

Temperature:	Heart Rate:	Respirations:
Blood Pressure:	Blood Glucose:	A1C:

F. CARDIOPULMONARY ASSESSMENT

☐ Coronary Artery Bypass	☐ Pitting Edema	☐ Pedal Pulse	☐ Compression Hose Class:
☐ Central Line	☐ Hypertension	☐ Chest Pains	☐ Pacemaker

G. INTEGUMENTARY ASSESSSMENT

☐ No Concerns ☐ Concerns: Indicate on body diagram & assessment chart any skin tears, abrasions, wounds, decubitus ulcers, etc.

H. LEVEL OF CARE DETERMINATION

BEHAVIORAL:

- Determine if the applicant or recipient:
  - Receives monitoring for mental condition
  - Exhibits one of the following mood or behavior symptoms - wandering, physical abuse, socially inappropriate or disruptive behavior, inappropriate public sexual behavior or public disrobing; resists care
  - Exhibits one of the following psychiatric conditions - abnormal thoughts, delusions, hallucinations

COMMENT:	
○ 0 pts	Stable mental condition **AND** no mood or behavior symptoms observed **AND** no reported psychiatric conditions
○ 3 pts	Stable mental condition monitored by a physician or licensed mental health professional at least monthly **OR** behavior symptoms exhibited in past, but not currently present **OR** psychiatric conditions exhibited in past, but not recently present
○ 6 pts	Unstable mental condition monitored by a physician or licensed mental health professional at least monthly **OR** behavior symptoms are currently exhibited **OR** psychiatric conditions are recently exhibited
○ 9 pts	Unstable mental condition monitored by a physician or licensed mental health professional at least monthly **AND** behavior symptoms are currently exhibited **OR** psychiatric conditions are currently exhibited

COGNITION:

- Determine if the applicant or recipient has an issue in one or more of the following areas:
- Cognitive skills for daily decision making
- Memory or recall ability (short-term, procedural, situational memory)
- Disorganized thinking/awareness - mental function varies over the course of the day
- Ability to understand others or to be understood

COMMENT:	
○ 0 pts	No issues with cognition **AND** no issues with memory, mental function, or ability to be understood/understand others
○ 3 pts	Displays difficulty making decisions in new situations or occasionally requires supervision in decision making AND has issues with memory, mental function, or ability to be understood/understand others
○ 6 pts	Displays consistent unsafe/poor decision making requiring reminders, cues or supervision at all times to plan, organize and conduct daily routines **AND** has issues with memory, mental function, or ability to be understood/understand others
○ 9 pts	Rarely or never has the capability to make decisions **OR** displays consistent unsafe/poor decision making or requires total supervision requiring reminders, cues or supervision at all times to plan, organize and conduct daily routines **AND** rarely or never understood/able to understand others
○ 18 pts	TRIGGER: No discernible consciousness, coma

MOBILITY:

- Determine the applicant or recipient's primary mode of locomotion
- Determine the amount of assistance the applicant or recipient needs with:
  - Locomotion - how moves walking or wheeling, if wheeling how much assistance is needed once in the chair
  - Bed Mobility - transition from lying to sitting, turning, etc.

COMMENT:	
○ 0 pts	No assistance needed **OR** only set up or supervision needed
○ 3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
○ 6 pts	Maximum assistance needed, i.e. applicant or recipient needs two (2) or more individuals or more than 50% weight- bearing assistance **OR** total dependent for bed mobility
○ 18 pts	TRIGGER: Applicant or recipient is bedbound **OR** totally dependent on the others for locomotion

EATING:

- Determine the amount of assistance the applicant or recipient needs with eating and drinking. Includes intake of nourishment by other means (e.g. tube feeding or total parenteral nutrition (TPN).
- Determine if the participant requires a physician ordered therapeutic diet.

DIET ORDERED BY PHYSICIAN:

COMMENT:	
○ 0 pts	No assistance needed **AND** no physician ordered diet
○ 3 pts	Physician ordered therapeutic diet **OR** set up, supervision, or limited assistance needed with eating
○ 6 pts	Moderate assistance needed with eating, i.e. applicant or recipient performs more than 50% of the task independently
○ 9 pts	Maximum assistance needed with eating, i.e. applicant or recipient requires an individual to perform more than 50% for assistance
○ 18 pts	TRIGGER: Totally dependent on others

TOILETING:

- Determine the amount of assistance the applicant or recipient needs with toileting. Toileting includes: the actual use of the toilet room (or commode, bedpan, or urinal), transferring on/off the toilet, cleansing self, adjusting clothes, managing catheters/ostomies, and managing incontinence episodes.

COMMENT:	
◯ 0 pts	No assistance needed **OR** only set up or supervision needed
◯ 3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
◯ 6 pts	Maximum assistance needed, i.e. applicant or recipient needs two (2) or more individuals, or more than 50% of weight- bearing assistance
◯ 9 pts	Total dependence on others

BATHING:

- Determine the amount of assistance the applicant or recipient needs with bathing.
  Bathing includes: taking a full body bath/shower and the transferring in and out of the bath/shower.

