

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised:</b> X <b>Current:</b>	<b>Date:</b> <b>Date:</b> 02/01/05
<b>Section: Nursing Facility</b>	<b>Section:</b> 36.08 <b>Pages:</b> 2	
<b>Subject: Admission Requirements</b>	<b>Cross Reference:</b>	

All admissions to a nursing facility require a pre-admission screening in order that individuals determined as mentally ill or individuals with mental retardation not be admitted to a nursing facility unless the State mental health authority (Mississippi Department of Mental Health) (DMH) has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, that

- Because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
- If the individual requires such level of services, whether or not the individual requires specialized services for mental illness or for mental retardation.

Mental retardation as defined in 42 CFR 483.102(b)(3), or as amended, is a person with a related condition as described in 42 CFR 435.1009. Mental illness is defined at 42 CFR 483.102(b)(1).

Section 1919(b)(3)(f) mandates pre-admission screening for all individuals with mental illness or mental retardation who apply to a nursing facility. Resident re-admission and individuals who initially apply to a nursing facility directly following a discharge from an acute hospital stay are exempt if:

- They are certified by a physician prior to admission to require a nursing facility stay of fewer than 30 days; and
- They require care at the nursing facility for the same condition for which they were hospitalized.

The State mental health authority is responsible for providing specialized services to residents with mental illness or mental retardation residing in Medicaid-certified facilities. The facility is required to provide all other care and services appropriate to the resident's condition including resident rights, quality of life and quality of care.

The requirements for admission to a nursing facility are as follows:

- 1) A physician's certification for Nursing Facility Care and Mental Illness (MI)/Mental Retardation (MR) Screening (Level I Screening) must be completed no longer than thirty (30) days prior to the admission of the individual to a nursing facility. Contact the fiscal agent to receive copies of the Level I Screening form or refer to the DOM's website at [www.dom.state.ms.us](http://www.dom.state.ms.us).
- 2) The Level I Screening must be submitted either by the nursing facility to which the individual is being considered for admission or the hospital from which the individual is being discharged. If mental illness or mental retardation is indicated, a Level I must be completed prior to admission.
- 3) A transfer from one facility to another may not require an additional Level I screening if there has been no break in institutional residence.
- 4) A Level I Screening and Level II (if required) must be submitted to the Medicaid Regional Office of the individual's county of residence for LTC Eligibility Determination. (Refer to DOM's website for addresses of the Regional offices: [www.dom.state.ms.us](http://www.dom.state.ms.us).)

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- 5) The nursing facility receiving the individual for admission must complete a Form DOM-317 for each individual receiving Medicaid upon admission and for those applying for Medicaid. The only exception to sending a 317 form is for dually eligible individuals (meaning the person has Medicaid and Medicare) where Medicare will be responsible for the entire admission. In this situation, Medicare crossover claims will process without a 317 form. If Medicaid will be billed for room and board for any portion of an admission, a 317 form to the appropriate Regional Office is required. The Medicaid Regional Office of the individual's county of residence is responsible for authorizing Medicaid reimbursement payments via DOM-317 for each Medicaid resident, including SSI recipients. Refer to Section 36.0 for specific instructions for completion of form.

Additional requirements for admission to a Private Nursing Facility for the Severely Disabled (PNF-SD):

- 1) The beneficiary's diagnosis must include at a minimum: Spinal Cord Injury, Closed Head Injury, or Long-Term Ventilator dependency. Other diagnoses allowed should be similar or closely related to severity and involvement of care.
- 2) The MDS classification must be one of the following categories, as defined in the MS Medicaid Nursing Facility Provider Manual, Section 36.0, and State Operations MDS Manual for Resident Assessment Instrument:

SE1	SSC
SE2	SSB
SE3	SSA

Any beneficiary whose classification falls into a lower classification category will be considered to require a less specialized level of care than that available through a Private Nursing Facility for the Severely Disabled.

- 3) The extent of care medically necessary cannot be provided in a traditional nursing facility in Mississippi.
- 4) DOM will deny payment for beneficiary admissions by PNF-SD that do not fall within the parameters of this policy section.

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<b>Section: Nursing Facility</b>	<b>Section: 36.10</b> <b>Pages: 2</b>	
<b>Subject: Temporary Leave Payment</b>	<b>Cross Reference:</b>	

Under the provisions outlined in this section (42 CFR 447.40), a temporary absence of a resident from a nursing facility will not interrupt the monthly payments to the facility. The period of leave will be determined by counting the day the resident left the facility as the first day of leave.

An absence from the facility for eight (8) to twenty-four (24) hours constitutes a leave day. The facility must reserve the resident's bed in anticipation of the resident's return. The bed may not be filled with another resident during the covered period of leave. Leave days may not be billed if the facility refuses to readmit the resident under their resident return policy.

A refund of payment will be demanded for all leave days taken in excess of the allowable or authorized number of days.

The Division of Medicaid (DOM) pays for the day of admission to a facility. The day of discharge is not paid by DOM unless it is the same day as the date of admission. Facilities may not bill the resident or responsible party for the day of discharge.

Each facility is required to maintain leave records and indicate periods of hospitalization and therapeutic leave days on billing forms and MDS 2.0 Section S.

Before the resident departs on therapeutic or in-patient leave, the facility must provide written information to the resident and/or family member or legal representative explaining leave policies. This information must define the period of time during which the resident will be permitted to return and resume residence in the facility. The notice must also state that, if the resident's absence exceeds Medicaid's bed-hold limit, the resident will be readmitted to the facility upon the first availability of a semi-private bed if the resident still requires the services provided by the facility.

#### **Home/Therapeutic Leave**

Residents in a nursing facility may have absences for home/therapeutic leave from the nursing facility other than for in-patient hospital leave. Home/therapeutic leave also includes dialysis and other outpatient treatments. Specific requirements applicable to home/therapeutic leave are as follows:

- Medicaid coverage of home/therapeutic leave days per State fiscal year (July 1 to June 30) for nursing facilities is fifty-two (52) days in addition to Christmas Day, the day before Christmas, the day after Christmas, Thanksgiving Day, the day before Thanksgiving and the day after Thanksgiving. Thus, a resident may have up to fifty-eight (58) total days in a State fiscal year for home/therapeutic leave.
- All home/therapeutic leave days must be approved by the attending physician.
- Fifteen (15) days home/therapeutic leave are allowed each absence. A resident must be discharged from the facility for Medicaid billing if he/she remains on home/therapeutic leave for more than fifteen (15) days.
- A leave of absence for home/therapeutic leave is broken only if the resident returns to the facility for twenty-four (24) hours or longer.

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### **In-Patient Leave in a Hospital**

Nursing facility residents are allowed fifteen days hospital leave for each hospital stay. There is no maximum number of hospital leave days each year. Hospital leave applies to acute care hospital stays in a licensed hospital, including ger-psychiatric units.

The hospital leave rules apply as follows:

- A resident must be discharged from the facility for Medicaid billing if he remains in the hospital for more than fifteen (15) days. When the resident is readmitted to the facility after a hospital stay, readmission certification on a new DOM-260NF form is not necessary if the resident has been continuously institutionalized. Refer to Section 36.11, Minimum Data Set Plus 2.0, for the appropriate assessment and timing of the assessment to file. A leave of absence for hospitalization is broken only if the resident returns to the facility for twenty-four (24) hours or longer.
- Facilities may not refuse to readmit a resident from in-patient hospital leave when the resident has not been hospitalized for more than (15) days and still requires nursing facility services.
- Facilities which bill Medicaid for fifteen (15) days of in-patient hospital leave, discharge the resident, and subsequently refuse to readmit the resident under their resident return policy when a bed is available, must repay Medicaid for the fifteen (15) days of hospital leave and are subject to additional remedies for failure to comply with the requirements relating to residents' rights.
- In-patient hospital leave will not be paid for days in which the resident is placed in a Medicare skilled nursing facility (SNF) or a swing bed.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 02/01/04
Section: Nursing Facility	Section: 36.17 Pages: 1	Cross Reference:
Subject: Out-of-State Placements		

### **Ventilator Dependent- Out of State Nursing Facility Placements**

Beneficiaries may be approved for out-of-state nursing facility placement when the individual is ventilator dependent and the needs of the beneficiary cannot be met in the state of Mississippi. The out-of-state facility accepting the beneficiary must complete a Mississippi Medicaid provider enrollment packet, meet all provider requirements, and have prior authorization from the Division of Medicaid's Executive Director. Failure to obtain prior authorization will result in denial of payment. For additional requirements, contact the Bureau of Long Term Care, Institutional Long Term Care Division.

To qualify for out-of-state placement, the beneficiary must be:

- 1) Mississippi Medicaid eligible and;
- 2) Eligible for long term care placement and;
- 3) Ventilator dependent with a physician's order for nursing facility placement.

In addition, the referring facility must provide the following documentation to DOM:

- Physician Certification for Nursing Facility and MI/MR Screening form (DOM-260); this form can be downloaded from the DOM website at [www.dom.state.ms.us](http://www.dom.state.ms.us);
- Copies of all medical records pertaining to the beneficiary's ventilator dependency and;
- A list of all nursing facilities contacted for placement and their denials for placement.

### **Dual Eligibles**

Beneficiaries covered under Medicare and Medicaid (dual eligibles) may be admitted to an approved facility for the purpose of weaning from ventilator dependency. The criteria for out-of-state placement must be met. If the beneficiary fails to become weaned and the stay is extended, DOM requires that the out-of-state facility receive additional approval from the executive director before any continued reimbursement is made. When the beneficiary is successfully weaned from the ventilator, DOM will discontinue reimbursement.

### **Reimbursement**

Reimbursement must be established for each beneficiary utilizing Mississippi's Case Mix payment rate system. The out of state facility must provide an initial and quarterly Minimum Data Set (+) for review and desk audit to determine category classification utilizing the M3PI for reimbursement.

This information must be sent to the Division of Medicaid, Bureau of Reimbursement. Documentation requested by DOM not received in a timely manner may result in denial of reimbursement.

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Revised: Current:	Date: 03/01/06 Date:
Section: HCBS/Elderly & Disabled Waiver	Section: 65.06 Pages: 1	
Subject: Prior Approval/Physician Certification	Cross Reference:	

Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver Program. To obtain initial approval, the following forms must be submitted:

- DOM 260 HCBS Physician Certification
- HCBS 305 Assessment
- DOM 301 HCBS Plan of Care

### **DOM 260 HCBS Physician Certification**

The DOM 260 HCBS Physician Certification form is completed by a physician, certifying that the client meets the medical criteria for nursing facility care. The physician's signature must be dated within thirty (30) days of the submission of the form.

### **HCBS 305 Assessment**

The HCBS 305 Assessment form is completed by the case manager. The tool is used to determine eligibility for case management and services needed to maintain the beneficiary in the home.

### **DOM 301 HCBS Plan of Care**

The DOM 301 HCBS Plan of Care form is completed by the case manager. This form, in conjunction with the HCBS 305 Assessment, contains objectives, types of services to be furnished, and frequency of services.

All three (3) forms must be submitted to the HCBS section of the Bureau of Long Term Care. DOM HCBS staff will review/process the documents. If approved, an enrollment date will be established, appropriate forms will be forwarded to the fiscal agent, and the beneficiary will be locked into the waiver program. The original DOM 260 HCBS Physician Certification and the DOM 301 HCBS Plan of Care will be returned to the case management provider to retain as part of the case record.

**A beneficiary may be locked into only one program at a time. Any request to add or decrease services listed on the approved plan of care requires prior approval.**

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Revised: Current:	Date: 10/01/06 Date:
Section: HCBS/Independent Living Waiver	Section: 66.05 Pages: 2	Cross Reference:
Subject: Prior Approval/Physician Certification		

Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver Program. To obtain initial approval, the following forms must be submitted to the HCBS division of the Bureau of Long Term Care:

- DOM 260 HCBS Physician Certification
- HCBS 305 Assessment
- DOM 301 HCBS Plan of Care
- HCBS 105 Home and Community-Based Services Recipients Admitted and Discharged Form

### **DOM 260 HCBS Physician Certification**

The DOM 260 HCBS Physician Certification form is completed by a physician, certifying that the client meets the medical criteria for nursing facility care. The physician's signature must be dated within thirty (30) days of the submission of the form. The beneficiary must be recertified by the physician on an annual basis. Certification is valid 364 days from the date of the physician's signature.

### **HCBS 305 Assessment**

The HCBS 305 Assessment form is the tool used to determine eligibility for case management and services needed to maintain the beneficiary in the home.

### **DOM 301 HCBS Plan of Care**

The DOM 301 HCBS Plan of Care form, in conjunction with the HCBS 305 Assessment, contains objectives, types of services to be furnished, and frequency of services.

### **HCBS 105 Home and Community-Based Services Recipients Admitted and Discharged Form**

The HCBS 105 form is used to admit and discharge a beneficiary into and from the Home and Community-Based Services waiver program. It must be completed at the time of the initial certification into the program, at each recertification, and anytime there is a change in the beneficiary's status.

At the time of initial certification, the HCBS 305 Assessment form, the DOM 301 Plan of Care form, and the HCBS 105 Home and Community-Based Services Recipients Admitted and Discharged form must be completed jointly by the TBI/SCI counselor AND registered nurse. Forms completed as part of recertification may be completed by the counselor OR the registered nurse.

DOM HCBS staff will review/process all four (4) documents. If approved, an enrollment date will be established, appropriate forms will be forwarded to the fiscal agent, and the beneficiary will be locked into the waiver program. DOM HCBS staff will indicate program approval/denial, retain a copy of all forms and forward originals to the IL counselor/registered nurse to retain as part of the case record.

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A beneficiary may be enrolled in only one DOM HCBS waiver program at a time. Any request to add services listed on the approved plan of care requires prior approval.

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Revised: Current:	Date: 06/01/06 Date:
Section: HCBS/Assisted Living Waiver	Section: 68.05 Pages: 1	
Subject: Prior Approval/Physician Certification	Cross Reference:	

Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver Program. To obtain initial approval, the following forms must be submitted:

- DOM 260 HCBS Physician Certification
- HCBS 305 Assessment
- DOM 301 HCBS Plan of Care

#### **DOM 260 HCBS Physician Certification**

The DOM 260 HCBS Physician Certification form is completed by a physician, certifying that the beneficiary meets the medical criteria for nursing facility care.

#### **HCBS 305 Assessment**

The HCBS 305 Assessment form is completed by the case manager. The tool is used to determine eligibility for Case Management and Assisted Living services.

#### **DOM 301 HCBS Plan of Care**

The DOM 301 HCBS Plan of Care form is completed by the case manager. This form, in conjunction with the HCBS 305 Assessment, contains objectives, types of services to be furnished, and frequency of services.

DOM HCBS staff will review/process all three (3) documents. If approved, an enrollment date will be established, appropriate forms will be forwarded to the fiscal agent, and the beneficiary will be locked into the waiver program. The original of all three (3) forms will be retained by the HCBS case manager as part of the original case record.

**A beneficiary may be locked into only one waiver program at a time.**

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Revised: Current:	Date: 10/01/06 Date:
Section: HCBS/Traumatic Brain Injury/Spinal Cord Injury Waiver	Section: 69.05 Pages: 2	
Subject: Prior Approval, Physician Certification	Cross Reference:	

Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver Program. To obtain initial approval, the following forms must be submitted to the HCBS Division of the Bureau of Long Term Care:

- DOM 260 HCBS Physician Certification
- Traumatic Brain Injury/Spinal Cord Injury Verification Form
- HCBS 305 Assessment
- DOM 301 HCBS Plan of Care
- HCBS 105 Home and Community-Based Services Recipients Admitted and Discharged Form

#### **DOM 260 HCBS Physician Certification**

The DOM 260 HCBS Physician Certification form is completed by a physician, certifying that the client meets the medical criteria for nursing facility care. The physician's signature must be dated within thirty (30) days of the submission of the form. The beneficiary must be recertified by the physician on an annual basis. Certification is valid 364 days from the date of the physician's signature.

#### **Traumatic Brain Injury/Spinal Cord Injury Verification Form**

The Traumatic Brain/Spinal Cord Injury Verification Form must be completed by the primary physician. **Brain or spinal cord injury that is due to a degenerative or congenital condition, or that results (intentionally or unintentionally) from medical intervention, is excluded.**

#### **HCBS 305 Assessment**

The HCBS 305 Assessment form is the tool used to determine eligibility for case management and services needed to maintain the beneficiary in the home.

#### **DOM 301 HCBS Plan of Care**

The DOM 301 HCBS Plan of Care form, in conjunction with the HCBS 305 Assessment, contains objectives, types of services to be furnished, and frequency of services.

#### **HCBS 105 Home and Community-Based Services Recipients Admitted and Discharged Form**

The HCBS 105 form is used to admit and discharge beneficiary into and from the Home and Community-Based Services waiver program. It must be completed at the time of the initial certification into the program, at each recertification, and any time there is a change in the beneficiary's status.

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At the time of initial certification, the HCBS 305 Assessment form, the DOM 301 Plan of Care form, and the HCBS 105 Home and Community-Based Services Recipients Admitted and Discharged form must be completed jointly by the TBI/SCI counselor AND registered nurse. Forms completed as part of recertification may be completed by the counselor OR the registered nurse.

