ALABAMA MEDICAID AGENCY
GATEWAY TO COMMUNITY LIVING/LOCAL CONTACT AGENCY RETURN TO COMMUNITY ASSESSMENT TOOL

Admission Date to Facility: ____________________ **Date of Referral:** ____________
Local Contact Agency Name: ____________________ Phone: ____________
Transition Coordinator Name: ____________________

Referring Nursing Facility Name:	
Address	
City	
Phone:	
Contact Person:	

Resident's Name:	
County of Residence:	
Medicare #:	
Medicaid #:	
Source:	

Primary Physician (After transition, if different):				
Address:				
City:				
Zip:				
Phone:				
Case Manager has copy of completed MDS 3.0 Section Q Checklist:		Yes		No
Current Primary Physician:				
Phone:				

FINANCIAL INFORMATION
List all sources of income and amounts (e.g., SSA, SSI, other retirement benefits, savings, checking accounts, etc.)

Source	Amount	Source	Amount

MEDICAID ELIGIBILITY

Is resident eligible or likely to be eligible for Medicaid when/if discharged from the facility?		Yes		No

HCBS AVAILABILITY

Is there Home and Community Based Service (HCBS) availability?		Yes		No

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REASON(S) FOR INSTITUTIONAL PLACEMENT

Check all reasons and provide description of circumstances at time of placement for each category. Each reason must be identified as a potential barrier and addressed in the assessment of current status below.
☐ Health Needs ☐ Acute ☐ Chronic
☐ Lack of available caregivers
☐ Lack of home and community based supports
☐ Lack of appropriate/accessible housing
☐ Mental Health Needs
☐ Other

HOUSING

Is housing available to the resident?		Yes		No	If "Yes" Resident will live:
					If other, please list

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CAREGIVER SUPPORT

Primary Caregiver's Name:	
Relationship:	
Phone:	
Caregiver Support System:	
Describe/Discuss needs and how OR if they might be addressed in the community:	

GENERAL HEALTH ASSESSMENT

List Current Diagnoses: Include current Mental Health Diagnosis(es), if applicable		
*If resident has decubitus ulcers, discuss/describe stage, and treatment:		

List Current Medications		

List Current Therapies		

List Durable Medical Equipment		

List Allergies		

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PAIN MANAGEMENT

Does the resident suffer from pain?							Yes		No
If yes, please select type:									
How is pain managed?									
	Pharmacological		Exercise		Relaxation Exercises				
	Diet		Stress Management		Other:				
*Describe/Discuss how pain is managed.									

NUTRITIONAL STATUS/ASSESSMENT

Has resident's food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? If yes:		Yes		No
Has there been weight loss during the last 3 months?		Yes		No

MEDICATION MANAGEMENT

Assess resident's ability to prepare and take all prescribed medications reliably and safely.
Resident is able…

ADL/IADL NEEDS

ADL Function	Independent	Needs Help	Dependent	Cannot Do
Bathing				
Dressing				
Grooming				
Mouth care				
Toileting				
Transferring bed/chair				
Walking				
Climbing stairs				
Eating				
Shopping				
Cooking				
Using the phone and looking up numbers				
Doing Housework				
Doing Laundry				
Driving or using public transportation				
Managing Finances				

*Describe/Discuss needs and how OR if they might be addressed in the community:

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MENTAL/EMOTIONAL/BEHAVIORAL ASSESSMENT

Resident…				
	Yes		No	Alert/oriented, able to focus and shift attention, comprehend and recall task directions independently.
	Yes		No	Somewhat dependent
	Yes		No	Totally dependent due to constant disorientation, coma, persistent vegetative state, or delirium
Resident Requires…				
	Yes		No	Prompting (cueing, repetition, reminders) but only under stressful or unfamiliar conditions
	Yes		No	Assistance and some direction in specific situations
	Yes		No	Considerable assistance in routine situations
*Describe/Discuss needs and how OR if they might be addressed in the community:				

ADVERSE BEHAVIORS

Resident exhibits/expresses…	
	Memory deficits
	Verbal disruptions (yelling, threatening, excessive profanity, sexual references, etc.)
	Aggression toward others
	Disruptive, infantile, or socially inappropriate behavior
	Substance Abuse or history of substance abuse
	Delusional hallucinatory or paranoid behavior
*Describe/Discuss needs and how OR if they might be addressed in the community:	

DEPRESSIVE FEELINGS

Has resident suffered psychological stress or acute disease in the past 3 months?		Yes		No
If yes, please describe:				
Resident exhibits/expresses…				
	Depressed mood			
	Sense of failure			
	Hopelessness			
	Thoughts of suicide			
	Recurrent thoughts of death			
Select One:				
*Describe/Discuss needs and how OR if they might be addressed in the community:				

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COMMUNITY RESOURCE NEEDS (List community resource needs not addressed by HCBS)

Are you interested in employment after discharge is complete?				Yes		No
		If yes, would you like to be referred to VR?		Yes		No
Are there unavailable needed resources? (If yes, please list below)				Yes		No

REFERRALS TO AVAILABLE COMMUITY RESOURCES (List referrals that have been or will be made…)

Agency	Phone	Date Referred

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FEASIBILITY SCALE

Medicaid Eligibility		0 = Resident will not be eligible for Medicaid upon return to the community. 1 = Resident is likely to be eligible for Medicaid upon return to the community.
HCBS Availability		0 = Resident will not have access to an HCBS program upon return to the community. 1 = Resident will have access to an HCBS program upon return to the community.
Safe , Affordable Housing		0 = Resident will not have access to safe, affordable housing upon return to the community. 1 = Resident will have access to safe, affordable housing upon return to the community.
Willing, Able Caregiver		0 = There is not a willing and able caregiver. 1 = There is a willing and able caregiver.
Available Mental/ Emotional/ Behavioral Supports		0 = Needed mental/ emotional behavioral supports are not available. 1 = Needed mental/ emotional behavioral supports are available. 2 = No mental/ emotional behavioral supports are needed.
Community Resource Availability		0 = Needed community resources are not available. 1 = Needed community resources are available. 2 = No community resources are needed.
Manageable Health Conditions		0 = Resident will not be eligible for Medicaid upon return to the community. 1 = Resident is likely to be eligible for Medicaid upon return to the community.
Available ADL/ IADL Supports		0 = Resident will not have access to an HCBS program upon return to the community. 1 = Resident will have access to an HCBS program upon return to the community.

FEASIBILITY SCORE: ________
(Max.= 10 Points)

8- 10 = Successful transition is very likely
5- 7 = Successful transition is likely
0-4 = Successful transition is highly unlikely

Client Referred to the Following Waiver… [ ]

SUMMARY: (Address whether or not and HOW any identified barriers might be overcome.)

[ ]

Alabama Medicaid Agency Gateway to Community Living Use Only:

MFP Eligibility Confirmed: ☐ Yes ☐ No

Date of Confirmation: ____________________