STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES

NURSING FACILITY LEVEL OF CARE ASSESSMENT

All questions on this form must be answered- write N/A if not applicable. Blank areas will result in return of document and delay in payment.

SECTION A.	**INDIVIDUAL'S IDENTIFYING INFORMATION**
NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX)	DATE OF BIRTH:
DCN (MEDICAID NUMBER):	SSN NUMBER:
RACE:	GENDER:

SECTION B.	**CURRENT LOCATION/PROPOSED PLACEMENT**
REASON FOR SUBMITTING APPLICATION:	
INDIVIDUAL'S CURRENT PHYSICAL LOCATION:	
NAME OF PROPOSED SKILLED NURSING FACILITY:	FACILITY ID NUMBER:
ADMIT DATE TO NF:	DISCHARGE DATE FROM NF:

SECTION C.	**RECENT MEDICAL INCIDENTS (I.E., CVA, SURGERY, FRACTURE, HEAD INJURY, ETC., AND GIVE DATES)**

INDICATE THE DIAGNOSES RELEVANT TO APPLICANT'S FUNCTIONAL AND/OR SKILLED NURSING NEEDS

☐ See Attached

SECTION D.	**ASSESSED NEEDS**

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

Date of the last consult completed by a physician or licensed mental health professional:

Behavioral Symptoms (Check one box for each)

None	Min	Mod	Max	
☐	☐	☐	☐	Withdrawn/Depressed
☐	☐	☐	☐	Suspicious/Paranoid
☐	☐	☐	☐	Wanders
☐	☐	☐	☐	Hallucinations/Delusions
☐	☐	☐	☐	Abnormal Thought Process
☐	☐	☐	☐	Aggressive (Physical/Verbal)
☐	☐	☐	☐	Suicidal/Homicidal Ideation
☐	☐	☐	☐	Restraints
☐	☐	☐	☐	Sexually Inappropriate
☐	☐	☐	☐	Controlled with Medications

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 issues 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

ORIENTATION: ☐ Person ☐ Place ☐ Time ☐ Situation

MEMORY:

LEVEL OF SUPERVISION:

ABILITY TO MAKE A PATH TO SAFETY: ☐ No ☐ Yes

HEARING IMPAIRMENT: ☐ No ☐ Yes

SPEECH IMPAIRMENT: ☐ No ☐ Yes

COMMENT:

Points	Description
◯ 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:

Points	Description
◯ 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:

Points	Description
◯ 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:

Points	Description
◯ 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 PHYSICIAN-ORDERED 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 by a license professional

	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

SECTION E. REFERRING INDIVIDUAL COMPLETING APPLICATION

FIRST AND LAST NAME:			
POSITION/TITLE:			
TYPE OF ENTITY:			
NAME OF ENTITY:	TELEPHONE NUMBER:	EXT:	FAX NUMBER:
EMAIL ADDRESS:	DATE REFERRAL COMPLETED:		

CHECK IF SAME AS REFERRING INDIVIDUAL OR COMPLETE CONTACT PERSON IF LEVEL II SCREENING INDICATED: ☐	TELEPHONE NUMBER:	EXT:
EMAIL:	FAX NUMBER:	

Central Office Use Only (DRL/COMRU)	
Level of Care Determination by DRL Central Office	
MEETS LEVEL OF CARE ☐ Yes ☐ No	
SIGNATURE	DATE