DOM HCBS staff will review/process all five (5) documents. If approved, an enrollment date will be established, appropriate forms will be forwarded to the fiscal agent, and the beneficiary will be locked into the waiver program. DOM HCBS staff will indicate program approval/denial, retain a copy of all forms, and forward originals to the TBI/SCI counselor/registered nurse to retain as part of the case record.

A beneficiary may be enrolled in only one DOM HCBS waiver program at a time. Any request to add or increase services listed on the approved plan of care requires prior approval.

## **Mississippi Department of Medicaid Long Term Care Pre-Admission Screening Process**

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### **Introduction**

The Mississippi Division of Medicaid (DOM) is the state agency responsible for determining eligibility for Medicaid long term care services. DOM administers a Single Point of Entry system for elderly and physically disabled individuals applying or being recertified for eligibility and placement into the following long term care service settings/programs:

- ✓ Nursing Facility
- ✓ Assisted Living Waiver
- ✓ Elderly and Disabled Waiver
- ✓ Independent Living Waiver
- ✓ Traumatic Brain Injury/Spinal Cord Injury Waiver

The Single Point of Entry concept is supported through use of a common Pre-Admission Screening Instrument (PAS) designed to fill two primary functions: 1) determine eligibility for Medicaid long term care across both institutional and Home- and Community-Based service settings; and 2) facilitate informed choices by persons applying for services. The Pre-Admission Screen is intended for use by: hospital discharge planners; nursing facility staff; Planning and Development District (PDD) staff; employees from Medicaid and the Department of Rehabilitative Services; and other providers assisting DOM beneficiaries seeking placement in the long term care program.

The common, or universal, PAS instrument also supports the state's "No Wrong Door" policy for persons seeking services. Regardless of where an individual applies for services, s/he will be advised of all available placement options as part of ensuring that an informed choice is made.

The PAS is designed to be completed and submitted electronically. However, the instrument also initially will be available for submission in hard copy format. When the electronic PAS is used, the person's informed choice will be documented on a separate PAS-Informed Choice signature form.

### **Individuals for whom a PAS must be Completed**

The new Pre-Admission Screening process will take effect on July 1, 2007. All persons applying for Medicaid long term care on July 1, 2007 and beyond will require a completed PAS for eligibility determination. The PAS must be submitted within thirty days of completion. Individuals already enrolled in Medicaid long term care on that date will not require a new screening.

Individuals enrolled in Medicaid long term care must be recertified annually, with the exception of nursing facility residents, until otherwise specified by DOM. The PAS must be submitted at least ten days (but no more than ninety days) prior to the one-year anniversary date of the most recent eligibility determination date. Failure to submit timely may result in a lapse in eligibility.

### **Situations that do not require a PAS**

The PAS does not have to be completed on persons being admitted to a Nursing Facility when Medicaid coverage is not being sought. This includes short stay admissions covered under Medicare Part A. A PAS will be required only if and when the resident applies for Medicaid coverage.

Nursing Facilities must still comply with federal Pre-Admission Screening and Resident Review (PASRR) requirements, regardless of resident payer source.

### **PAS Screeners – Qualifications & Responsibilities**

The PAS must be completed by a qualified individual or individuals, instructed on the use of the instrument by a DOM trainer or individual certified by DOM to provide such training. Detailed instructions for completing the PAS are provided in the [DOM PAS User's Manual](#)

Qualified individuals, by setting, include:

- Nursing Facilities – Physician, Nurse Practitioner or Registered Nurse/Licensed Social Worker team
- E&D Waiver – Registered Nurse/Social Worker team
- Assisted Living Waiver – Licensed Social Worker
- Independent Living Waiver – Registered Nurse/Counselor team
- TBI/SCI Waiver – Registered Nurse/Counselor team

In completing the PAS, including the PASRR Level I screen, screeners will:

1. Conduct face-to-face interview with the person being screened (applicant/recipient) to the extent feasible, given the person's physical and cognitive status
2. Obtain information from caregiver(s) and/or designated representative, to the extent practicable
3. Review medical records and other relevant medical documentation to verify major medical conditions and services, to the extent practicable

4. Provide information to the applicant/recipient and his/her responsible party/designated representative about available placement options, to facilitate informed decision making
5. Provide information about alternative services/resources for persons who may not be eligible for Medicaid long term care
6. Provide information about the secondary review process and appeal rights for persons who may not be eligible for Medicaid long term care

## PAS Instrument Components

The PAS consists of ten domains, or sections, most of which have two or more subsections. The table below lists the sections/subsections and identifies the populations for whom each subsection applies.

Section/Subsection	Applies to:
<b>I Intake</b>	All persons
<b>II Functional Screen</b>	
IIA ADL's & IADL's	All persons
IIB Communication/Sensory	All persons
<b>III Cognitive Screen</b>	All persons (caregiver response component applies only if caregiver is present)
<b>IV Mood/Psychosocial &amp; Behaviors</b>	
IVA Mood/Psychosocial	All persons
IVB Behaviors	All persons
<b>V Medical Screen</b>	
VA Medical Conditions	All persons
VB Health-Related Services	All persons
VC Medications	All persons
VD Medical Stability	All persons
VE Medical Summary	All persons
<b>VI Social Supports</b>	
VI.1 Primary Caregiver	All persons with a primary caregiver
VI.2 Formal Agency Supports	All persons
<b>VII Home Environment</b>	All persons except Nursing Home and other institutional residents not seeking community placement
<b>VIII Informed Choice</b>	
VIII.1 Person Strengths	All persons except Nursing Home and other institutional residents not seeking community placement
VIII.2 Program Options & Desired Assistance	All persons
VIII.3 Person Choice	All persons
<b>IX Level II Determination (PASRR)</b>	All persons presented with Nursing Facility placement as an option in Section VIII
<b>X PAS Summary &amp; Physician Certification</b>	All persons

## **Completion and Submission of the PAS**

The PAS can be submitted in hard copy format or electronically. DOM reserves the right to require 100 percent electronic submissions in the future.

### Hard Copy Submission

Screeners will conduct a face-to-face interview with the applicant/recipient, and with caregiver(s) and/or the applicant/recipient's designated representative, as applicable. The screener(s) will complete PAS sections I through IX and will obtain all necessary signatures/initials from the applicant/recipient or his/her designated representative.

Following completion of the PAS, the screener(s) will transfer the information recorded in Sections I through IX to Section X (PAS Summary & Physician Certification) and will forward Section X to the applicant's/recipient's physician for the necessary certification. Once the physician's certification has been received, Section X of the PAS must be faxed or mailed to the appropriate parties:

- Hospitals discharging to a Nursing Facility must fax/mail to DOM/LTC and the Nursing Facility
- Nursing Facilities screening a prospective or current resident must fax/mail to DOM/LTC
- Entities screening an applicant/recipient for placement into the E&D waiver program must fax/mail to DOM/LTC and the local Planning and Development District (if the PDD is not conducting the screening)
- Entities screening an applicant/recipient for placement into the IL or TBI/SCI waiver programs must fax/mail to DOM/LTC and the Department of Rehabilitative Services (if DRS is not conducting the screening).
- The Assisted Living waiver is directly administered by DOM/LTC, which will be responsible for the PAS

The complete hard copy PAS must be retained by the screening organization in accordance with Medicaid record retention policies. The complete PAS must be available for DOM inspection upon request. It also may be submitted to DOM as part of a re-consideration following a denial determination.

A flow diagram of the hard copy PAS submission process is included as Attachment 1.

### Electronic Submission

Screeners will conduct a face-to-face interview with the applicant/recipient, and with caregiver(s) and/or the applicant/recipient's designated representative, as applicable. The screener(s) will complete PAS sections I through IX and will obtain all necessary signatures/initials from the applicant/recipient or his/her designated representative.

If the PAS is being completed in hard copy format for later electronic entry, signatures/initials can be recorded on the full instrument. If the PAS is being completed electronically, signatures/initials must be obtained using the separate PAS-Informed Choice form.

Following completion of the electronic version of the PAS, screener(s) must obtain a physician's certification in one of two ways. Section X of the PAS can be printed and forwarded to the applicant/recipient's physician for signature. The physician must return the certification to the screening organization before the PAS is submitted. The hard copy signature page must be retained by the screening organization for later review by DOM, if requested, and as required by state and federal laws and regulations.

Alternatively, the physician can provide his/her certification directly on the electronic PAS. This is accomplished by means of an electronic attestation.

Once the physician's certification has been received, either in hard copy or electronically, the PAS will be submitted electronically for adjudication.

- Hospitals discharging to a Nursing Facility must submit to DOM/LTC through the PAS web portal, and email/fax/mail to the Nursing Facility
- Nursing Facilities screening a prospective or current resident must submit to DOM/LTC through the PAS web portal
- Entities screening an applicant/recipient for placement into the E&D waiver program must submit to DOM/LTC through the PAS web portal, and email/fax/mail to the local Planning and Development District (if the PDD is not conducting the screening)
- Entities screening an applicant/recipient for placement into the IL or TBI/SCI waiver programs must submit to DOM/LTC through the PAS web portal, and email/fax/mail to the Department of Rehabilitative Services (if DRS is not conducting the screening).
- The Assisted Living waiver is directly administered by DOM/LTC, which will be responsible for the PAS.

A flow diagram of the electronic PAS submission process is included as Attachment 2.

## **Documentation of Informed Choice**

The applicant/recipient will initial by his/her placement preference either in the Informed Choice section of the complete hard copy PAS instrument, or on the separate PAS – Informed Choice form if the PAS is being completed electronically. The screener also will sign an attestation that s/he has informed the person and/or the person's legal representative of the available DOM-covered long term care options, including alternatives to Nursing Facility placement, based on the results of the PAS and the person's desired services. The initials and signature will be witnessed by a third party and the initial/signature page must be retained by the screening organization for alter review by DOM, if requested.

## **Initial Eligibility Determination**

The completed PAS will be adjudicated through application of an eligibility algorithm that generates a numerical score. The numerical score will be compared to a DOM-defined threshold. If an individual's score is equal to or greater than the threshold, s/he will be determined eligible for Medicaid long term care. The initial eligibility determination process will be completed within thirty days.

## **Secondary Review**

If an individual scores below the threshold, s/he may qualify for a secondary review. Secondary reviews will be performed in the following circumstances:

- ✓ Individual scores below the eligibility numerical threshold, but falls into a DOM-defined "automatic secondary review" range
- ✓ Individual is under the age of 12 on the date of the screening
- ✓ Individual scores below the "automatic secondary review" range and his/her screener requests a secondary review at time of denial, in a manner specified by DOM. Such requests will be granted by DOM at its sole discretion
- ✓ Individual appeals the denial in accordance with Medicaid's appeal procedures

Secondary reviews will be performed by DOM Registered Nurses, Nurse Practitioners, Licensed Social Workers and/or physicians, as deemed by DOM to be appropriate. DOM reviewers may request additional supporting documentation from the screener(s) before making a determination, if judged necessary for making an informed decision. The screener(s) also may submit additional supporting documentation, in a format specified by DOM, for consideration during the secondary review.

Reviews will be completed within thirty days of a PAS triggering an automatic secondary review, or a valid review request being made. In conducting the secondary review, the reviewer may consider all available information from the PAS as well as any additional documentation provided by the screener. The reviewer also may consult with the screener(s) and/or the certifying physician.

Once the secondary review is completed, DOM will notify the applicant/recipient and screening organization of its determination. If the secondary review upholds the finding of ineligibility, the applicant/recipient retains the right of appeal.

### **Notice of Determination**

DOM will notify the applicant/recipient or designated representative and the screening organization of its determination in a manner specified by the Division, in accordance with state and federal noticing requirements. In the event of a denial, the notice will advise the applicant/recipient of his/her screening organization's right to request a secondary review, as well as the applicant/recipient's right of appeal.

### **Eligibility Period**

Eligibility will be granted for a period of one year, with the exception of nursing facility residents, until otherwise specified by DOM. If the individual's condition changes prior to the scheduled recertification date, s/he must be re-screened and the updated PAS sent to DOM for adjudication.

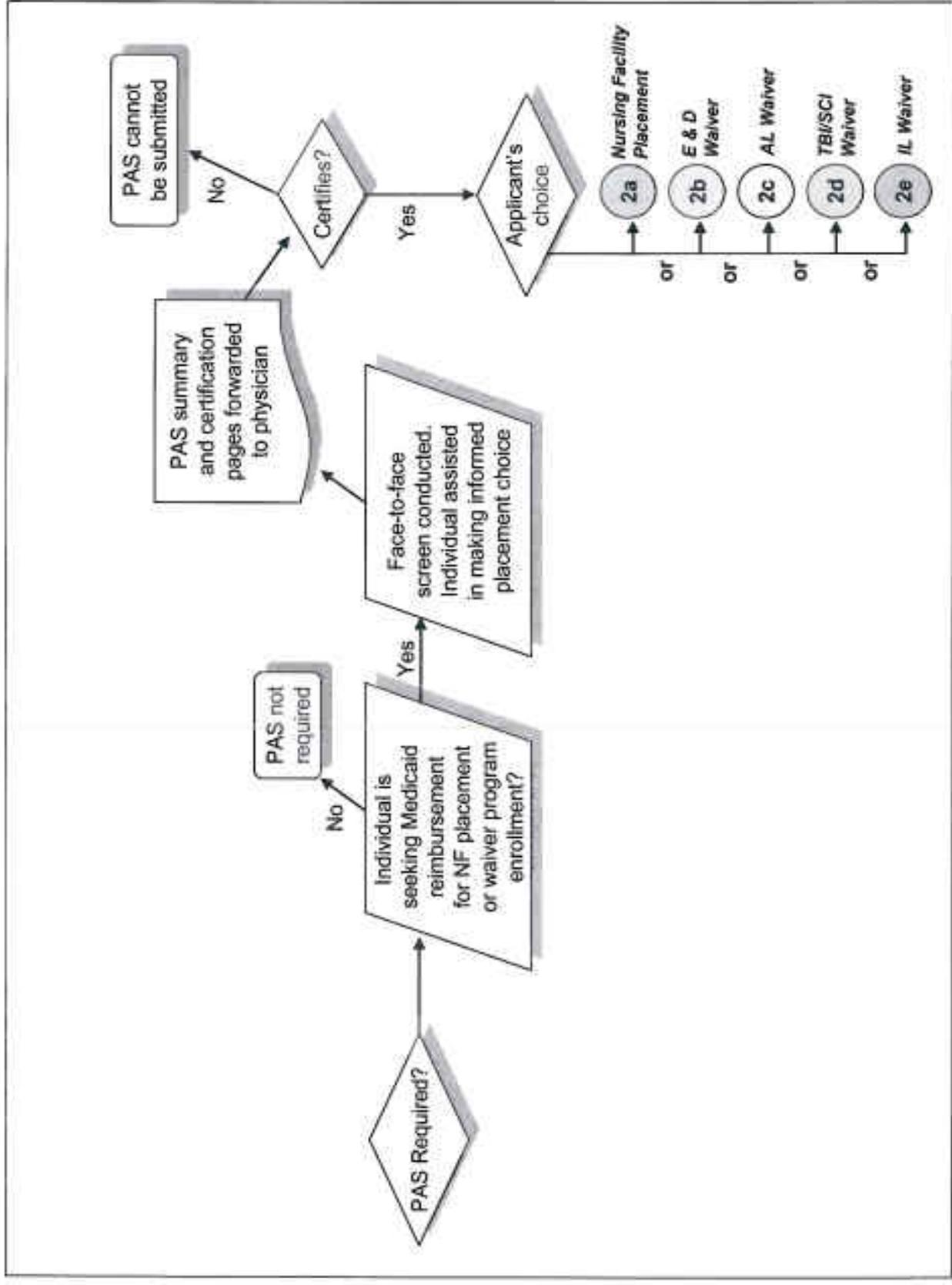
### **Emergency Admissions**

Nursing Facilities will be reimbursed by Medicaid for resident days associated with qualifying emergency admissions, even if the resident's eligibility is subsequently denied. The nursing facility must comply with all PAS and PASRR submission requirements to qualify for payment under this provision.

