Ascend
Ascend Management Innovations LLC

Connecticut LTC Level of Care Determination Form

To be maintained in the individual's medical record.

I. Application Type

LOC Type: ☐ Chronic and Convalescent Nursing Home ☐ Rest Home with Nursing Supervision

Screen Type: ☐ Applicant ☐ Resident applying for LTC Medicaid
☐ Resident/Medical improvement ☐ Resident/Prior ST Decision

Expected length of stay: ☐ Long Term ☐ Short Term Estimated at (# of days) : ○<30 ○30-60 ○60-90 ○90-120

II. Demographics

A. **Individual**

First Name:_____ Middle Initial:_____ Last Name:_____

Mailing Address:_____ City:_____ State:___ Zip:_____ Phone:_____

Social Security #:___-___-___ Date of Birth:___/___/___ Marital Status: ☐ M ☐ S ☐ W ☐ D

Gender: ☐ Male ☐ Female

Payment Method: ☐ Medicaid Active ☐ Medicaid Eligible ☐ Medicaid Pending ☐ Medicare/Medicaid Eligible
☐ Medicare ☐ Medicare and Medicaid ☐ Self Pay/Insurance

Medicare#_____ Medicaid #_____

B. **Conservator/Legal Guardian**

Name: _____

Address: ☐ Check here if same as II.A (if not, specify below)

Street:_____ City_____ State_____ Zip: _____

C. **Typical Living Situation:** ☐ NF ☐ Hospital ☐ Homeless ☐ Home with family ☐ Home alone
☐ Group Home ☐ Other (Specify: _____

D. **Current Location**

☐ Medical Facility ☐ Psychiatric Facility ☐ NF ☐ Hospital ED ☐ Community ☐ Other_____

Facility Name_____ Admit Date: _____

Location Address: ☐ Check here if same as II.A (if not, specify below)

Street_____ City_____ State_____ Zip: _____

E. **Admitting Information**

Admitting Facility: _____ Admission Date:_____

Street_____ City_____ State_____ Zip: _____

III. Functional Capabilities Needs Assessment

1. ACTIVITIES OF DAILY LIVING (ADL)

Choose the single best answer for each ADL.		
0 – Independent or supervision < daily		Requires no assistance or supervision. If assistive devices are used, needs no monitoring, assistance, or supervision to use those devices.
1 – Supervision daily		Capable of completing most parts of the activity independently but needs some supervision or assistance (e.g., cues/prompts, etc).
2 – Hands on		Capable of completing some parts of the activity but needs continual supervision or assistance (e.g., assistance with weight bearing tasks, extensive physical assistance).
3 – Total Dependence		Requires total assistance with the activity.
	Bathing	Abilities to get into and out of the bathing area, adjust the water temperature, and cleanse the body and hair.
	Dressing	Abilities to select weather appropriate clothing and put on and adjust clothing.
	Eating/ feeding	Abilities to use utensils, set up food tray, eat appropriate amount, and eat at appropriate pace; feeding by nasogastric, gastrostomy, jejunostomy, or parenteral route. Does not include supervision of obesity or weight reduction.

Client First/Middle Name: _____ Last Name: _____

	Toileting	Abilities to transfer to/from the toilet, adjust clothing, and attend to hygiene, and/or ostomy or catheter care.
	Mobility	Ambulation and use of wheelchair, cane, walker, crutch, or other mobility aid.
	Transfer	Movement from surface to surface (e.g., chair to wheelchair or bed to chair).
	Continence	Includes supports needed to either: assist the individual to control one's body to empty the bladder and/or bowel appropriately, or, to appropriately change incontinence pads/briefs, cleanse the changing pads, and dispose of soiled articles.

For each ADL rated 1, 2, or 3, describe assistance needed, including frequency and reason for support needs (including physical and cognitive). If applicable, include details about tube feedings, IV fluids, fluid monitoring, catheter or ostomy care, mobility aids, transfer aids, and incontinence care: _____

_____

_____

2. MEAL PREPARATION (Choose the single best answer.)

☐ Requires no assistance or supervision.
☐ Capable of preparing meals with minimal assistance (e.g., set-up of ingredients, oversight, or cueing).
☐ Requires continual supervision or physical assistance with multiple components of meal preparation.
☐ Requires total physical assistance with meal preparation.

3. MEDICATION SUPPORTS (Choose all that apply.)

Supports Needed	Medication Supports Needed to be physically capable of adhering to physician ordered medication regimen. Rate compliance issues separately under item #9 of this section (*Behaviors*).
☐	None and/or does not apply
☐	Set ups
☐	Verbal or gestural assistance (reminding, instructing, coaching, pointing)
☐	Physical assistance with some or all of the physical steps of taking medications, and adherence cannot be ensured with verbal and gestural support alone.
☐	Injections
☐	Other (Specify):
If support needs were selected, describe the reason for the needed support and either complete Section IV.1 or fax a copy of the medication list (e.g., MAR or MD orders)	

4. ORIENTATION

Choose the single best answer for each type of orientation.	
0 – Fully oriented and needs no prompting or cueing.	_____ **Self** (awareness of own name)
1 – Occasionally disoriented & needs prompting or cueing.	_____ **Place** (awareness of current location)
2 – Disoriented all or most of the time.	_____ **Time** (awareness of current date & time)
	_____ **Situation** (awareness of current situation)

5. MEMORY (CHOOSE ONE)

☐ Able to remember past and present events with no cueing or prompting.
☐ Needs cueing or prompting to remember past and/or present events.
☐ Unable to remember past and present events such that daily supervision is needed to prevent harm

6. JUDGMENT (CHOOSE ONE)

☐ Solves problems and makes decisions with no assistance.
☐ Solves problems & makes decisions with minimal assistance (e.g., prompts or cues may be required).
☐ Unable to solve problems well and make appropriate decisions such that daily supervision is needed to prevent harm

7. COMMUNICATION (CHOOSE ONE)

☐ Communicates information in intelligibly & understands information conveyed without assistance.

