ALABAMA MEDICAID AGENCY

Admission and Evaluation Assessment Tool for PACE

From _____
Name of PACE Organization

NPI Number _____

_____
Address of PACE Organization

Telephone Number _____

LOC Assessment Date_____ Projected PACE enrollment date _____

Assessment

Initial ☐

Annual ☐

Applicant Name _____
Last, First, Middle

Date of Birth _____ SSN _____ - _____ - _____

Living Arrangement

Alone ___ Spouse ___

Child ___ Parent ___

Other _____
(Identify)

Caregiver _____

Relationship to Applicant _____

Primary Physician or Clinic Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Name _____ Medicaid No._____

FUNCTIONAL AND SOCIAL ASSESSMENTS

(Complete ALL areas; select ONLY ONE answer for each area)

I. EATING: Process of obtaining nourishment, by any means, from a receptacle, into the body.

- ☐ 0 Eats or tube feeding independently without any physical assistance (feeds self)
- ☐ 1 Feeds self with reminders or verbal encouragement (supervision/coaching)
- ☐ 2 Constant observation is required and/or fed part of each meal (1-2 days per week)
- ☐ 3 Fed entire meal or requires tube feeding (3 or more days per week)

II. TRANSFER: Applicant's ability to move between the bed, chair, wheelchair, etc…

- ☐ 0 Transfers independently without physical assistance
- ☐ 1 Transfers with standby supervision
- ☐ 2 Transfers with physical assistance of one person (multiple (2) or more times per week)
- ☐ 3 Transfers with physical assistance of two or more persons or a mechanical lift. (daily)

III. MOBILITY: Applicant's ability to walk without physical assistance from others.

- ☐ 0 Independently mobile (without physical assistance) with or without assistive devices (cane, wheelchair, walker)
- ☐ 1 Mobile with standby supervision
- ☐ 2 Requires physical assistance from another person for mobility on an ongoing basis (multiple (2) or more times per week)
- ☐ 3 Totally dependent on others for mobility. Unable to actively participate in mobility. (daily)

IV. TOILETING: Applicant's physical ability to get into, onto, and from a bathroom, toilet, commode, bedpan or urinal.

- ☐ 0 Toilets independently without physical assistance
- ☐ 1 Requires supervision, reminders or verbal cueing for toileting. Does not need physical assistance
- ☐ 2 Requires direct physical assistance from another person to use the toilet (toileting, incontinence care, ostomy care or indwelling catheter care) on an ongoing basis (multiple (2) or more times per week)
- ☐ 3 Always requires complete physical assistance with toileting (toileting, incontinence care, ostomy care or indwelling catheter care) daily

V. ORIENTATION: Applicant's orientation to person (remembers name, recognizes family) or place (knows where s/he is and able to locate common areas in living environment).

Orientation to Person

- ☐ 0 Always oriented to person
- ☐ 1 Usually oriented to person
- ☐ 2 Usually not oriented to person
- ☐ 3 Never oriented to person

Orientation to Place

- ☐ 0 Always oriented to place
- ☐ 1 Usually oriented to place
- ☐ 2 Usually not oriented to place
- ☐ 3 Never oriented to place

VI. COMMUNICATION

EXPRESSIVE: Applicant's ability to express basic wants and needs.

- ☐ 0 Always able to express basic wants/needs using verbal/written language or assistive communication device
- ☐ 1 Usually able to communicate basic wants/needs using verbal/written language or assistive communication device
- ☐ 2 Usually not able to communicate basic wants/needs using verbal/written language or assistive communication device
- ☐ 3 Never able to communicate basic wants/needs

Name _____ Medicaid No._____

RECEPTIVE: Applicant's ability to understand and follow simple instructions (e.g., perform basic activities of daily living such as dressing or bathing) without continual caregiver intervention.

- ☐ 0 Always able to understand and follow simple instructions and commands
- ☐ 1 Usually able to understand and follow simple instructions and commands
- ☐ 2 Usually not able to understand and follow simple instructions and commands
- ☐ 3 Never able to understand and follow simple instructions and commands

VII. MEDICATION: Applicant's ability to self-administer medications with limited assistance from others (e.g., reminding, encouraging, reading labels, opening bottles, handing to applicant, monitorin dosage. This includes PO, IV, IM Enteral, RX Otics, Optics, Topicals, Inhalers, and continuous SQ pain management.

- ☐ 0 Always physically and mentally capable of self administering prescribed medications
- ☐ 1 Physically and mentally capable of self administering prescribed medications with limited assistance
- ☐ 2 Not physically or mentally capable of self administering prescribed medications despite the availability of limited assistance from another person

VIII. BEHAVIORS: Does applicant require persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems? (e.g., aggressive physical behavior, disrobing, or repetitive elopement attempts)?

- ☐ 0 Does not have a persistent pattern of behavior problems requiring caregiver intervention
- ☐ 1 Requires caregiver intervention 1-3 days per week due to an established and persistent pattern of behavior problems
- ☐ 2 Requires caregiver intervention 3 or more days per week due to an established and persistent pattern of behavior problems
- ☐ 3 Requires caregiver intervention daily due to an established and persistent pattern of behavioral problems

SKILLED NURSING SERVICES (Check all that apply and indicate frequency needed)

These services must be ordered by a physician and supported by documentation in the applicant's record and have been provided prior to enrollment in PACE