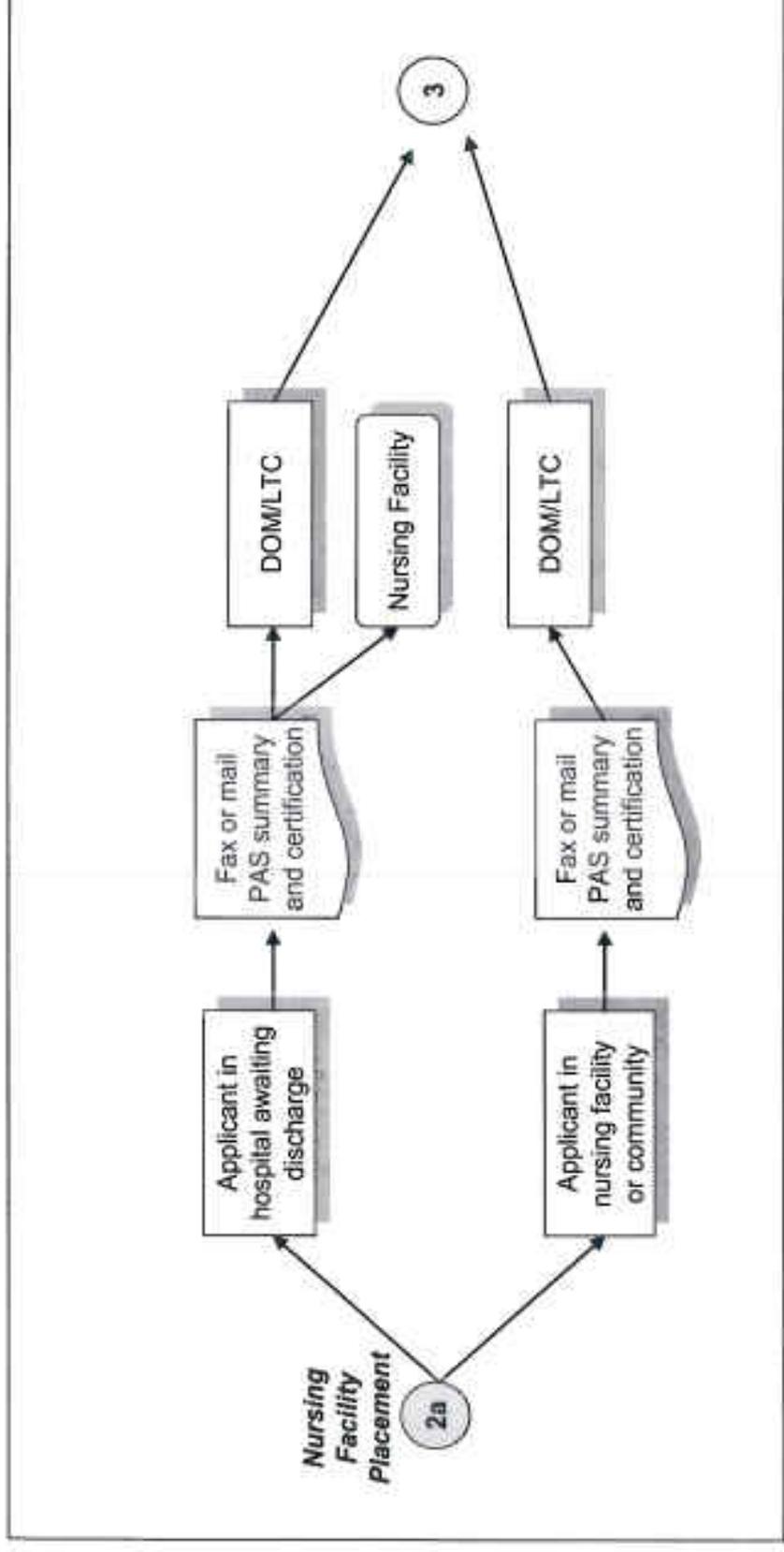
### **Appeals**

Applicants/recipients have the right to appeal eligibility denials. If an individual files an appeal, and the case has not already been subject to the secondary review process, it will be handled in the manner described in the preceding section. If the secondary review has already occurred, the case will be reviewed again by a supervisory level clinician who has not previously reviewed the case. Appeals will be processed in accordance with existing state policies for eligibility appeals.

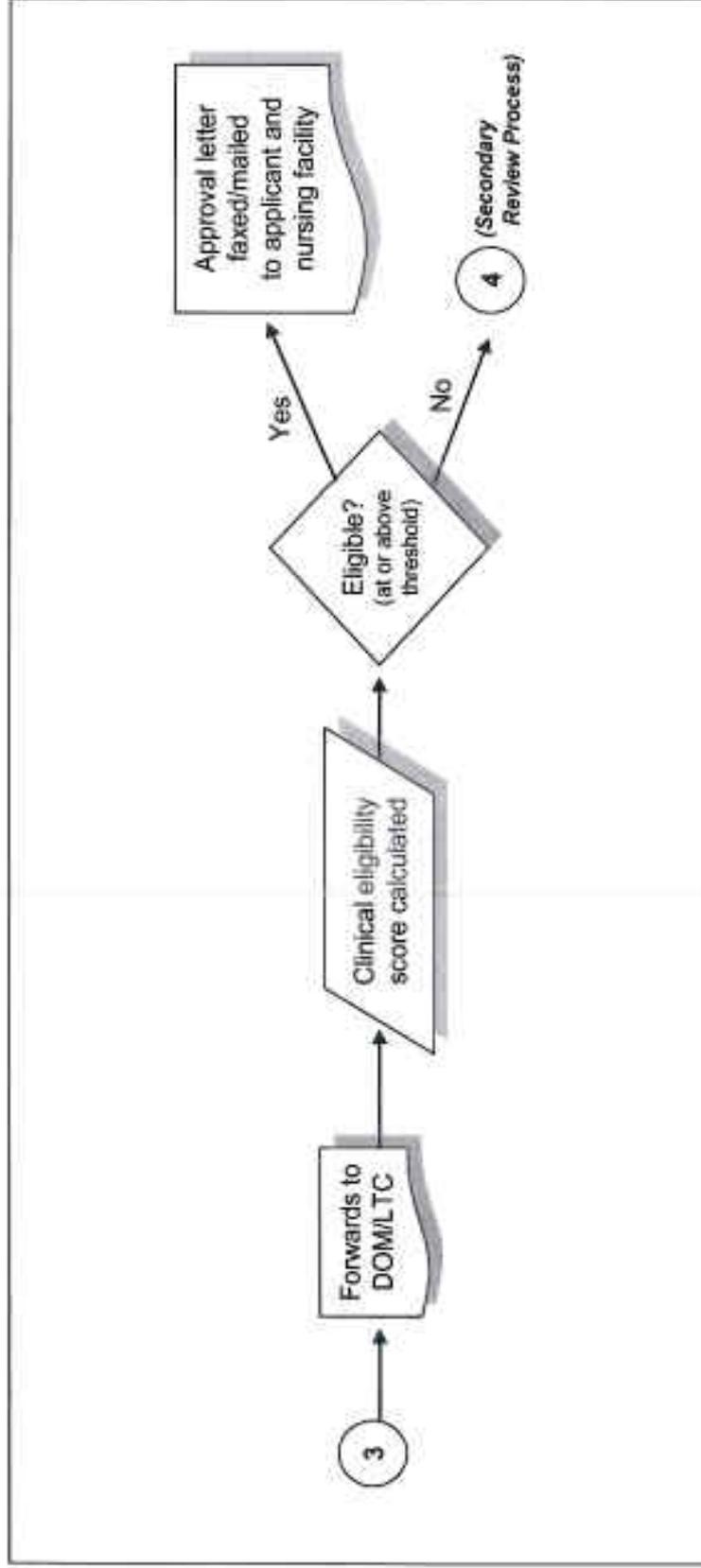
**Attachment 1 - Hard Copy PAS Submission Process**



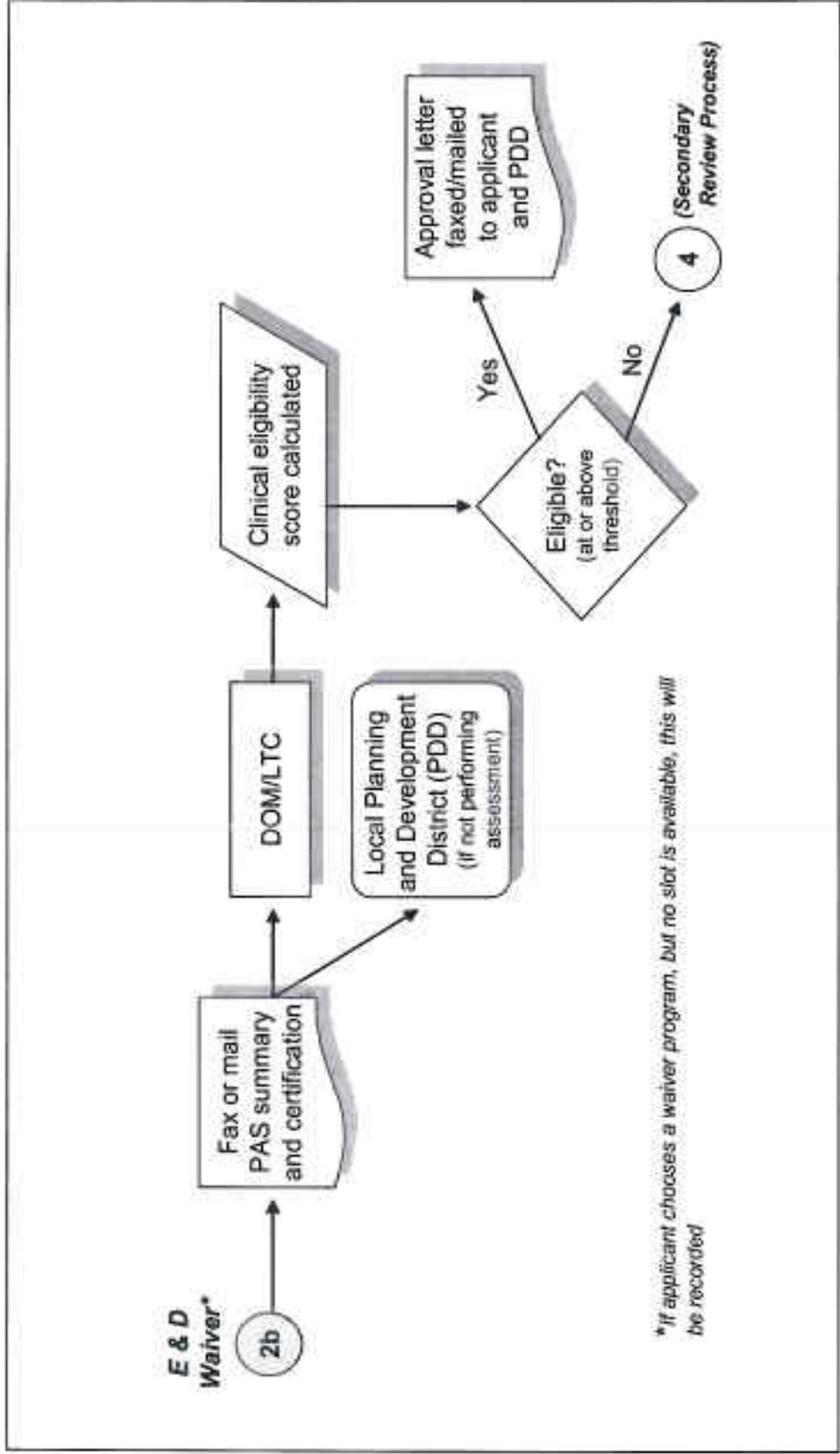
**Attachment 1 - Hard Copy PAS Submission Process**



# Attachment 1 - Hard Copy PAS Submission Process

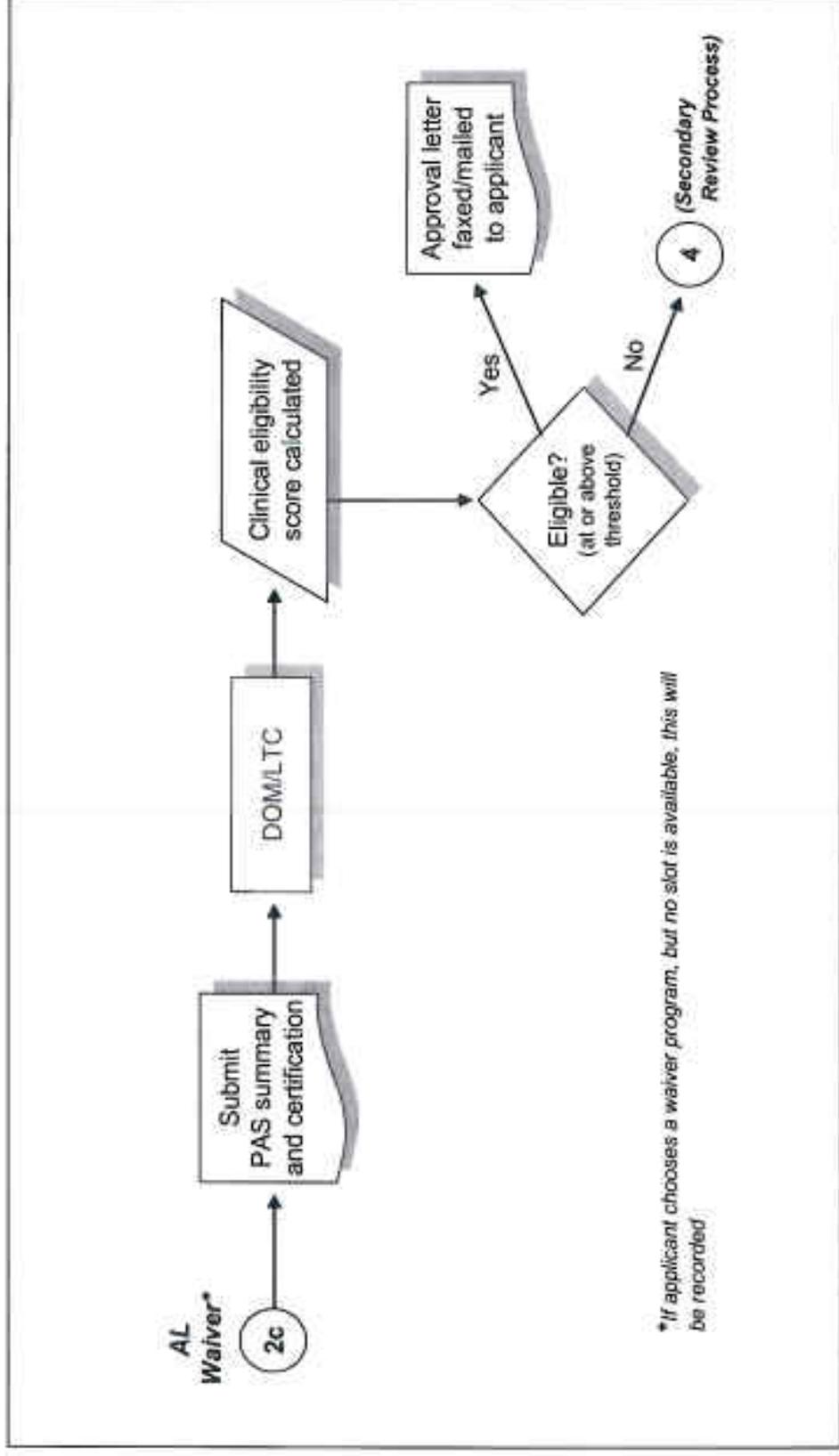


# Attachment 1 - Hard Copy PAS Submission Process

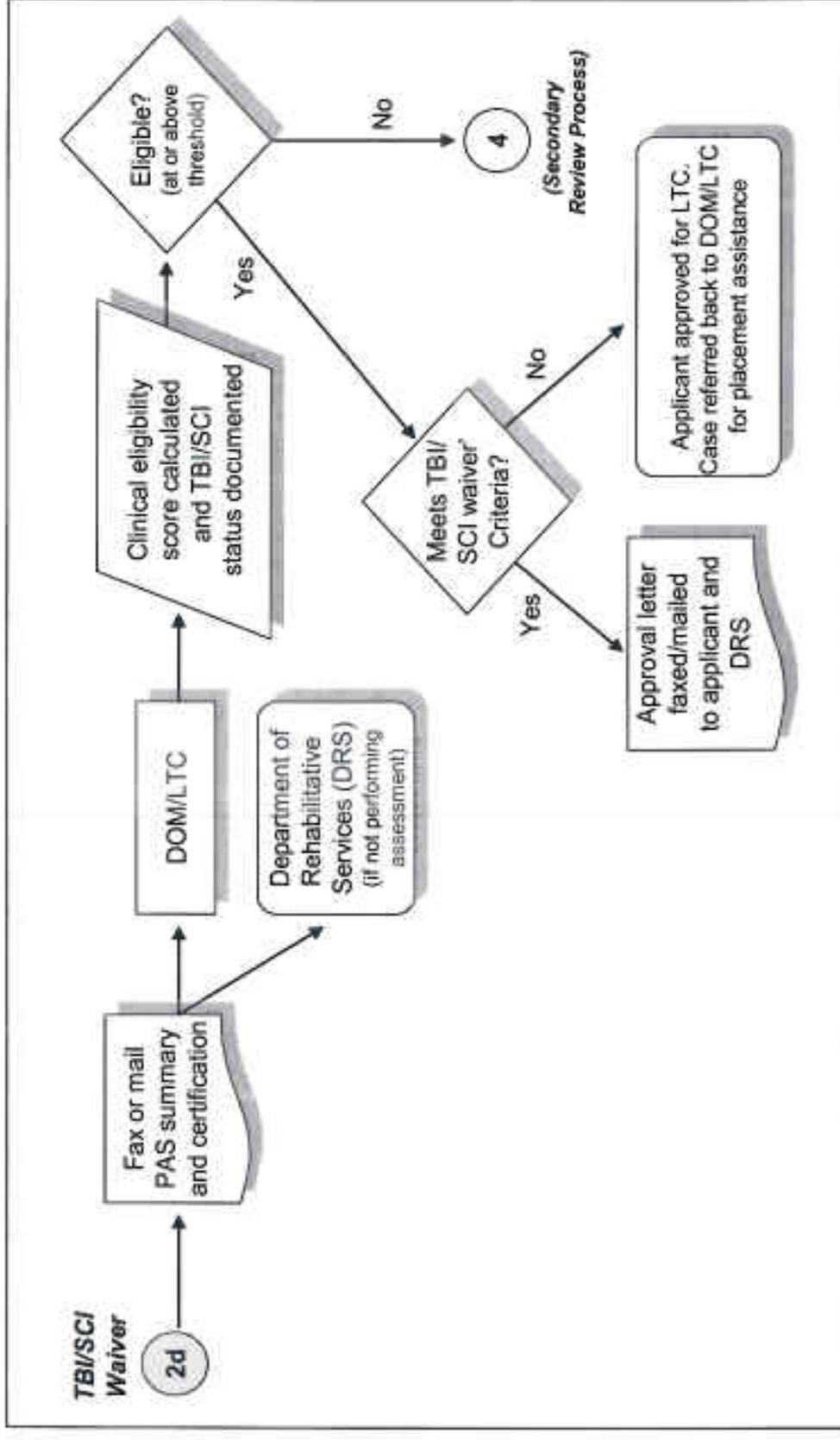


\*If applicant chooses a waiver program, but no slot is available, this will be recorded