Client First/Middle Name: _____ Last Name: _____

☐ Needs assistance to communicate information and/or understand information conveyed.
☐ Inability to communicate information in an intelligible manner and/or understand information conveyed
(choose all that apply)
Communication Method: ☐ Verbal ☐ Sign language ☐ Writing ☐ Gestures ☐ Other:

8. VISION: (CHOOSE ALL THAT APPLY)
☐ No problems indicated
☐ Cataracts ☐ Glaucoma ☐ Blind
☐ Orientation/mobility problems due to vision
☐ Other (specify): _____

9. BEHAVIORS (CHOOSE ALL THAT APPLY)
☐ No problems indicated ☐ Verbally aggressive toward others ☐ Wanders/runs away
☐ Self-injurious ☐ Physically aggressive toward others
☐ Unsafe or unhealthy habits such as throwing or smearing food or excrement, disrobing in inappropriate situations, screaming, making inappropriate sexual advances.
☐ Threats to Health/Safety: Inability to follow a medication or dietary regimen without supervision; creating a fire hazard; exhibiting poor judgment which is potentially harmful to self or others.

Describe frequency and severity of behaviors: _____

_____

_____

Describe needs related to behaviors, including type of required intervention: _____

_____

_____

IV. Medical Needs

1. Provide the following information for each physician ordered medication (**This section is optional & should be provided if medication information is a factor in supporting or clarifying the individual's need for NF level of care and, if so, a medication list (such as a MAR or MD orders) may be faxed in lieu of completing this table**).

☐ Check here if you are faxing the MAR or Medication list

Medication	Diagnosis	Dosage	Route/Frequency

2. A. ☐ No ☐ Yes The physician has ordered at least one (or a combination) of the **rehabilitative services** listed below (complete the table below) If yes, to 2.A, ☐ No ☐ Yes The individual presents with restorative potential

	Start Date	Frequency (# of days/week)	Duration
☐ Speech Therapy			
☐ Physical Therapy			

Client First/Middle Name: _____ Last Name: _____

☐ Occupational Therapy			
☐ Respiratory Therapy			

3. a. ☐No ☐Yes (Chronic and Convalescent Nursing Home/CCNH) The individual has uncontrolled, unstable, and/or chronic conditions requiring continuous skilled nursing services and/or nursing supervision on a daily basis or has chronic conditions requiring substantial assistance with personal care on a daily basis.

b. ☐No ☐Yes (Rest Home with Nursing Supervision/RHNH) The individual has controlled and/or stable chronic conditions requiring skilled nursing services, nursing supervision, or assistance with personal care on a daily basis.

If yes to either #3.a or 3.b, ***complete the following:***

c. Describe medical diagnoses/history which qualify the individual under either 3.a or 3.b and note whether the condition is chronic or acute, stable/unstable, and/or current/status post.

_____

_____

_____

d. Describe required nursing services related to the medical condition(s). Include frequency, intensity and any associated fluctuations in medical presentation (e.g., changes in lab values, vitals, or levels, increase in frequency of MD visits, etc.) that necessitate skilled nursing services.

_____

_____

V. Additional Comments

Additional Notes/Comments (Use this area for any important information you think was not adequately addressed in the above sections.) _____

_____

VI. Practitioner Certification

Certification that the client meets the nursing facility level of care criteria described in Section 19-13- D(8)(t)(d)(1) of the Public Health Code must be provided by a physician, APRN, or physician assistant. This certification must be signed and dated by the practitioner; telephone and voice orders are not acceptable.

Signature: _____ Credentials: _____ Date: _____

VII. Attestation/Referral Source Information

By entering my name and credentials, I attest that I am the person who completed this form. I understand that CT DSS considers knowingly submitting inaccurate, incomplete, or misleading LOC information to be Medicaid fraud, and I have completed this form to the best of my knowledge.

Person completing form: _____ Facility: _____

Facility Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

VIII. Special Instructions

*This form may be completed at www.pasrr.com or faxed to Ascend at **877.431.9568**. The physician's attestation must be faxed once the screen is complete to 1-877-431-9568.* **Mailed forms may be sent to: Ascend Management Innovations • Attn: Connecticut Division • 227 French Landing Drive, Suite 250 • Nashville, TN 37228 • Phone: 877-431-1388 • Fax: 877-431-9568 •** ***For assistance with completing this form or accessing WEBSTARS™, call Ascend toll free at 1.877.431.1388 and ask to speak with a CT LTC nurse reviewer.***