Skilled Nursing or Rehab Service	Frequency
Tube feedings (PEG, NG, GT)	
Care of extensive decubitus ulcers or other widespread skin disorders	
IV or Hyperal Therapy	
Daily Intermittent Catheterization	
Bowel/Bladder training	
Complex Dressing Changes (excludes pressure ulcer care, peg site care, and skin tears) usually more than once per day. May include the following: • Wound vacuum, trach care, surgical wounds, stasis ulcers, skin graft sites	
Suctioning (nasopharyngeal, trach) excludes trach care and oral suctioning	
Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse (provide supporting documentation)	
Maintenance of tracheostomy, gastrostomy, colostomy, ileosotmy, and other tubes indwelling in the body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created	
Occupational Therapy by OT or OT assistant	
Physical Therapy by PT or PT assistant	
Other type:	

Name _____ Medicaid No._____

Medical Devices

	Does Not Need	Has, Uses	Has, Does Not Use	Needs, Does Not Have	Frequency Used
Artificial Limb					
Walker					
Cane					
Lift					
Wheelchair					
Oxygen					
Hearing Aids					
Glasses					
Shower Chair					
Bedside commode					
Incontinent Supplies					
Grab bars					
Hospital bed					
Ramps					
Other Home Modifications					

General Health Assessment:

How would you rate your overall health at the present time? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

How many times have you fallen in the last six months? _____

Have you been to the ER or been hospitalized in the last year? ☐ No ☐ Yes:

How many times? _____ ER _____ Hospital

In the past year have you lived in a nursing home or convalescent center? ☐ Yes ☐ No

Name _____ Medicaid No._____

Cognitive/Behavior Status

Attach a completed copy of a nationally recognized mini mental status questionnaire on those applicants who have a diagnosis of Dementia/Alzheimer's. This should include the answers as given by the applicant and any comments noted by the person administering the questionnaire.

Current Diagnosis (check all that apply)

☐ Alcoholism	☐Alzheimer's	☐Amputation	☐ Anemia	☐ Arthritis	☐ Asthma
☐ Cancer	☐ Cerebral Palsy	☐ Chronic Renal Failure	☐ COPD	☐ CVA	☐ Dementia
☐ Diabetes	☐ Emphysema	☐ Epilepsy/seizures	☐ Glaucoma	☐ Heart Disease	☐ Hernia
☐ HIV/AIDS	☐ Hypertension	☐ Multiple Sclerosis	☐ Organic Brain Syndrome		☐ Osteoporosis
☐ Paralysis	☐ Parkinson's	☐ Respiratory	☐ Skeletal Trauma		☐ Skin Disease
☐ Spinal Cord Injury	☐ Thyroid	☐ Traumatic Brain Injury	☐ Tuberculosis		☐ Ulcer

Additional Diagnoses/Comments

Name _____ Medicaid No._____

Medication and Substance Use

List all medications that the applicant is taking, either regularly or only as needed. Please include all types of supplements in the home that are regularly taken (non-prescription drugs, OTC, sleep aids, herbal remedies, vitamins and supplements). If client or caregiver cannot list these, ask to see pill bottles.		
Medication Name	**Dosage and Frequency**	**Administration Method (PO, IM, SQ etc)**

The medications on this list were provided by the client, their caregiver or their doctor

Name _____ Medicaid No._____

Admission criteria (Listed below are specific services and assistance with activities of daily living that a client requires on a regular basis. At least two of the a-k criteria must be met. Multiple criteria under *k* will count as one criterion)

- ☐ a. Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment. **(Cannot be counted as a second criterion if used in conjunction with criterion *k-7)***
- ☐ b. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders
- ☐ c. Nasopharyngeal aspiration required for the maintenance of a clear airway
- ☐ d. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created
- ☐ e. Administration of tube feedings by nasogastric tube
- ☐ f. Care of extensive decubitus ulcers or other widespread skin disorders
- ☐ g. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse (provide supporting documentation) **(Cannot be counted as a second criterion if used in conjunction with criterion *k-9*, must submit medical record documentation for the previous 30-90 days*)***
- ☐ h. Use of oxygen on a regular or continuing basis
- ☐ i. Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing innon-infected, postoperative, or chronic conditions per physician's orders
- ☐ j. Comatose resident receiving routine medical treatment
- ☐ k. Assistance with at least one of the activities of daily living below on an ongoing basis (*multiple times per week means two or more times/wk*):

1. ☐ Transfer - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or multiple times per week).
2. ☐ Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet his requirement.
3. ☐ Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.
4. ☐ Toileting - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).
5. ☐ Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g. how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.
6. ☐ Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g. does not know residence is a Nursing Facility).
7. ☐ Medication Administration - The individual is not mentally or physically capable of self administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose. (**Cannot be counted as a second criterion if used in conjunction with criterion *a*)**
8. ☐ Behavior - The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement attempts).
9. ☐ Skilled Nursing or Rehabilitative Services - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit **(Cannot be counted as a second criterion if used in conjunction with criterion g)**

Name _____ Medicaid No._____

Summary of applicant condition(s)/problems that put the participant at risk of nursing home placement (required, not optional):

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CERTIFICATIONS

CERTIFICATION OF ASSESSMENT

I certify that the level of care information provided in this Admission and Evaluation tool is accurate. I understand that this information will be used to determine the applicant's eligibility for PACE services.

Registered Nurse Reviewer Signature _____

Date _____

CERTIFICATION OF LEVEL OF CARE (Must be completed by MD)

I certify that the level of care information will be used to determine the applicant's eligibility for PACE services and without these services this applicant would require nursing facility care.

Signature of Physician _____

Date _____

Physician Printed Name _____

Physician's Address _____

MEDICAID USE ONLY

I certify that the LOC is justified based on the information I have received and reviewed as contained in this document and that the participant meets two of the criteria for nursing home level of care.

LOC Approved ☐ LOC Denied ☐

Criteria met _____

PACE Unit RN Signature _____

Date_____