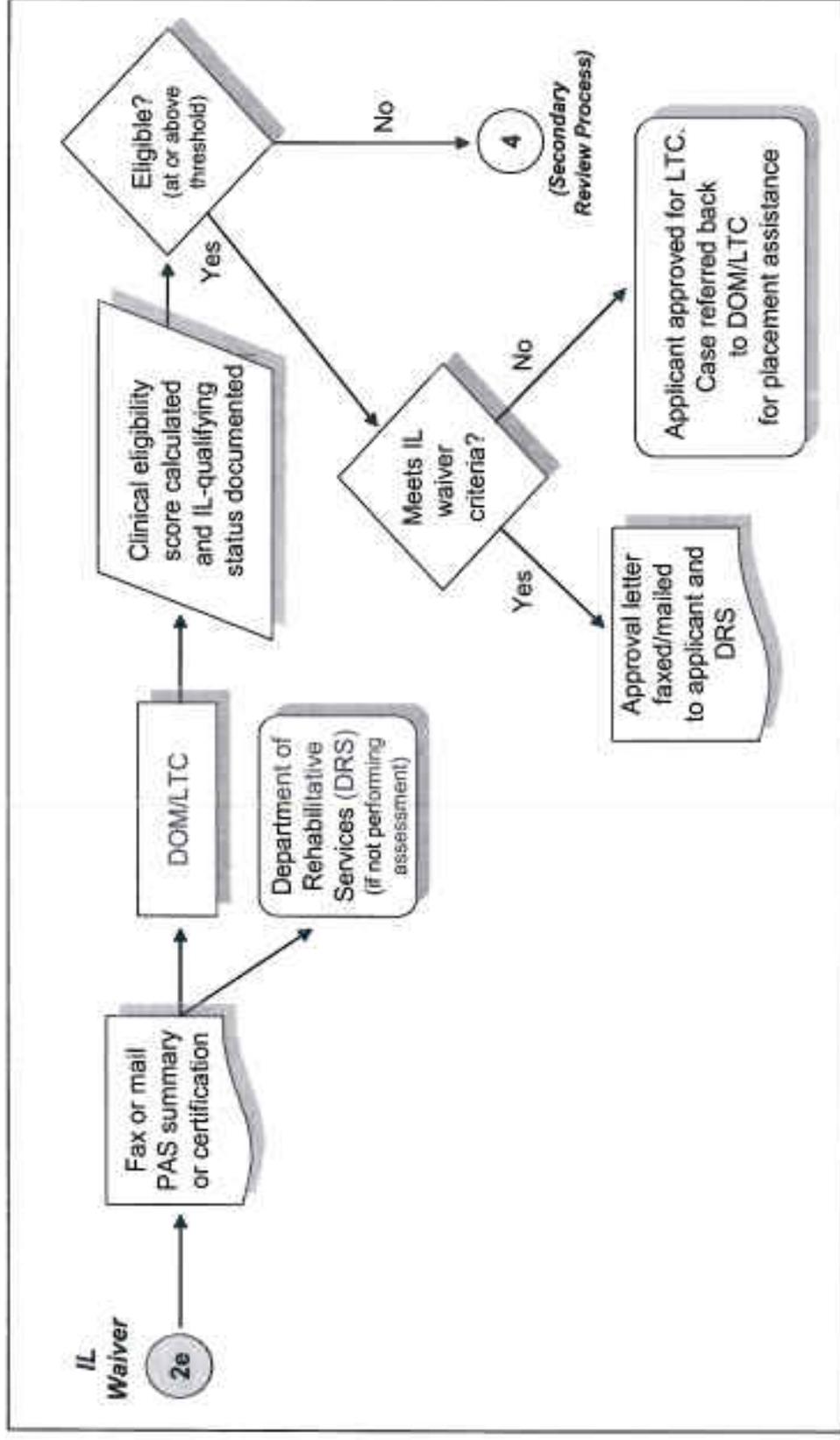
# Attachment 1 - Hard Copy PAS Submission Process



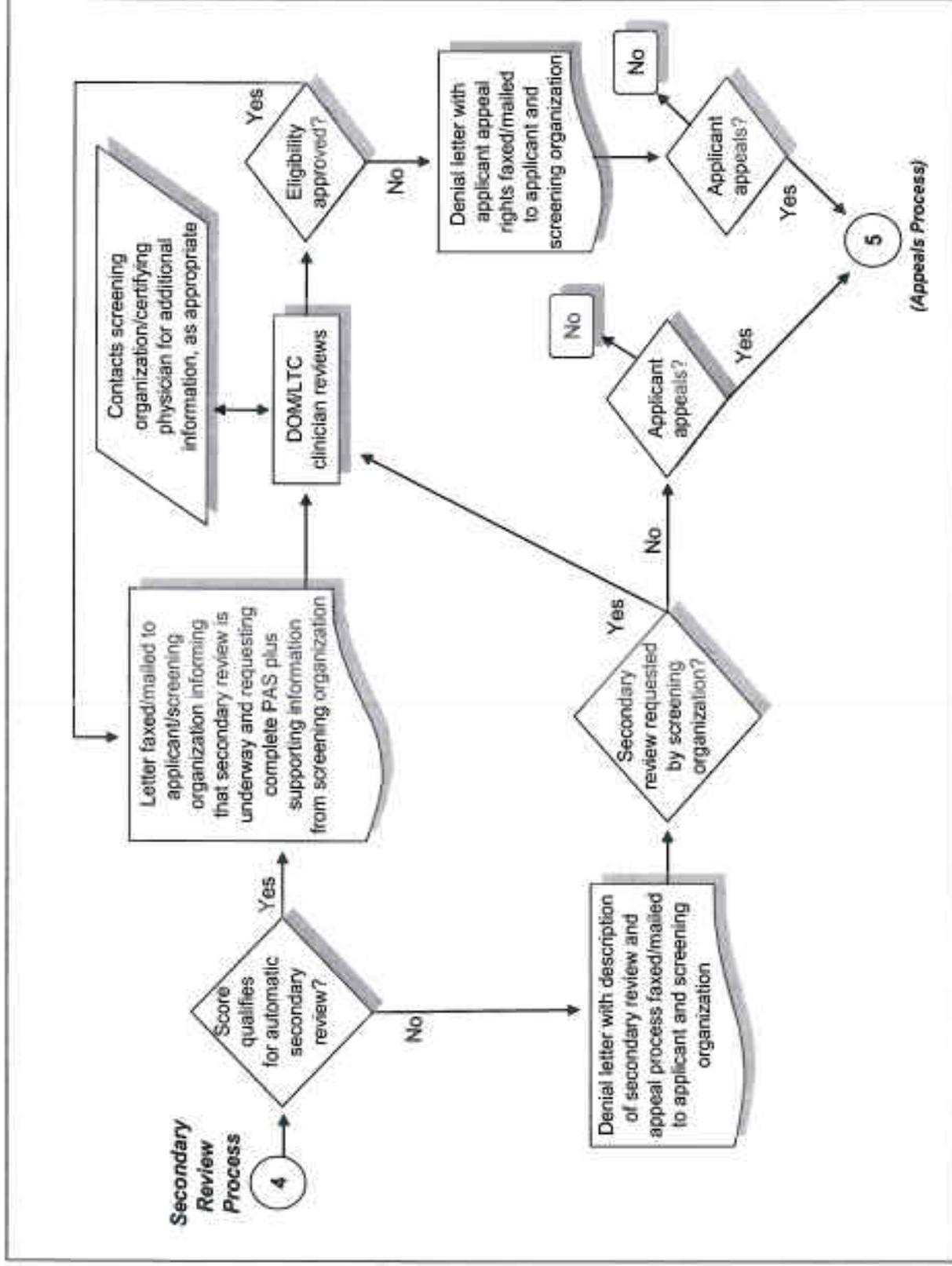
**Attachment 1 - Hard Copy PAS Submission Process**



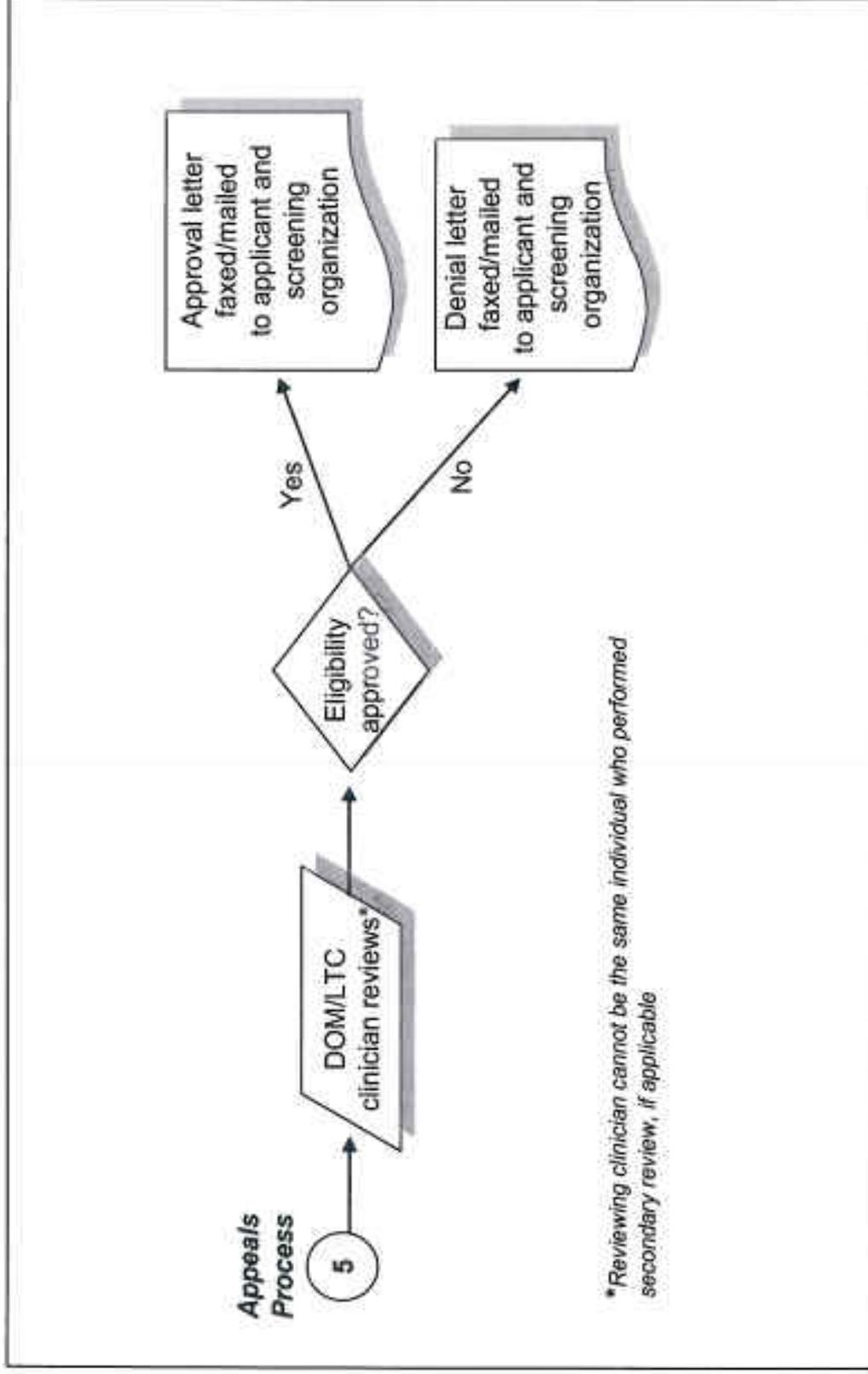
# Attachment 1 - Hard Copy PAS Submission Process



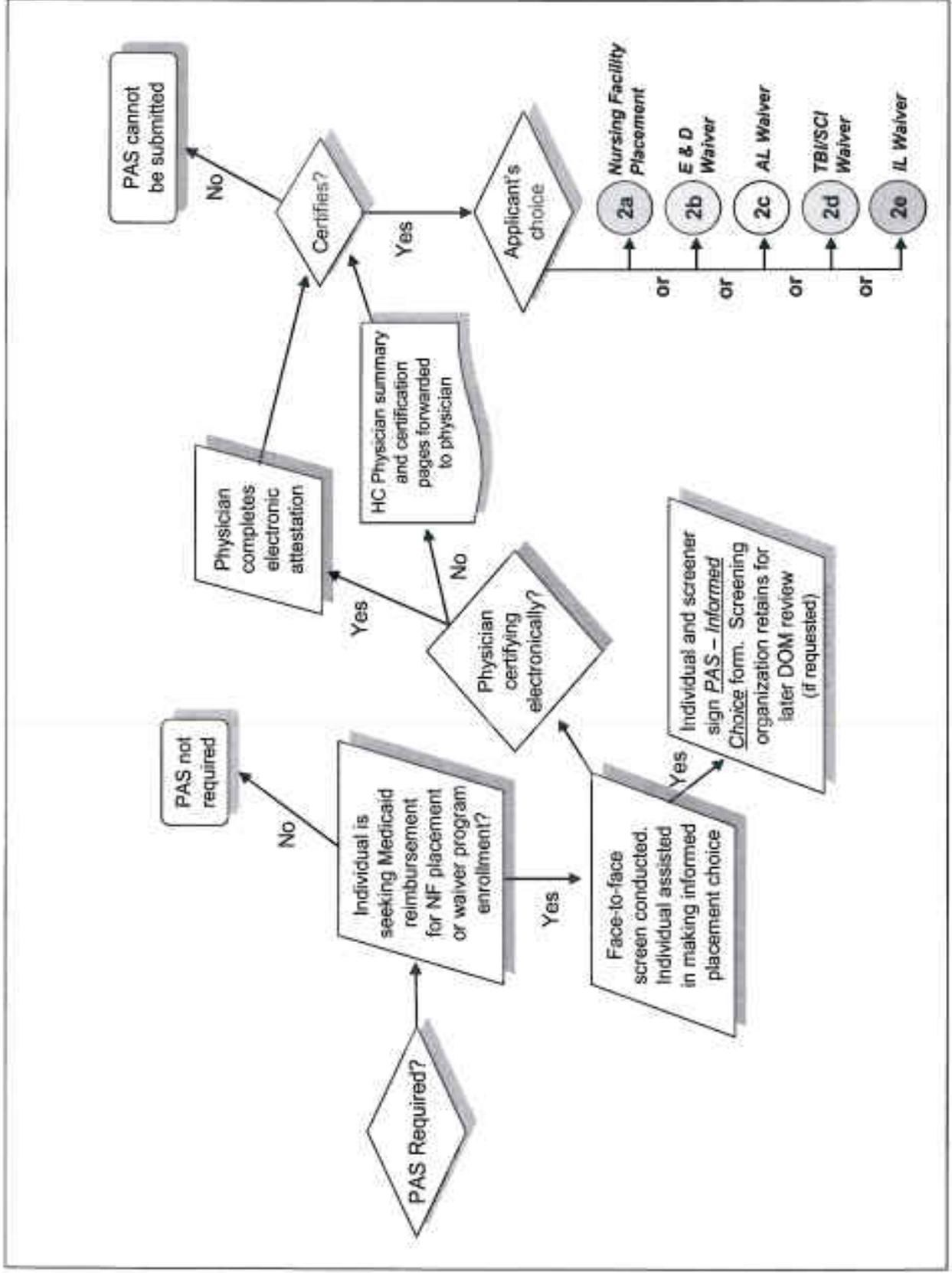
# Attachment 1 - Hard Copy PAS Submission Process



