RETURN TO

Southern Alabama Regional Council on Aging

1075 S. Brannon Stand Road
Dothan, AL 36305

HCBS Admission and Evaluation Data

To be completed by Case Manager
with assistance of Attending Physician

Do Not Fill In This Space
For UC Use Only
Prior Approval Date _____
Denied _____
UC RN _____

Client _____ Date of Birth _____

Medicaid Number _____
(SSN if Inst. Deeming)

By signing below, I authorize the release of information for the purpose of determining my eligibility to receive home and community based services.

_____ Date _____

By signing below, I acknowledge I have been given a choice between Community Services and nursing home care and I have chosen Community Services.

_____ Date _____

By signing below, I acknowledge that my estate may be subject to recovery of any funds expended by Medicaid pursuant to this application and/or redetermination.

_____ Date _____

Check if patient has a diagnosis of:

	Yes	No
Mentally Retarded (MR)	☐	☐
Mental Illness (MI)	☐	☐
Developmentally Disabled (DD)	☐	☐

Check if patient has had the following evaluations and attach a summary.

	Yes	No
Psychological	☐	☐
Psychiatric	☐	☐

CURRENT DIAGNOSIS **Check all that apply:**

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

Additional Diagnoses
Describe

Special or therapeutic diet ☐ Yes ☐ No
Describe

Allergies ☐ Yes ☐ No
Describe

Is patient free from communicable disease? ☐ Yes ☐ No

PHYSICIAN'S CERTIFICATION

I certify that without Home and Community Based Services this patient would require nursing facility care.

Physician's Signature _____ Date _____

Physician's Address City, ST Zip _____ Telephone Number _____

Medications Prescribed (See Attached 3rd Page)

Medicaid Number _____

Date of Birth _____

Physician Date _____

Admission Criteria

(Check all that the resident requires on a regular basis: Resident must meet at least **two** of the A-K criteria for admissions and re-determinations)

☐ **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 clients 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. *(Cannot be counted as a second criterion if used in conjunction with criterion K-3 if the ONLY stoma (opening) is a G or PEG tube). (Cannot be counted as a second criterion if used in conjunction with criterion K-4 if used for colostomy and Ileostomy.*

☐ **E.** Administration of tube feedings by naso-gastric 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. (*Cannot be counted as a second criterion if used in conjunction with criterion K-9)*

☐ **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 in non-infected, postoperative, or chronic conditions per physician's orders.

☐ **J.** Comatose client receiving routine medical treatment.

K. Assistance with at least one of the activities of daily living below on an ongoing basis: (Check all boxes below that apply. See additional information concerning criterion K below.)

☐ **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** two or more times per week).

☐ **2.** Mobility- The individual requires physical assistance from another person for mobility on an ongoing basis (daily **or** two or more 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 this 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. *(Cannot be counted as a second criterion if used in conjunction with criterion D if the ONLY stoma (opening) is a G or PEG tube).*

☐ **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** two or more times per week*). (Cannot be counted as a second criterion if used in conjunction with criterion D if used for colostomy or ileostomy).*

☐ **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 of 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 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)*

➢ Criterion K should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance. Multiple items being met under (K) will still count as one criterion.

Medicaid Number _____

Date of Birth _____

Physician Date_____

Medications Prescribed: Route, Dosage, Frequency, Diagnosis

_____ _____

Physician's Signature Date