A. IDENTIFICATION

1. Social Security # (Optional)

___ ___ ___ - __ __ - ___ ___ ___ ___

2. Customer Last Name

_____

First Name **MI**

_____ _____

3. Customer Address

Street_____

City_____County _____

State _____ Zip _____

Phone_____

4. Date Of Birth_____/_____/_____

5. Gender ❑ Male ❑ Female

6. Date of Assessment ___/____/_____

7. Assessor's Name

_____

8. Assessment Location

_____

9. Primary Language

❑ Arabic ❑ Chinese ❑ English
❑ French ❑ German ❑ Hindi
❑ Pilipino ❑ Spanish ❑ Tagalog
❑ Urdu ❑ Vietnamese
❑ Sign Language ❑ Other_____

10. Ethnic Background

❑ Hispanic or Latino
❑ Non Hispanic or Latino

11. Race

❑ American Indian or Alaskan Native
❑ Asian
❑ Black or African American
❑ Native Hawaiian, or Other Pacific Islander
❑ White
❑ Other_____

12. Contact Person Information

Name_____

Street_____

City_____

State _____ Zip _____

Phone_____

Guardian ❑ Yes ❑ No

B. PASRR

1. Is the customer considering placement in a nursing facility? ❑ Yes ❑ No

2. Has the customer been diagnosed as having a serious mental disorder?

❑ Yes ❑ No

3. What psychiatric treatment has the customer received in the past 2 years (check all that apply)?

❑ 2 Partial hospitalizations
❑ 2 Inpatient hospitalizations
❑ 1 Inpatient & 1 Partial hospitalization
❑ Supportive Services
❑ Intervention
❑ None

For those individuals who have a mental diagnosis and treatment history please record that information_____

_____

_____

4. Level Of Impairment?

❑ Interpersonal Functioning
❑ Concentration/ persistence/ and pace
❑ Adaptation to change
❑ None

5. Has the customer been diagnosed with one of the following conditions prior to age 18 for Mental Retardation / Developmental Disability, or age 22 for related condition, and the condition is likely to continue indefinitely?

❑ Developmental Disability (IQ_____)

❑ Related Condition

❑ None

For those individuals who have a development disability or related condition please record that information:

_____

6. Referred for a Level II assessment?

❑ Yes ❑ No

C. SUPPORTS

1. Live alone ❑ Yes ❑ No

2. Informal Supports available

❑ Yes ❑ Inadequate ❑ No

3. Formal Supports available

❑ Yes ❑ Inadequate ❑ No

D. COGNITION

1. Comatose, persistent vegetative state ❑ Yes ❑ No

2. Memory, recall

___ Orientation
___ 3-Word Recall
___ Spelling
___ Clock Draw

E. COMMUNICATION

1. Expresses information content, however able

❑ Understandable
❑ Usually understandable
❑ Sometimes understandable
❑ Rarely or never understandable

2. Ability to understand others, verbal information, however able

❑ Understands
❑ Usually understands
❑ Sometimes understands
❑ Rarely or never understands

F. RECENT PROBLEMS / RISKS

___ Falls (6 mo) ___ Falls (1 mo)

❑ Injured head during fall(s)
❑ Neglect/ Abuse/ Exploitation
❑ Wandering
❑ Socially inappropriate/ disruptive behavior
❑ Decision Making
❑ Unwilling/Unable to comply with recommended treatment
❑ Over the last few weeks / months - experienced anxiety / depression.
❑ Over the last few weeks/ months - experienced feeling worthless
❑ None

G. CUSTOMER CHOICE FOR LTC

❑ Home without services
❑ Home with services
❑ ALF/ Residential/ Boarding Care
❑ Nursing Facility (name below):

_____

❑ **Anticipated less than 90 days**

Street_____

City_____Zip_____

Phone_____

CUSTOMER NAME: _____

The line in front of each activity is to put the current (Average Day) level of functioning:

1=Independent; **2**=Supervision Needed; **3**=Physical Assistance Needed; **4**=Unable to Perform

The line in front of each service is for the availability code: **0**=Assessor does not know if available; **1**=Service is available; **2**=Service is available but waiting list; **3**=Service available but customer does not have resources to pay; **4**=Service is not available; **5**=Service is available but customer chooses not to use; or **6**=Service does not exist.