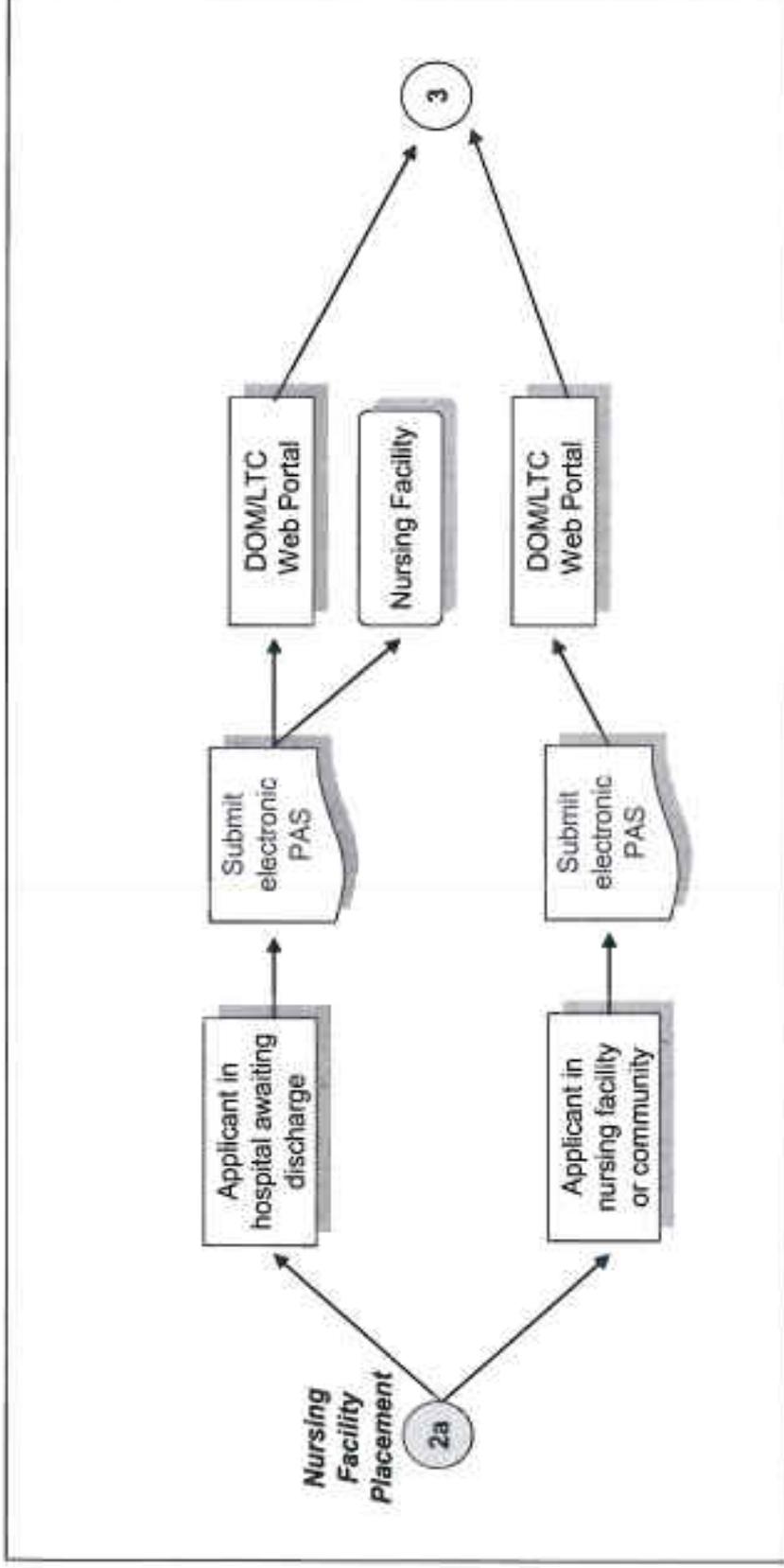
# Attachment 1 - Hard Copy PAS Submission Process



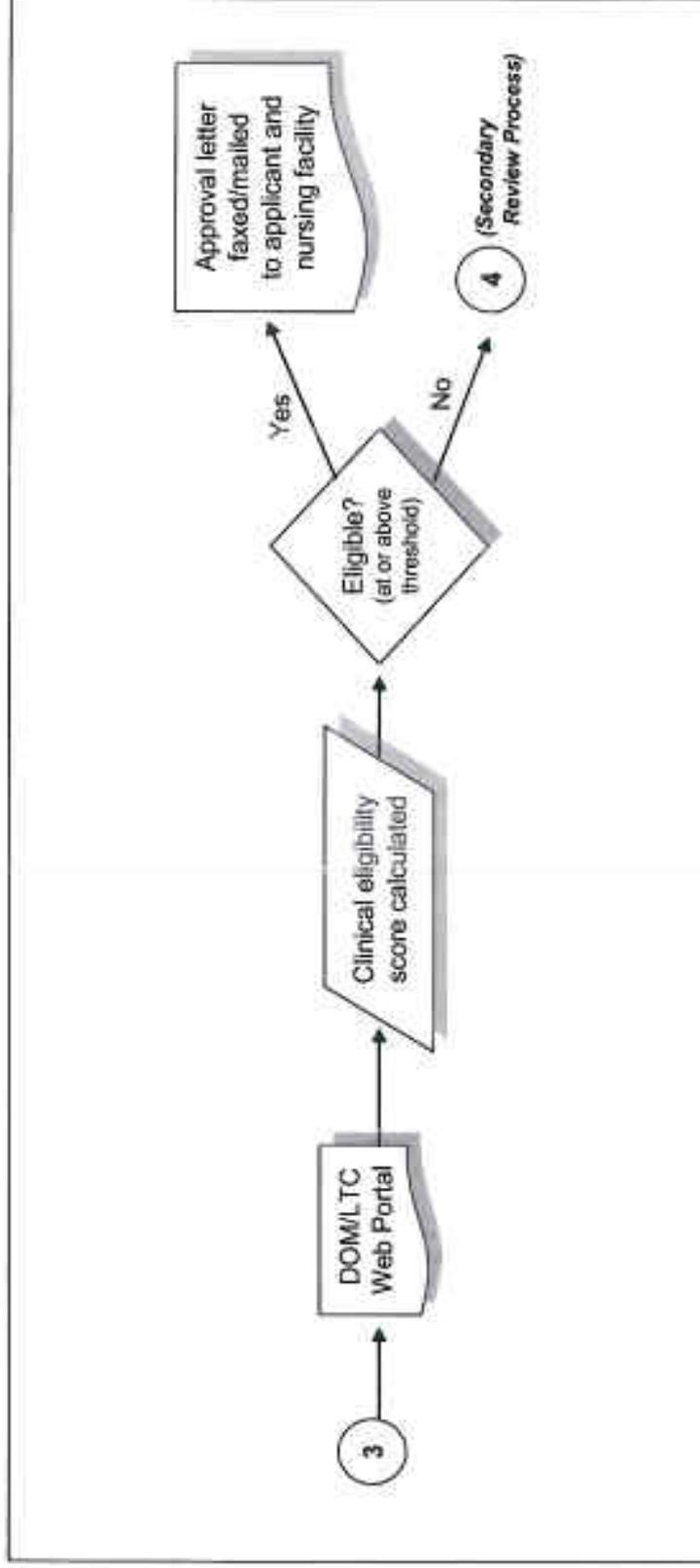
## Attachment 2 - Electronic PAS Submission Process



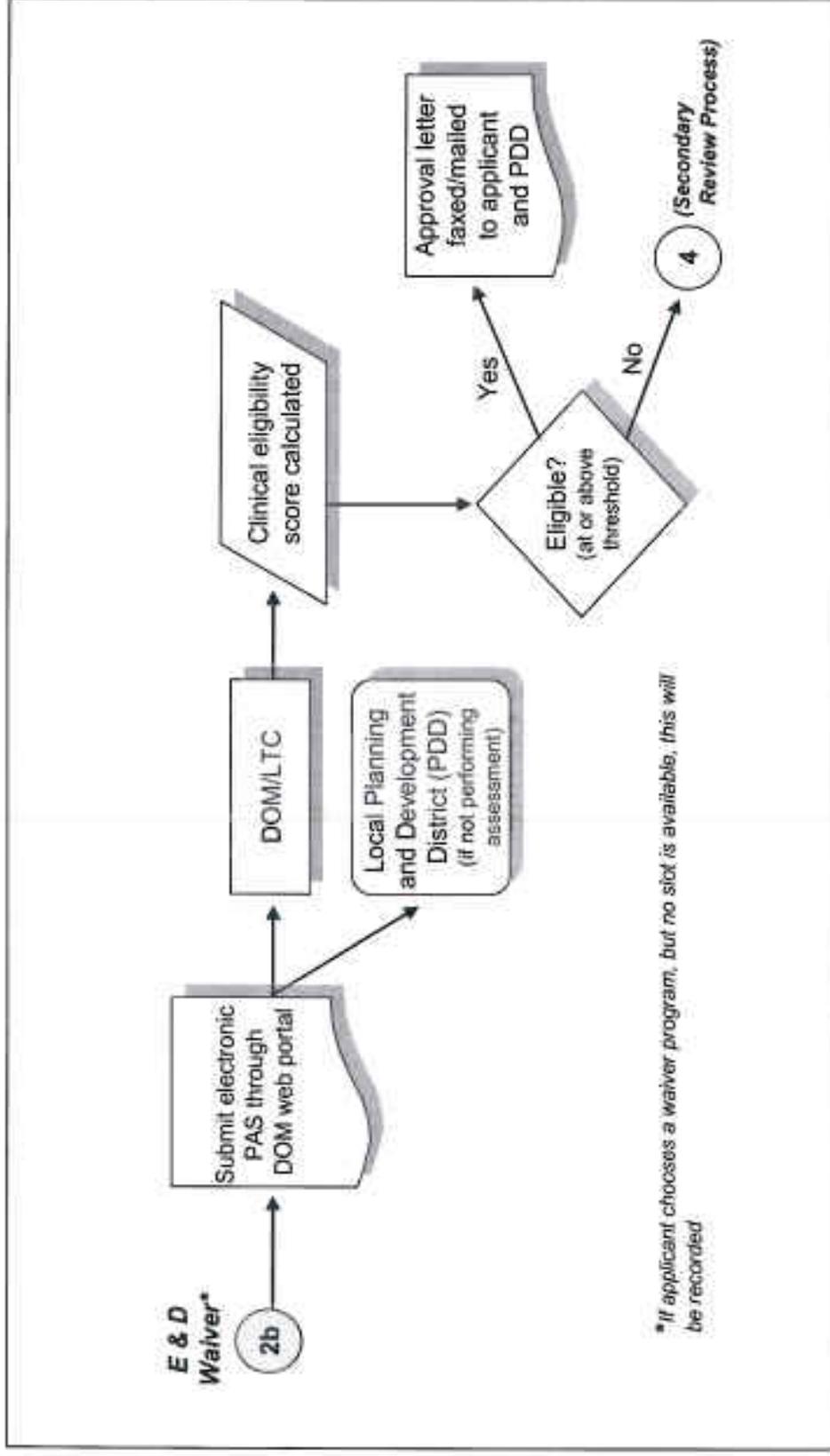
## Attachment 2 - Electronic PAS Submission Process



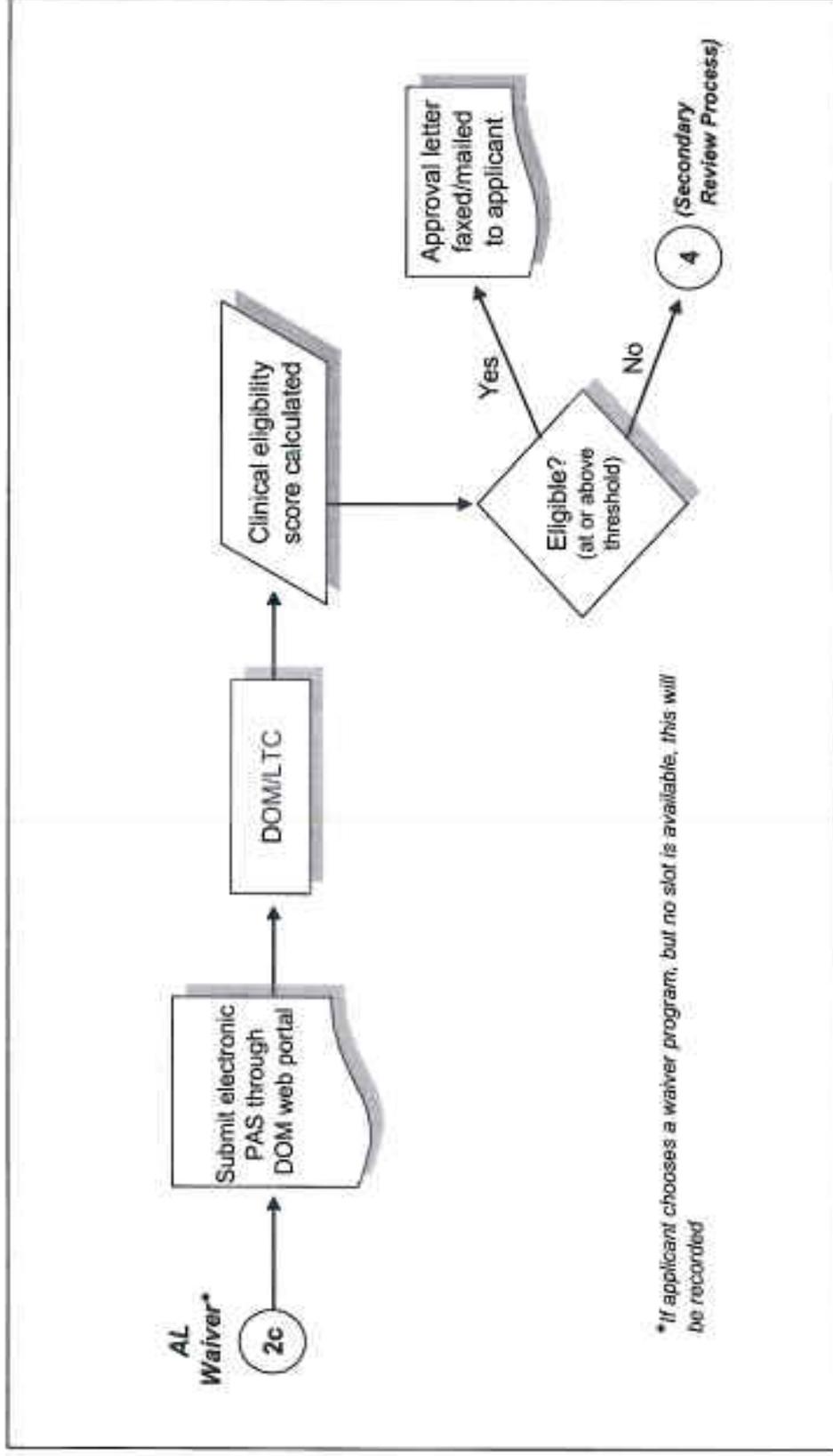
## Attachment 2 - Electronic PAS Submission Process



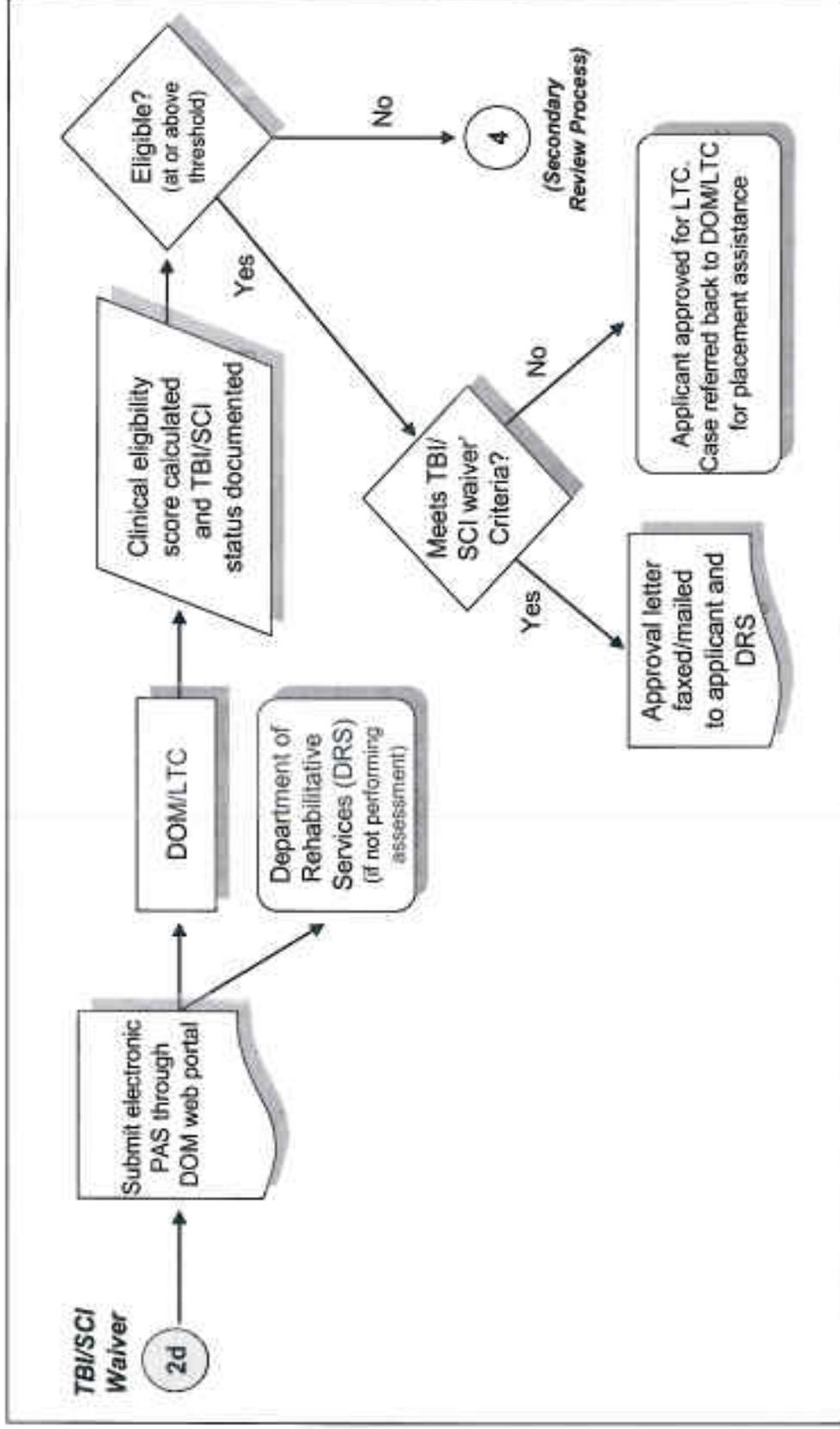
## Attachment 2 - Electronic PAS Submission Process