COMMENT:	
◯ 0 pts	No assistance needed **OR** only set up or supervision needed
◯ 3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
◯ 6 pts	Maximum assistance, i.e. applicant or recipient requires two (2) or more individuals, more than 50% of weight-bearing assistance **OR** total dependence on others

DRESSING AND GROOMING:

- Determine the amount of assistance needed by the applicant or recipient to dress, undress and complete daily grooming tasks

COMMENT:	
◯ 0 pts	No assistance needed **OR** only set up or supervision needed
◯ 3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
◯ 6 pts	Maximum assistance, i.e. applicant or recipient requires two (2) or more individuals, more than 50% of weight-bearing assistance **OR** total dependence on others

REHABILITATIVE SERVICES:

- Determine if the applicant or recipient has the following medically ordered rehabilitative services: Physical therapy/Occupational therapy/Speech therapy/Cardiac rehabilitation/Audiology.

TYPE OF PHYSICIAN-ORDERED REHABILITATIVE SERVICES AND FREQUENCY:

COMMENT:	
◯ 0 pts	None of the above therapies ordered
◯ 3 pts	Any of the above therapies ordered 1 time per week
◯ 6 pts	Any of the above therapies ordered 2-3 times per week
◯ 9 pts	Any of the above therapies ordered 4 or more times per week

TREATMENTS:

- Determine if the applicant or recipient requires any of the following treatments:
  - Catheter/Ostomy care
  - Alternate modes of nutrition (tube feeding, TPN)
  - Suctioning
  - Ventilator/respirator
  - Wound care (skin must be broken)

TYPE OF TREATMENT/COMMENT:

◯ 0 pts	None of the above treatments were ordered by the physician
◯ 6 pts	One or more of the above treatments was ordered by the physician requiring daily attention

MEAL PREPARATION:

- Determine the amount of assistance the applicant or recipient needs to prepare a meal. This includes planning, assembling ingredients, cooking, and setting out the food and utensils.

COMMENT:	
◯ 0 pts	No assistance needed **OR** only set up or supervision needed
◯ 3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks
◯ 6 pts	Maximum assistance, i.e. an individual performs more than 50% of tasks for the applicant or recipient **OR** total dependence on others

MEDICATION MANAGEMENT:

- Determine the amount of assistance the applicant or recipient needs to safely manage their medications. Assistance may be needed due to a physical or mental disability.

COMMENT:	
◯ 0 pts	No assistance needed
◯ 3 pts	Set up help needed **OR** supervision needed **OR** limited or moderate assistance needed, i.e.applicant or recipient performs more than 50% of tasks
◯ 6 pts	Maximum assistance needed, i.e. an individual performs more than 50% of tasks for the applicant or recipient **OR** total dependence on others

SAFETY:

- Determine if the individual exhibits any of the following risk factors:
  - Vision Impairment
  - Falling
  - Problems with balance. Balance is moving to standing position, turning to face the opposite direction, dizziness, or unsteady gait
- After determination of preliminary score, history of institutionalization and age will be considered to determine final score.
  - Institutionalization in the last 5 years - long-term care facility, mental health residence, psychiatric hospital, inpatient substance abuse, or settings for persons with intellectual disabilities.
  - Aged - 75 years and over.

DATE OF LAST FALL:	TYPE OF INSTITUTIONALIZATION:	TIMEFRAME OR DATE ADMITTED TO INSTITUTION:

COMMENT:	
◯ 0 pts	No difficulty or some difficulty with vision **AND** no falls in last 90 days **AND** no recent problems with balance
◯ 3 pts	Severe difficulty with vision (sees only lights and shapes) **OR** has fallen in the last 90 days **OR** has current problems with balance **OR** preliminary score of 0 **AND** Age **OR** Institutionalization
◯ 6 pts	No vision **OR** has fallen in last 90 days **AND** has current problems with balance **OR** Preliminary score of 0 **AND** Age **AND** Institutionalization **OR** Preliminary score of 3 **AND** Age **OR** Institutionalization
◯ 9 pts	Preliminary score of 6 **AND** Institutionalization
◯ 18 pts	TRIGGER: Preliminary score of 6 **AND** Age **OR** Preliminary Score of 3 **AND** Age **AND** Institutionalization

Needs assistance with the following: (indicate what help is needed and who is currently helping)

I. CURRENT AUTHORIZATION REVIEW

Was the Care Plan Discussed with the Participant? ☐ Yes ☐ No

Authorized Services Adequately Meet the Needs of the Participant? ☐ Yes ☐ No Explain:

Does the Aide Have the Ability to Perform Tasks as Assigned? ☐ Yes ☐ No

Does the participant need a care plan change? ☐ Yes ☐ No Explain:

Recent change in informal help? ☐ Yes ☐ No Explain:

Safety/Emergency Plan

Emergency Back-up Plan:	Priority Risk: ☐ 1 High ☐ 2 Medium ☐ 3 Low

DIRECTIONS TO LOCATE, SAFETY CONCERNS IN THE HOME, OR ADDITIONAL COMMENTS

J. VETERAN HISTORY

Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable? ☐ Yes ☐ No

If answering Question 1 in the affirmative, would you like to receive information and assistance regarding the agency's veteran services? ☐ Yes ☐ No

NURSE SIGNATURE	DATE
PARTICIPANT SIGNATURE	DATE
SUPERVISORY NURSE/PHYSICIAN SIGNATURE	DATE