H. ACTIVITIES OF DAILY LIVING

____Bathing **_____Dressing** **____Toileting**

____Transferring **____Walking/Mobility** **____Eating**

___ ASTE - Assistive Technology
___ ATCR - Attendant Care (Personal or Medical)
___ BATH - Bathroom (Items)
___ INCN - Incontinence Supplies
___ PHTP - Physical Therapy
___ MOBL - Mobility/Aids/Assistive technology/custom care

I. INSTRUMENTAL ACTIVITIES for DAILY LIVING

____Meal Preparation **____Shopping**

____Money Management **____Transportation**

____Telephone **____Laundry/Housekeeping**

____Management of Medication/Treatments

___ CHOR - Chore
___ CMEL - Congregate Meals
___ HHAD - Home Health
___ HMEL - Home Delivered Meals
___ HMKR - Homemaker
___ MEDIC - Medication Issues
___ MFMA - Money/Financial Management Assistance
___ MMEG - Medication Management Education
___ NCOU - Nutrition Counseling
___ SHOP - Shopping
___ TPHN - Telephoning
___ TRNS - Transportation

J. OTHER SERVICES

___ APSV – Abuse/ Neglect/ Exploitation Investigation
___ ADCC - Adult Day Care
___ ALZH - Alzheimer Support Service
___ CMGT - Case Management
___ CNSL - Counseling
___ HOUS - Community Housing/Residential Care/Training
___ HOSP - Hospice
___ IAAS - Information & Assistance
___ LGLA - Legal Assistance
___ NRSN - Nursing/ShortTerm Skilled/PartTime/Inpatient
___ NSPT - Night Support
___ OCCT - Occupational Therapy
___ PAPD - Prevention of Depression Activities
___ PEMRI - Personal Emergency Response System
___ RESP - Respite Care
___ RMNR - Repairs/Maintenance/Renovation
___ SENS - Sensory Aids
___ SLPT - Speech & Language Therapy
___ VIST - Visiting
___ OTEM - OTHER _____

K. ADDITIONAL RESOURCES/NEEDS:

___ ALVG - Assisted Living Facility
___ EMPL - Employment
___ GUAR - Guardianship/Conservator
___ MCID - Medicaid Eligibility
___ VBEN - Veteran's Benefits
___ HINS - Home Injury Control Screening
___ CMHC - Community Mental Health Center
___ CDDO - Community Developmental Disability Organization
___ CILS - Centers for Independent Living Services
___ RPCC - Regional Prevention Center Contacts

COMMENTS_____

_____

_____

_____

_____

_____

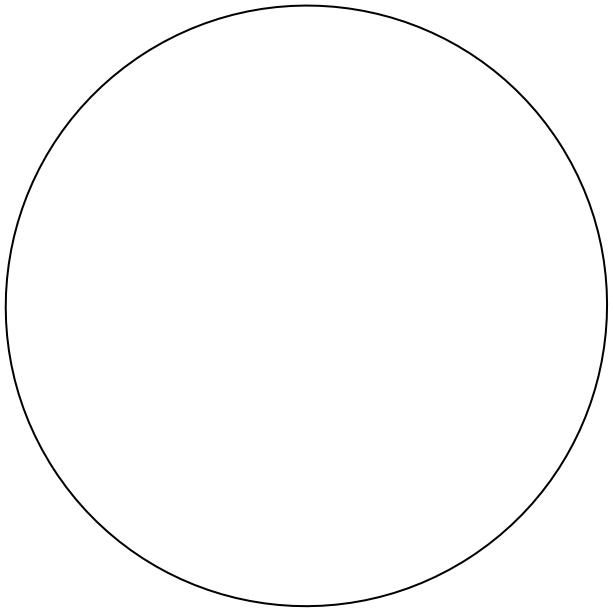
_____

_____

_____

Customer Name _____ Date _____

Clock Draw



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, Social Security Number: __ __ - __ __ - __ __ __ __ DOB ___/____/___
Name of client **[optional]**

hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that signing this form is voluntary.