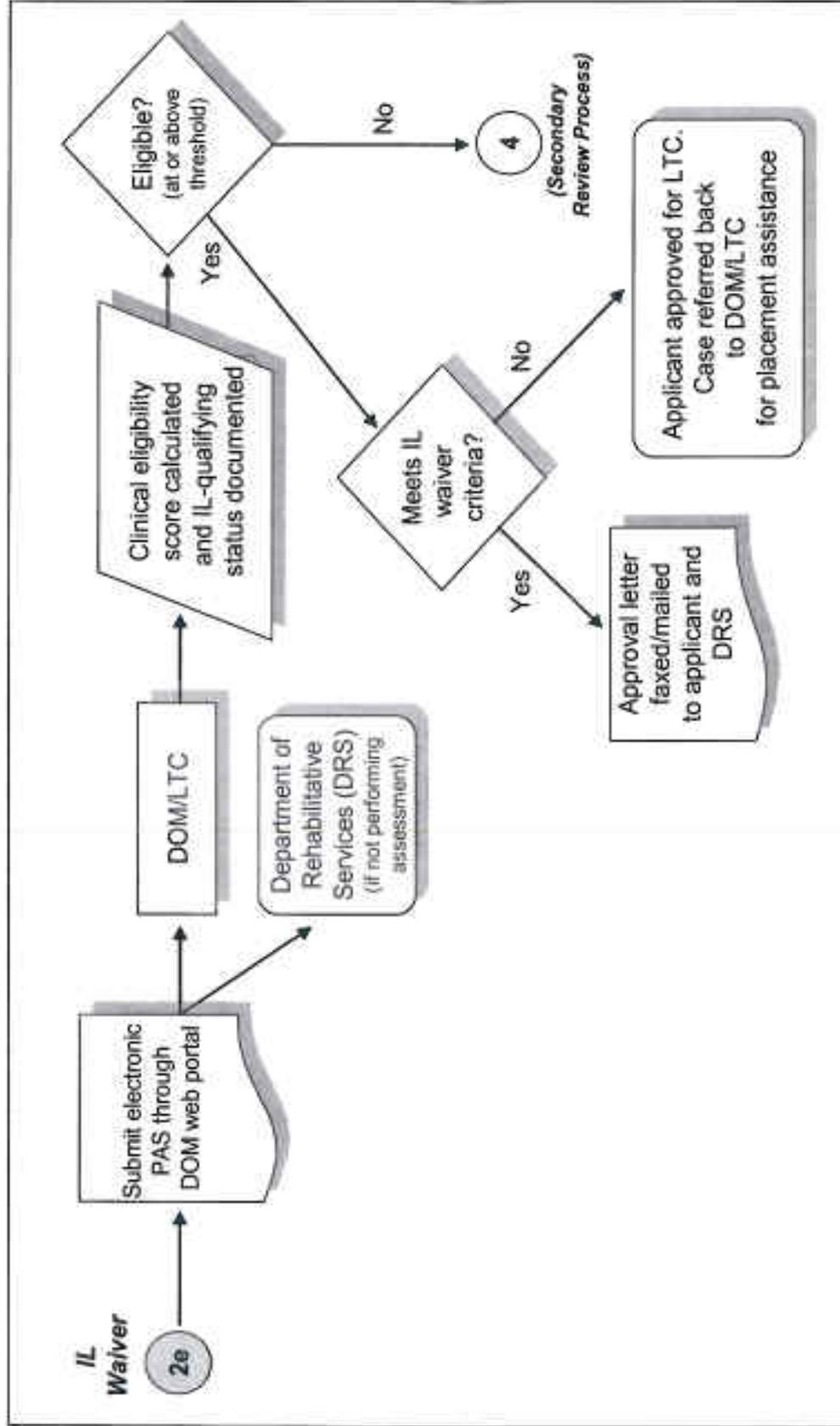
## Attachment 2 - Electronic PAS Submission Process



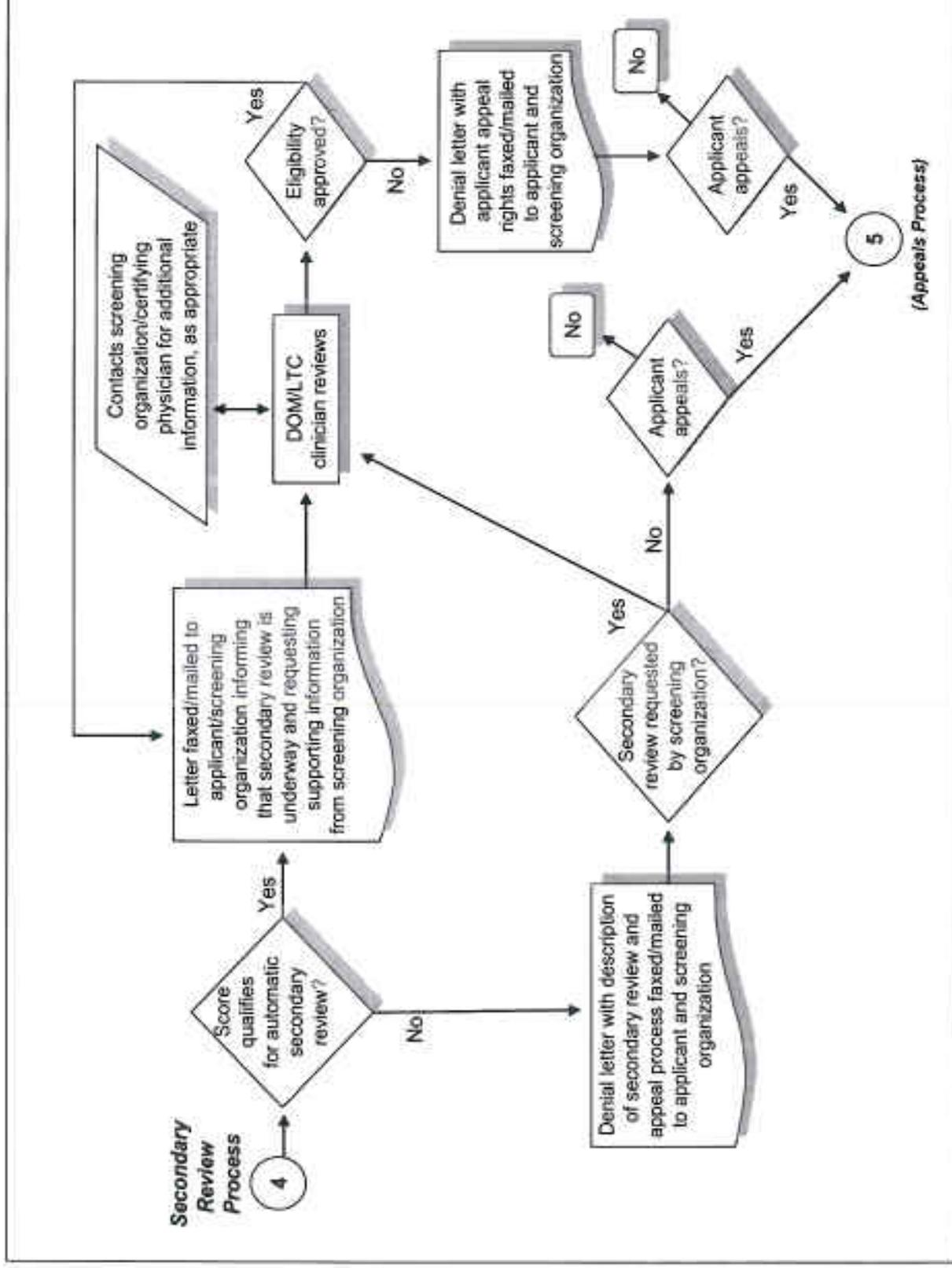
## Attachment 2 - Electronic PAS Submission Process



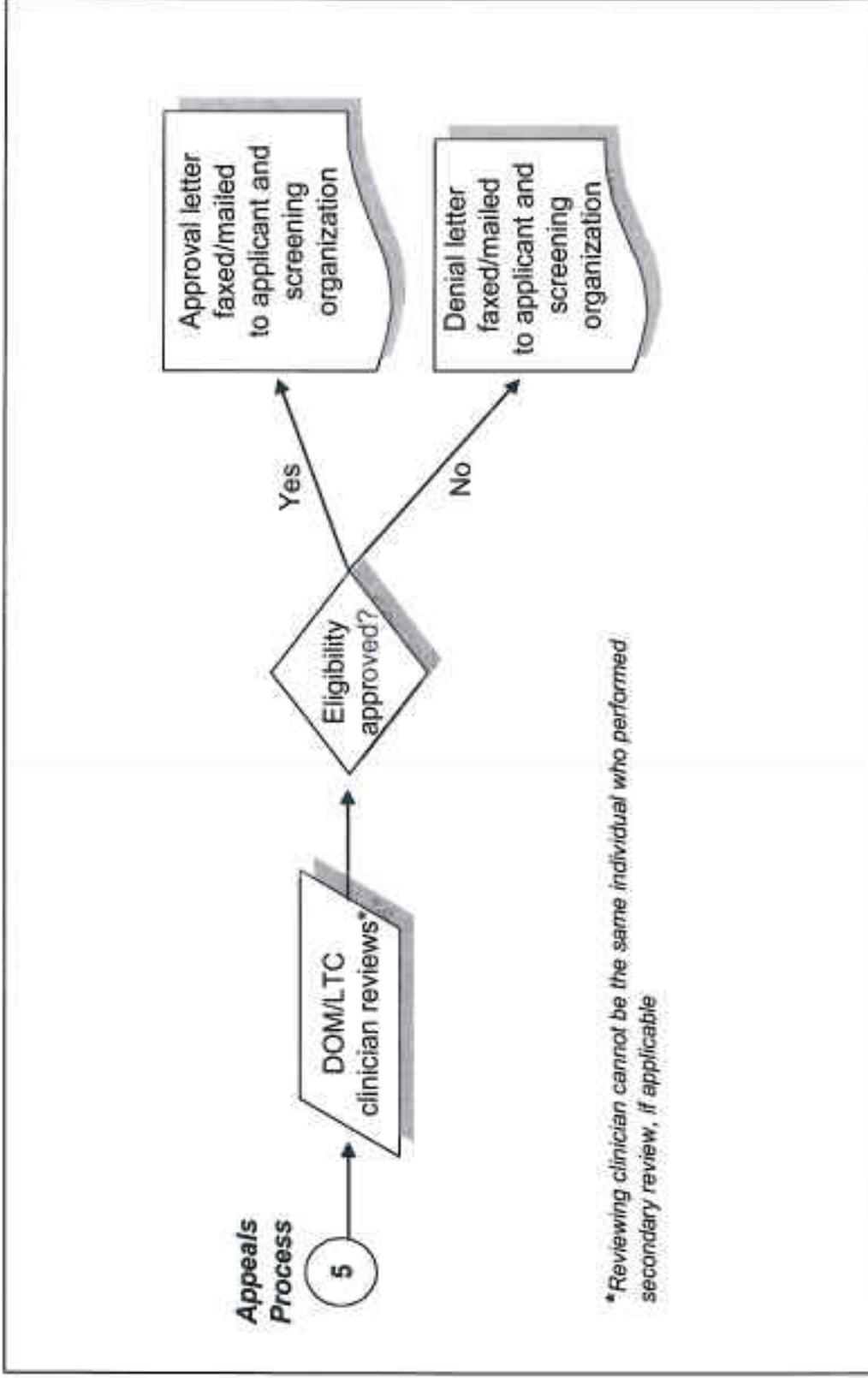
## Attachment 2 - Electronic PAS Submission Process



## Attachment 2 - Electronic PAS Submission Process



## Attachment 2 - Electronic PAS Submission Process



**MISSISSIPPI DIVISION OF MEDICAID  
Application for Long Term Care**

Person Name: \_\_\_\_\_ Date: \_\_\_\_\_

**I. INTAKE**

<b>Screener(s)</b>		
Screener 1 Name (Last, First) & Credential:		Screener 2 Name (Last, First) & Credential:
Screener 3 Name (Last, First) & Credential:		Screener 4 Name (Last, First) & Credential:
Organization:		
Mailing Address:		
City:	State:	Zip Code:
Telephone:	Fax:	Email:
Provider Number (if applicable):		
Location at time of screen (check box): <input type="checkbox"/> Person's Residence <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify): _____		

<b>Person</b>		
Name (Last, First, Middle):		
Street Address:		
City:	County:	State:
Zip Code	Telephone:	
Medicaid Number:	Medicare Number:	
SSN:	DOB (MM/DD/YR)	Gender (check box) <input type="checkbox"/> Male <input type="checkbox"/> Female

<b>Designated Representative</b> <i>If none, enter "none" on Name line</i>		
Name (Last, First, Middle):		
Street Address:		
City:	State:	Zip Code:
Relationship to Person:	Telephone:	
Comments:		

**MISSISSIPPI DIVISION OF MEDICAID  
Application for Long Term Care**

Person Name: \_\_\_\_\_ Date: \_\_\_\_\_

**I. INTAKE - continued**

<b>Other Contacts</b>	
Physician:	Telephone:
Physician Mailing Address:	
Case Manager (if different from screener):	Telephone:
Case Manager Mailing Address (if different from screener):	

<b>Usual Living Arrangement</b>		
<input type="checkbox"/> Lives Alone	<input type="checkbox"/> Nursing Facility	Other:
<input type="checkbox"/> Lives with Spouse	<input type="checkbox"/> Assisted Living Facility	
<input type="checkbox"/> Lives with other Relative	<input type="checkbox"/> ICF/MR	
<input type="checkbox"/> Lives with non-Relative	<input type="checkbox"/> Other (specify)	
Facility Name (if applicable):		

<b>Application Type</b>
<input type="checkbox"/> New Long Term Care Applicant
<input type="checkbox"/> Recertification – Institutional Resident (no requested change in living arrangement)
<input type="checkbox"/> Recertification – Institutional Resident (request for return to community)
<input type="checkbox"/> Recertification – Elderly & Disabled Waiver
<input type="checkbox"/> Recertification – Assisted Living Waiver
<input type="checkbox"/> Recertification – Traumatic Brain Injury/Spinal Cord Injury Waiver
<input type="checkbox"/> Recertification – Independent Living Waiver
Comments:

**MISSISSIPPI DIVISION OF MEDICAID  
Application for Long Term Care**

Person Name: \_\_\_\_\_

Date: \_\_\_\_\_

**II. FUNCTIONAL SCREEN**

**A. ACTIVITIES OF DAILY LIVING (ADLs) & INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)**

- Enter score in box (must be whole number)
- Consider the past 30 days
- Score based on functionality achieved with assistive device(s), if used

ADL SCALE	
0 =	<b>Independent</b> - Person is independent in completing activity safely
1 =	<b>Supervision</b> - Person can complete activity safely with cueing, set-up or standby assistance OR limited/occasional physical/hands-on assistance
2 =	<b>Physical Assistance</b> - Person can participate in activity but requires physical/hands-on assistance to complete safely
3 =	<b>Total Dependence</b> - Person is completely dependent on others to complete activity safely
Activity	Score
1. <b>MOBILITY/AMBULATION</b> – How well is the person able to purposefully move within his or her residence/living environment?	
2. <b>COMMUNITY MOBILITY</b> – How well is the person able to move around the neighborhood or community, including accessing buildings, stores and restaurants, and using any mode of transportation, such as: walking, wheelchair, cars, buses, taxis, bicycles etc.? This includes entering/exiting transportation, such as cars, buses and taxis.	
3. <b>TRANSFERRING</b> – How much human assistance does the person need on a consistent basis for safe transfer, including from bed/chair to wheelchair, walker or standing position; onto and off of toilet; and into and out of bath or shower?	
4. <b>EATING</b> – How well is the person able to eat and drink safely? This includes ability to cut, chew and swallow foods. (Note – if person is tube fed or fed intravenously, circle "0" if s/he can feed self independently, or "1", "2", or "3" if s/he requires another person to assist.) <u>Excludes meal preparation</u>	
5. <b>MEAL PREPARATION</b> – How well is the person able to safely obtain and prepare routine meals? This includes the ability to independently open containers and use kitchen appliances. (Note – if person is tube fed or fed intravenously, circle "0" if s/he can prepare the tube/IV feeding independently, or "1", "2", or "3" if s/he requires another person to assist.)	
Comments:	

**MISSISSIPPI DIVISION OF MEDICAID**  
**Application for Long Term Care**

Person Name: \_\_\_\_\_ Date: \_\_\_\_\_

**II. FUNCTIONAL SCREEN - *continued***

**A. ADLs & IADLs (cont'd)**

- Enter score in box (must be whole number)
- Consider the past 30 days
- Score based on functionality achieved with assistive device(s), if used

ADL SCALE	
0 =	<b>Independent</b> - Person is independent in completing activity safely
1 =	<b>Supervision</b> - Person can complete activity safely with cueing, set-up or standby assistance OR limited/occasional physical/hands-on assistance
2 =	<b>Physical Assistance</b> - Person can participate in activity but requires physical/hands-on assistance to complete safely
3 =	<b>Total Dependence</b> - Person is completely dependent on others to complete activity safely
Activity	Score
6. <b>TOILETING</b> – How well is the person able to use the toilet, commode, bedpan or urinal safely? This includes flushing, cleansing of self, changing of protective garment, adjusting clothing, washing hands, managing an ostomy or catheter. <u>Excludes transfer and continence</u> (Note – limited hands-on assistance includes emptying bedpans.)	
7. <b>BATHING</b> – How well is the person able to bathe, shower or take sponge baths safely for the purpose of maintaining adequate hygiene and skin integrity? Includes washing hair. <u>Excludes transfer</u> (Note – limited hands-on assistance includes helping with hard to reach areas, such as the back.)	
8. <b>DRESSING</b> – How well is the person able to safely dress and undress as necessary regardless of clothing type? This includes ability to put on prostheses, braces, anti-embolism hose and choice of appropriate clothes for the weather and for personal comfort. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit. (Note: if person can dress independently, but normally requires 30 minutes or longer doing so, score as "Supervisory" (1).)	
9. <b>PERSONAL HYGIENE</b> – How well is the person able to perform personal hygiene/grooming activities safely, including but not limited to combing hair, shaving, oral care? Exclude nail care and washing hair (which is addressed under bathing).	
10. <b>MEDICATION MANAGEMENT</b> – How well is the person able to safely manage and administer pills, liquids, inhalers, nebulizers, eye drops, ear drops, self-administered injectables, IV medications, medication pumps? Excludes insulin and monthly injections, such as B-12 shots.	
<i>Does person use insulin? If yes, go to Question 11. Otherwise, skip to Question 12</i>	
Comments:	

**MISSISSIPPI DIVISION OF MEDICAID**  
**Application for Long Term Care**

Person Name: \_\_\_\_\_ Date: \_\_\_\_\_

**II. FUNCTIONAL SCREEN - *continued***

**A. ADLs & IADLs (cont'd)**

- Enter score in box (must be whole number)
- Consider the past 30 days
- Score based on functionality achieved with assistive device(s), if used

**11. INSULIN ADMINISTRATION**

How well is the person able to safely manage and administer insulin? If person does not use insulin, select N/A for all items.

Activity	Yes	No	N/A
11a. Can person administer finger sticks and understand Accu-Chek® (glucose testing) results?			
11b. If on a fixed dose, can person self-inject insulin with a pre-filled syringe?			
11c. If on a sliding scale, can person draw up the correct amount and inject insulin?			

Comments:

**MISSISSIPPI DIVISION OF MEDICAID**  
**Application for Long Term Care**

Person Name: \_\_\_\_\_ Date: \_\_\_\_\_

**II. FUNCTIONAL SCREEN - *continued***

**A. ADLs & IADLs (cont'd)**

- Enter score in box (must be whole number)
- Consider the past 30 days
- Score based on functionality achieved with assistive device(s), if used (Includes catheter and ostomy)

<b>CONTINENCE SCALE</b>	
<b>0 =</b>	<b>Complete voluntary control</b>
<b>1 =</b>	<b>Incontinent episodes less than weekly</b>
<b>2 =</b>	<b>Incontinent episodes once per week</b>
<b>3 =</b>	<b>Incontinent episodes two or more times per week</b>
<b>Activity</b>	<b>Score</b>
<b>12. BLADDER CONTINENCE</b> – How well is the person able to voluntarily control the discharge of body waste from the bladder?	
<b>13. BOWEL CONTINENCE</b> –How well is the person able to voluntarily control the discharge of body waste from the bowel?	
Comments: <div style="border: 1px solid black; height: 300px; margin-top: 5px;"></div>	

**MISSISSIPPI DIVISION OF MEDICAID**  
**Application for Long Term Care**

Person Name: \_\_\_\_\_

Date: \_\_\_\_\_

**II. FUNCTIONAL SCREEN - *continued***

**A. ADLs & IADLs (cont'd)**

**14. UNDERLYING CAUSES OF ADL/IADL LIMITATIONS – Check all that apply**

Part A General Underlying Causes (across ADLs/IADLs)		Part B Specific to Medication Management			
<i>Physical Impairments:</i>		<i>Physical Impairments (cont'd):</i>			
<input type="checkbox"/>	Amputation	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	Cannot Crush Pills
<input type="checkbox"/>	Balance Problems	<input type="checkbox"/>	Physiological Defect	<input type="checkbox"/>	Cannot Open Blister Pack
<input type="checkbox"/>	Bladder Incontinence	<input type="checkbox"/>	Poor Dentition	<input type="checkbox"/>	Cannot Open Containers
<input type="checkbox"/>	Bowel Incontinence	<input type="checkbox"/>	Sensory Impairment – Hearing	<input type="checkbox"/>	Cannot use Ear/Eye Drops
<input type="checkbox"/>	Catheter	<input type="checkbox"/>	Sensory Impairment – Vision	<input type="checkbox"/>	Liquid Medications Only
<input type="checkbox"/>	Choking	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Poor Coordination
<input type="checkbox"/>	Decreased Endurance	<input type="checkbox"/>	Swallowing Problems	<input type="checkbox"/>	Unable to Draw Medication
<input type="checkbox"/>	Fine or Gross Motor Impairment	<input type="checkbox"/>	Tube Feeding	<input type="checkbox"/>	Unable to put Medication in Mouth
<input type="checkbox"/>	Fracture(s)	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	Unable to Read Labels
<input type="checkbox"/>	Lack of Assistive Devices	<b><i>Supervision Need/Mental Health:</i></b>		<b><i>Supervision Need:</i></b>	
<input type="checkbox"/>	Limited Range of Motion	<input type="checkbox"/>	Behavior Issues	<input type="checkbox"/>	Complex Regimen
<input type="checkbox"/>	Muscle Tone	<input type="checkbox"/>	Cognitive Impairment	<input type="checkbox"/>	Does not Follow Frequency
<input type="checkbox"/>	Neurological Impairment	<input type="checkbox"/>	History of Falls	<input type="checkbox"/>	Does not Follow Dosage
<input type="checkbox"/>	Obesity	<input type="checkbox"/>	Lack of Motivation/Apathy	<input type="checkbox"/>	Forgets to Take Medication
<input type="checkbox"/>	Ostomy	<input type="checkbox"/>	Memory Impairment	<input type="checkbox"/>	Mixes Alcohol with Prescription Drugs
<input type="checkbox"/>	Oxygen Use	<b><i>Other (specify)</i></b>		<b><i>Other (specify)</i></b>	
<input type="checkbox"/>	Pain	<input type="checkbox"/>		<input type="checkbox"/>	

Comments:

**MISSISSIPPI DIVISION OF MEDICAID**  
**Application for Long Term Care**

Person Name: \_\_\_\_\_

Date: \_\_\_\_\_

**II. FUNCTIONAL SCREEN - continued**

**A. ADLs & IADLs (cont'd)**

**15. ASSISTIVE DEVICES** – Check all devices that the person either uses today or needs. (Note that some devices with multiple ADL/IADL uses are listed only under the most common ADL/IADL application. Check box even if used or needed for a different ADL/IADL.)

Uses Today	Needs	Device	Uses Today	Needs	Device
<b>Mobility Related:</b>			<b>Toileting/Continenence Related:</b>		
		Cane – Standard			Adult Diapers
		Cane – Quad			Bedside Commode/Bedpan
		Cane Grip Strap			In/Out Catheter
		Crutches			Raised Commode Seat
		Leg Brace			Toilet Paper Wiper Aid
		Motorized Scooter			Washable Bed Pads
		Prostheses			Zipper Hooks/Pulls
		Ramp	<b>Bathing Related:</b>		
		Walker – Not Wheeled			Handheld Shower Head
		Walker – Wheeled			Shower Chair
		Walker with Seat (trough)			Shower Slide/Swivel Chair
		Wheelchair – Standard			Specialized Brushes
		Wheelchair – Motorized	<b>Dressing Related:</b>		
		Wheelchair – Customized			Button Hook
<b>Transfer Related:</b>					Dressing Stick
		Bed Pull-Up Straps			Elastic Shoe Laces
		Furniture Risers			Long-Handled Shoe Horn
		Grab Bars/Hand Rails			Sock Aid
		Hospital Bed	<b>Personal Hygiene Related:</b>		
		Leg Lifters			Hair Dryer Stand
		Lift Chair			Velcro Handles/Cushion Holders for Brushes, Razors, Toothbrushes
		Lift/Ceiling Track System	<b>Medication Related:</b>		
		Mechanical Lift (not chair)			Alarm Device
		Overhead Trapeze			Pillbox
		Raised Seat Cushion	<b>Communication Related:</b>		
		Shower Slide/Swivel Chair			Communication Board
		Transfer Board/Disk			Other Communication Aid (specify)
<b>Eating/Meal Preparation Related:</b>			<b>Other (Specify):</b>		
		Adaptive Cups/Plates			
		Adaptive Utensils			
		Home Delivered Meals			
		Mechanically Altered Food			
Comments:					

**MISSISSIPPI DIVISION OF MEDICAID**  
**Application for Long Term Care**

Person Name: \_\_\_\_\_ Date: \_\_\_\_\_

**II. FUNCTIONAL SCREEN - *continued***

**B. COMMUNICATION/SENSORY** – Enter score in box (must be whole number)

	<b>Score</b>	
<b>1. EXPRESSIVE COMMUNICATION</b> - How well is the person able to express him or herself in their own language, including non-English languages and ASL or other generally recognized non-verbal communication?		
0.	Person can fully communicate with no impairment or only mild impairment (e.g., slow speech)	
1.	Person can fully communicate with the use of assistive device	
2.	Person can communicate only basic needs to others	
3.	Person has no effective communication	
Comments:		

	<b>Score</b>	
<b>2. ABILITY TO UNDERSTAND OTHERS</b> – How well is the person able to understand verbal information content?		
0.	Person understands	
1.	Person usually understands – may miss some part/intent of message	
2.	Person sometimes understands – responds adequately to simple, direct communication	
3.	Person rarely/never understands	
Comments:		

**MISSISSIPPI DIVISION OF MEDICAID**  
**Application for Long Term Care**

Person Name: \_\_\_\_\_

Date: \_\_\_\_\_

**II. FUNCTIONAL SCREEN - continued**

**B. COMMUNICATION/SENSORY (cont'd) – Enter score in box (must be whole number)**

		<b>Score</b>	<input type="text"/>
<b>3.</b>	<b>VISION – The ability to see in adequate light, and with glasses (if used)</b>		
0.	ADEQUATE – Sees fine detail, including regular print in newspapers/books		
1.	MILDLY IMPAIRED – Sees large print, but not regular print in newspapers/books		
2.	MODERATELY IMPAIRED – Limited vision; not able to see newspaper headlines, but can identify objects		
3.	HIGHLY IMPAIRED – Object identification in question, but eyes appear to follow objects		
4.	SEVERELY IMPAIRED – No vision OR sees only light, colors and shapes; eyes do not appear to follow objects		
UNK	Unable to determine appropriate score		
Comments:			

		<b>Score</b>	<input type="text"/>
<b>4.</b>	<b>HEARING – The ability to hear, with hearing appliances (if used)</b>		
0.	HEARS ADEQUATELY – Normal talk, TV, phone		
1.	MILDLY IMPAIRED – Minimal difficulty when not in quiet setting		
2.	MODERATELY IMPAIRED – Hears in special situations only; speaker has to adjust tonal quality and speak distinctly		
3.	HIGHLY IMPAIRED – Absence of useful hearing		
UNK	Unable to determine appropriate score		
Comments:			

**MISSISSIPPI DIVISION OF MEDICAID**  
**Application for Long Term Care**

Person Name: \_\_\_\_\_

Date: \_\_\_\_\_

**III. COGNITIVE SCREEN (ORIENTATION)**

What is the person's level of awareness to person, place and time?

- Check appropriate boxes, based on responses (check "does not know" if person is non-responsive due to severe cognitive impairment, such as advanced Alzheimer's)
- A caregiver should be familiar with the person's orientation on a daily basis. It can be a relative or non-relative, including a staff member in an Assisted Living Facility or Nursing Home
- Instruct caregivers to consider the past 90 days

Check if Caregiver not present (skip Caregiver Judgment items in III.A.1 through III.A.4)

1. PERSON				Caregiver Judgment (if present)		
At time of screen, does person know their:						
First Name	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Last Name	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Caregiver's Name	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Comments:						

2. PLACE				Caregiver Judgment (if present)		
At time of screen, does person know their:						
Immediate Environment	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Place of Residence	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
City	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
State	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Comments:						

**MISSISSIPPI DIVISION OF MEDICAID**  
**Application for Long Term Care**

Person Name: \_\_\_\_\_

Date: \_\_\_\_\_

**III. COGNITIVE SCREEN (ORIENTATION) - continued**

3. TIME				Caregiver Judgment (if present)		
At time of screen, does person know their:						
Day	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Month	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Year	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Time of Day	<input type="checkbox"/> Knows	<input type="checkbox"/> Does not know	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> Always knows	<input type="checkbox"/> Usually Knows	<input type="checkbox"/> Seldom/ never knows
Comments:						

← <b>Screener's Score</b>	<b>Caregiver's Score</b> →
<b>4. OVERALL RATING OF ORIENTATION/SITUATIONAL AWARENESS</b>	
<b>0 = No problem</b> – Person is completely unimpaired or has slight impairment or confusion of doubtful clinical significance (e.g., misses the date by one day).	
<b>1 = Mildly or Moderately Disoriented/Confused</b> – Mild, but definite impairment or confusion (e.g., unsure about orientation to time, or some impairment in a few aspects of short term or long term memory) OR moderate impairment or confusion (e.g., unsure about where s/he is and what is occurring right now, or cannot recall important events in his/her life)	
<b>2 = Severely Disoriented/Confused</b> – Thoroughly disoriented or confused to person, place, time and what is occurring right now; significant impairment in short term and/or long term memory OR unable to respond due to severe cognitive impairment.	
Comments:	

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Person Name: \_\_\_\_\_ Date: \_\_\_\_\_

**IV. MOOD/PSYCHOSOCIAL & BEHAVIORS**

**A. CURRENT MOOD/PSYCHOSOCIAL** – Check current Mood/PsychoSocial status as applicable (exception – check ‘Psychological Illness History’ if illness was diagnosed but is no longer symptomatic)

<i>Mood/PsychoSocial</i>			
<i>PsychoSocial Problems</i>	Check if Applicable	<i>Significant Losses</i>	Check if Applicable
Psychological Illness Present		Death of Spouse	
Psychological Illness History		Death of Other Family Member or Friend	
Depression		Death of Pet	
Nervousness/Anxiety		Other (Specify in Comments)	
Crying		<b><i>Significant Changes</i></b>	
Insomnia		Change in Residence	
Nightmares		Divorce/Separation	
Loss of Appetite		Retirement	
Concerns Regarding Potential PsychoSocial Situation		Other (Specify in Comments)	
Poor Eye Contact		<b><i>Threats/Victimization</i></b>	
Withdrawal from Activities of Interest		Financial Concerns	
Loneliness/Isolation		Safety Concerns	
Other (Specify in Comments)		Victim of Assault/Theft	
		Victim of Abuse/Neglect	
		Other (Specify in Comments)	
Comments:			

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Date: \_\_\_\_\_

**IV. MOOD/PSYCHOSOCIAL & BEHAVIORS - *continued***

**B. BEHAVIORS**

- Consider behaviors during the past 90 days that required some level of intervention to address (You may mark "H" for behaviors that occurred historically, defined as greater than 90 days ago but within the past two years)
- For interventions, consider the most common level of intervention required
- "Easily altered" applies to persons who can be redirected verbally without difficulty
- "Not easily altered" applies to persons who can be redirected verbally with difficulty, or who require physical or chemical restraints (to the extent allowed by law)

<b>Frequency of Behavior:</b>	<b>If "Frequency of Behavior" is Greater than "0" What Intensity of Intervention is Required?</b>
0 = Has not occurred	0 = Behavior is easily altered
H = Has occurred historically (greater than past 90 days)	1 = Behavior is not easily altered
1 = Occasional behavior requiring intervention no more than once per week	
2 = Frequent behavior requiring intervention more than weekly, but less than daily	
3 = Constant behavior requiring daily intervention	

**1. VERBALLY AGGRESSIVE: Threatening, screaming and/or cursing at others**

BEHAVIOR FREQUENCY (circle)	REQUIRED INTERVENTION INTENSITY (circle)
0    H    1    2    3	0    1
BEHAVIOR EXAMPLES - IF FREQUENCY IS GREATER THAN "0" (check all that apply)	
<input type="checkbox"/> Falsely accuses others of stealing <input type="checkbox"/> Spitting at others <input type="checkbox"/> Verbal threats <input type="checkbox"/> Screaming/cursing at others. <input type="checkbox"/> Other (please specify): _____	

**2. PHYSICALLY AGGRESSIVE: Hitting, shoving, scratching and/or sexually abusing others**

BEHAVIOR FREQUENCY (circle)	REQUIRED INTERVENTION INTENSITY (circle)
0    H    1    2    3	0    1
BEHAVIOR EXAMPLES - IF FREQUENCY IS GREATER THAN "0" (check all that apply)	
<input type="checkbox"/> Combative regarding personal care <input type="checkbox"/> Hits/shoves/scratches others <input type="checkbox"/> Intimidating/threatening physical harm <input type="checkbox"/> Sexually abusive <input type="checkbox"/> Throws items at others <input type="checkbox"/> Other (please specify): _____	

**3. RESISTIVE: Inappropriately stubborn and uncooperative. Includes both passive and active behaviors.**

BEHAVIOR FREQUENCY (circle)	REQUIRED INTERVENTION INTENSITY (circle)
0    H    1    2    3	0    1
BEHAVIOR EXAMPLES - IF FREQUENCY IS GREATER THAN "0" (check all that apply)	
<input type="checkbox"/> Refuses to eat <input type="checkbox"/> Refuses to participate in personal care (non-violent) <input type="checkbox"/> Refuses to take necessary medications <input type="checkbox"/> Other (please specify): _____	

Comments:

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Date: \_\_\_\_\_

**IV. MOOD/PSYCHOSOCIAL & BEHAVIORS - continued**

**B. BEHAVIORS (cont'd)**

**4. WANDERING/ELOPEMENT:** Movement with no rational purpose, seemingly oblivious to needs or safety

BEHAVIOR FREQUENCY (circle) 0    H    1    2    3	REQUIRED INTERVENTION INTENSITY (circle) 0    1
BEHAVIOR EXAMPLES - IF FREQUENCY IS GREATER THAN "0" (check all that apply)	
<input type="checkbox"/> Leaves home and becomes lost <input type="checkbox"/> Wanders – seeking exit <input type="checkbox"/> Wanders – NOT seeking exit	
<input type="checkbox"/> Other (please specify): _____	

**5. INAPPROPRIATE/UNSAFE:** Includes socially inappropriate behaviors, unsafe behaviors and disruptive behaviors. Excludes aggression toward others.