Providing the information:
Person(s)/Organization(s) (check all that applies)
____ Community mental health center(s)
name _____
____ Intermediate care facility/nursing facility/hospital
name _____
____ State Agency/Department
name _____
____ Community developmental disability organization(s)
name _____
____ Aging and Disability Resource Center
Other(s): name/address/phone_____
_____

Receiving the information:
Person(s)/Organization(s) (check all that applies)
____ Aging and Disability Resource Center
name _____
____ Kansas Department for Aging and Disability Services

Other(s): name/address/phone_____
_____
_____
_____
_____

Description of Information to be Used or Disclosed (place a check mark or an "x" next to the item(s) to be used or disclosed):
___ *Recent History and Physical, signed by a physician within the last 6 months* ___*Listing of in patient or partial psych stays*
___ *List of SPMI Diagnosis* ___*List of IDD/RC Diagnosis* ___*With dates and locations in the last 2 years.*
___ *Substantiation of increase in supportive services (30 days) in the last 2 years.* ___ *LEO/APS/Housing Interventions*

The purpose of the Use or Disclosure: *Completion of a Level II PASRR Evaluation*
****Return requested documentation to: ATTN: Susan at* KDADS.CARE@KS.GOV *or FAX to (785)291-3427*

The Individual or the Individual's Representative must read or have the following read to them and initial by each item below:

_____ *(Initials)* I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that the refusal to sign this authorization may mean that the use and/or disclosure described in this form will not be allowed.

_____ *(Initials)* I understand this Release is valid for one year from today's date.

_____ *(Initials)* I understand that I may revoke this Release at any time by notifying the **providing organization** in writing. It will not have an effect on actions that were taken prior to the revocation.

_____ *(Initials)* I understand that once the uses and disclosures have been made pursuant to this authorization, the information released may be subject to re-disclosure by any recipient and will no longer be protected by federal privacy laws.

_____ *(Initials)* This will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I certify that I agree to the uses and disclosures listed above and that I have received a copy of this Authorization. (Form must be completed before signing).

_____ _____
Signature Date

_____ _____ _____
Signature of Personal Representative (if applicable) Date Description of Authority

Certificate of CARE Assessment

This certificate is evidence of completion of a CARE assessment. Keep it with your medical records.

If you want to live in a nursing facility, you must take a copy of this certificate with you when you apply for admission. If you want to live in your home or other community-based setting, the Area Agency on Aging can help you find appropriate services.

This certificate is good for one year. If your health status or abilities change, you may request a new assessment. Should you need additional copies of this certificate or your completed two-page assessment, or want additional information, contact your Area Agency on Aging at: ______________________________

• •

I certify that I have completed a CARE assessment for ______________________________
(client's name)

on ______________________________ . The preadmission requirement found in Public Law 100-203 has been met.
(date)

The Preadmission Screening and Annual Resident Review (PASARR) portion of the assessment:

___ did not indicate a need for further evaluation.

___ indicated a need for further evaluation. I am referring the client to a Level II assessor.

I am referring the client to a community-based service:

___ Area Agency on Aging ___ DCF Adult Services ___ Independent Living ___ Other ______________

No referral is necessary, the client:

___ does not need / does not wish help in finding community-based services.

___ has selected a nursing facility. ___ has not made final LTC decision.

______________________________ (Assessor Signature)

______________________________ (Assessor Number)

I hereby acknowledge that I have received a copy of the ***Notice of Right to Request a Fair Hearing*** attached to my copy of the Certificate of CARE Assessment.

______________________________ (Client's Signature)

______________________________ (Date)

Notice of Right to Request A Fair Hearing

If you do not agree with the determination of the PASARR column (Section II of the Level I CARE Assessment) referral regarding a Level II assessment as set forth on your CARE Certificate, you have the right to request a fair hearing to appeal this decision. This determination was made in accordance with the Health Care Financing Administration Rules and Regulations relating to Preadmission Screening and PASARR, 42 CFR Section 483.100 et. seq.

To request a fair hearing in accordance with K.A.R. 30-7-64 et. seq., **your request shall be in writing and delivered, or mailed to the following address so that it is received by the agency at the *Department of Administration Office of Administrative Hearings, 1020 S. Kansas, Topeka, KS 66612* within 30 days from the date on this Certificate of CARE Assessment.** (Pursuant to K.S.A. 77-531, an additional three days shall be allowed if you receive this certificate by mail.) Failure to timely request or pursue a fair hearing may adversely affect your rights.

At the hearing you will be given the opportunity to explain why you disagree with the agency action. You may represent yourself or be represented at the hearing by legal counsel, a friend, a relative, or other spokesperson.