BEHAVIOR FREQUENCY (circle) 0    H    1    2    3	REQUIRED INTERVENTION INTENSITY (circle) 0    1
BEHAVIOR EXAMPLES - IF FREQUENCY IS GREATER THAN "0" (check all that apply)	
<input type="checkbox"/> Breaks objects <input type="checkbox"/> Hiding items <input type="checkbox"/> Hoarding <input type="checkbox"/> Inappropriate noises	
<input type="checkbox"/> Inappropriate talk or actions <input type="checkbox"/> Inappropriate toileting/menses <input type="checkbox"/> Puts inappropriate non-food items in mouth	
<input type="checkbox"/> Repetitive movements <input type="checkbox"/> Rummaging/takes belongings <input type="checkbox"/> Unsafe cooking <input type="checkbox"/> Unsafe smoking	
<input type="checkbox"/> Other (please specify): _____	

**6. SELF-INJURIOUS:** Repeated behaviors that cause harm to self. Also can include suicidal behavior.

BEHAVIOR FREQUENCY (circle) 0    H    1    2    3	REQUIRED INTERVENTION INTENSITY (circle) 0    1
BEHAVIOR EXAMPLES - IF FREQUENCY IS GREATER THAN "0" (check all that apply)	
<input type="checkbox"/> Biting/scratching/picking at self <input type="checkbox"/> Head slapping/banging <input type="checkbox"/> Suicidal	
<input type="checkbox"/> Other (please specify): _____	

**7. OTHER:** Delusions, hallucinations, manic symptoms, mood swings

BEHAVIOR FREQUENCY (circle) 0    H    1    2    3	REQUIRED INTERVENTION INTENSITY (circle) 0    1
BEHAVIOR EXAMPLES - IF FREQUENCY IS GREATER THAN "0" (check all that apply)	
<input type="checkbox"/> Delusions <input type="checkbox"/> Hallucinations <input type="checkbox"/> Manic symptoms/mood swings	
<input type="checkbox"/> Other (please specify): _____	

**Comments:**

**MISSISSIPPI DIVISION OF MEDICAID**  
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Date: \_\_\_\_\_

**V. MEDICAL SCREEN**

**A. MEDICAL CONDITIONS**

- Check only those diagnoses that have a current relationship to ADL status, cognitive/behavioral status, medical treatments, skilled nursing care or risk of death

<b>1. Cardiovascular:</b>		<b>5. Musculoskeletal:</b>		<b>7. Ophthalmologic/EENT:</b>	
<input type="checkbox"/>	Angina (chest pain)	<input type="checkbox"/>	Arthritis/Osteoarthritis	<input type="checkbox"/>	Blind
<input type="checkbox"/>	Arteriosclerotic Heart Disease	<input type="checkbox"/>	Arthritis/Rheumatoid	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	Cardiac Dysrhythmias	<input type="checkbox"/>	Degenerative Joint Disease	<input type="checkbox"/>	Diabetic Retinopathy
<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Fracture/Unspecified	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Cerebral Vascular Accident	<input type="checkbox"/>	Fracture/Hip	<input type="checkbox"/>	Hearing Impaired/Deaf
<input type="checkbox"/>	Deep Vein Thrombosis	<input type="checkbox"/>	Fracture/Pathological	<input type="checkbox"/>	Macular Degeneration
<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Gout	<b>8. Psychiatric/Mood:</b>	
<input type="checkbox"/>	Hypotension	<input type="checkbox"/>	Joint Repair or Replacement	<input type="checkbox"/>	Anxiety Disorder
<input type="checkbox"/>	Myocardial Infarction	<input type="checkbox"/>	Missing Limb	<input type="checkbox"/>	Bipolar Disorder
<input type="checkbox"/>	Peripheral Vascular Disease	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Depression (major)
<input type="checkbox"/>	Transient Ischemic Attack	<b>6. Neurological:</b>		<input type="checkbox"/>	Depression (other)
<b>2. Endocrine:</b>		<input type="checkbox"/>	ALS (Lou Gehrig's Disease)	<input type="checkbox"/>	Schizophrenia/other psychoses
<input type="checkbox"/>	Diabetes IDDM (insulin dependent)	<input type="checkbox"/>	Alzheimer's	<b>9. Respiratory:</b>	
<input type="checkbox"/>	Diabetes NIDDM (non-insulin dep.)	<input type="checkbox"/>	Aphasia	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Hyperlipidemia	<input type="checkbox"/>	Autism	<input type="checkbox"/>	Bronchitis/Chronic
<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease
<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	Dementia (not Alzheimer's)	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	Obesity	<input type="checkbox"/>	Developmental Disability	<input type="checkbox"/>	Influenza
<b>3. Gastrointestinal:</b>		<input type="checkbox"/>	Hemiplegia	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	GI Ulcers	<input type="checkbox"/>	Huntington's Disease	<input type="checkbox"/>	Tuberculosis (positive Mantoux)
<input type="checkbox"/>	Gastroesophageal Reflux Disease	<input type="checkbox"/>	Impairment/Central Nervous	<b>10. Other:</b>	
<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	Allergies (specify type in comments)
<b>4. Genitourinary:</b>		<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Renal Failure	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Urinary Retention	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	Cellulitis
<input type="checkbox"/>	Urinary Tract Infection	<input type="checkbox"/>	Paraplegia	<input type="checkbox"/>	Coma
		<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	Constipation
		<input type="checkbox"/>	Quadriplegia	<input type="checkbox"/>	Decubitus Ulcer (describe number and type(s) in comments)
		<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	Explicit Terminal Diagnosis
		<input type="checkbox"/>	Traumatic Brain Injury	<input type="checkbox"/>	Functioning at Brain Stem Level
		<input type="checkbox"/>		<input type="checkbox"/>	HIV/AIDS
				<input type="checkbox"/>	Septicemia
				<input type="checkbox"/>	Other (specify in comments)
<p>Comments: Use Medical Summary at end of Medical Section, if needed</p>					

**MISSISSIPPI DIVISION OF MEDICAID**  
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Person Name: \_\_\_\_\_ Date: \_\_\_\_\_

**V. MEDICAL SCREEN – continued**

**B. HEALTH-RELATED SERVICES - Indicate frequency if receives today and amount is known**

Health-Related Services Needed or Receiving (Indicate which)	Currently Receives	Needs	Service Frequency					
			1 to 3 Times/ Month	Weekly	2 to 6 Times/ Week	1 to 2 Times/ Day	3 to 4 Times/ Day	Over 4 Times/ Day
<b>Bladder/Bowel:</b>								
• Bowel Dilation								
• Catheter Care								
• Ostomy Care								
<b>Feedings:</b>								
• Parenteral Feedings/TPN								
• Special Diet (specify)								
• Tube Feedings								
<b>Injections/IV:</b>								
• Intramuscular/Subcutaneous Injections								
• Intravenous Infusion Therapy								
<b>Medications:</b>								
• Drug Administration								
• Drug Regulation								
<b>Rehabilitative Nursing:</b>								
• Bowel/Bladder Training								
• Range of Motion								
• Teaching/Training								
• Turning and Positioning								
• Other Rehab Nursing								
<b>Respiratory:</b>								
• Chest-Physio Therapy								
• CPAP								
• Oxygen								
• Small Volume Nebulizer								
• Suctioning								
• Trach Care								
• Ventilator								
<b>Skin Care:</b>								
• Non Bowel/Bladder Care								
• Pressure/Other Ulcers								
• Wound Care								
<b>Therapies:</b>								
• Alcohol/Drug Treatment								
• Individual/Group Therapy – Psycho/Social								
• Occupational Therapy								
• Physical Therapy								
• Respiratory Therapy								
• Speech Therapy								
• Vocational Rehabilitation								
<b>Other Services &amp; Treatments:</b>								
• Chemotherapy/Radiation								
• Fluid Intake/Output								
• Hemodialysis								
• Peritoneal Dialysis								
• Restraints								
• Other (specify):								

Comments: Use Medical Summary at end of Medical Section, if needed

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**V. MEDICAL SCREEN – continued**

**C. CURRENT MEDICATIONS**

- Include both prescribed and over-the-counter medications currently being taken
- Identify dosage, frequency and prescribing physician (as applicable) for all current medications
- Check Psychotropic box if a medication is being administered for the purpose of treating a behavioral health condition

Medications	Dosage	Frequency	Prescriber	Psychotropic
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Comments:

**MISSISSIPPI DIVISION OF MEDICAID**  
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**V. MEDICAL SCREEN – *continued***

**D. MEDICAL STABILITY & STATUS – For stability, record episodes in past 90 days**

Incident Type	Number in past 90 days	
1. Emergency Room Visits		
2. Hospitalizations (if any, provide details, including discharge dates and diagnoses in Comments below)		
3. Physician Office Visits (total across all doctors)		
4. Number of Falls		
Medical Status	Yes	No
5. Does person have an active, life threatening condition? (If yes, describe in Comments below)		
6. Is person medically stable? (If no, describe in Comments below)		
7. Does person require 24-hour/7-day per week care? (If yes, describe in Comments below)		
8. Does person have a severe orthopedic and/or neurological impairment, <u>and</u> possess rehabilitative potential?		
Comments:		



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Date: \_\_\_\_\_

**VI. SOCIAL SUPPORTS**

- N/A – Person resides in nursing facility or other institutional setting and is not seeking placement in the community (skip section)**

<b>1. Primary Caregiver</b>	<input type="checkbox"/> Check if person has primary caregiver/contact, but person is not present at screening <input type="checkbox"/> Check if person has no caregiver or emergency contact	
Name		
Relation <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other		
Lives with Person? <input type="checkbox"/> Yes <input type="checkbox"/> No		Designated Representative? (if answered "No" to both, enter address below) <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address: (Write "Same" if lives with person and/or "DR" if Designated Representative)		
City:	Zip Code:	Telephone:
Frequency of Support	Type(s) of Support Typically Provided	
<i>Individual is emergency contact only/not serving as caregiver (skip remainder of table)</i>	Personal Care/ADLs (e.g., bathing, dressing etc.)	
Every day	Housekeeping/chores	
Several days per week	Meal Preparation	
At least once per week	Medication administration & oversight	
Less than once per week	Shopping/Errands	
← Estimated hours of support provided in previous seven days	Supervision for safety	
	Transportation	
	Other (specify in comments)	
Caregiver's health (self-reported) <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Don't Know		
Caregiver's emotional well-being (self-reported) <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Don't Know		
Is caregiver able/willing to maintain current level of support in foreseeable future? If no, explain in comments <input type="checkbox"/> Yes <input type="checkbox"/> No		
Comments:		

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Date: \_\_\_\_\_

**VI. SOCIAL SUPPORTS - *continued***

**2. Formal Agency Supports**

Check if person has no formal agency supports and complete "Needs" portion of table only

Agency 1 Name			Agency 2 Name		
Address (Street, City, Zip Code)			Address (Street, City, Zip Code)		
Telephone:			Telephone:		
Receives	Needs	Long Term Care Services	Receives	Needs	Long Term Care Services
		Adult Day Care			In-Home Respite
		Assisted Living			In-Home Nursing Respite
		Attendant Care			Institutional Respite
		Attendant Call System			Intermittent Skilled Nursing
		Case Management			Medication Administration/Oversight
		Chore Services			Personal Care
		Environmental Modifications			Programming
		Home Health Aide			Transition Services
		Expanded Home Health			Transportation (Escorted and non-Escorted)
		Homemaker			Other (specify in comments)
		Home Delivered Meals			
Comments:					

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Date: \_\_\_\_\_

**VII. HOME ENVIRONMENT**

- N/A – Person resides in nursing facility or other institutional setting and is not seeking placement in the community (skip section)
- Person resides in nursing facility or other institutional setting and is seeking placement in the community (check desired dwelling type and provide further details about availability of desired community placement in comments section, including whether placement arrangements have been made.)

<i>Characteristics</i>		For identified problems, address necessary action(s) in comments:	
<i>Dwelling Type</i>	Check One	<i>Heating/Cooling/Safety</i>	Check if Present
House		Air Conditioning Type: _____	
Apartment		Heat Type: _____	
Trailer		Working Smoke Detectors	
Congregate Housing		Fire Extinguishers	
Other (specify in comments)		Clear Pathways	
<i>Structural Concerns</i>	Check if Applicable	911 System	
Accessibility		Emergency Response System	
Roof		Severe Weather Procedure	
Walls		<i>Neighborhood</i>	Check One
Floor		High Crime	
Other (specify in comments)		Moderate Crime	
<i>Sanitation Concerns</i>	Check if Applicable	Low Crime	
Pests			
Plumbing			
Sewage			
Comments:			

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Person Name: \_\_\_\_\_

Date: \_\_\_\_\_

**VIII. INFORMED CHOICE**

The purpose of this section is to match the person's care needs, strengths and desires with DOM-covered long term care programs, to ensure the person, and person's family, is able to make an informed choice from the available DOM-covered options.

- N/A – Person resides in nursing facility or other institutional setting and is not seeking placement in the community (skip section)**

<b>1. Person Strengths</b>		Document person's strengths as they relate to remaining in their home or another community setting. Check all that apply and provide additional detail in comments section, as appropriate.	
<b>Social Supports</b>		<b>Outside Activities/Networks</b>	
<input type="checkbox"/>	Supportive Family	<input type="checkbox"/>	Active in church/faith-based organizations
<input type="checkbox"/>	Supportive Friends	<input type="checkbox"/>	Active in clubs/recreational groups
<input type="checkbox"/>	Supportive Neighbors	<input type="checkbox"/>	Active in sports
<input type="checkbox"/>	Other (specify in comments)	<input type="checkbox"/>	Employed
		<input type="checkbox"/>	Volunteers
		<input type="checkbox"/>	Other (specify in comments)
<b>Health &amp; Wellness</b>		<b>Personal Outlook</b>	
<input type="checkbox"/>	Adequate physical health	<input type="checkbox"/>	Positive self-image
<input type="checkbox"/>	Balanced mental health	<input type="checkbox"/>	Positive view of others
<input type="checkbox"/>	Adequate self-care ability (with support)	<input type="checkbox"/>	Positive view of the future
<input type="checkbox"/>	Adequate access to medical care	<input type="checkbox"/>	Desire to remain in (return to) home/community
<input type="checkbox"/>	Adequate communication skills	<input type="checkbox"/>	Sense of purpose
<input type="checkbox"/>	Commitment to health	<input type="checkbox"/>	Ability to ask for and accept help
<input type="checkbox"/>	Knowledge about how choices impact health	<input type="checkbox"/>	Other (specify in comments)
<input type="checkbox"/>	Other (specify in comments)		

Comments:

**MISSISSIPPI DIVISION OF MEDICAID**  
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Person Name: \_\_\_\_\_ Date: \_\_\_\_\_

**VIII. INFORMED CHOICE - *continued***

2. Program Options & Desired Assistance	Desired Assistance (check all that apply within potential placement options)				
	Nursing Facility	Assisted Living	Elderly/Disabled Waiver	Independent Living Waiver	TBI/SCI Waiver
Nursing Facility (all inclusive)					
Adult Day Care					
Assisted Living Placement					
Attendant Care					
Attendant Call System					
Case Management					
Chore Services					
Environmental Modifications					
Escorted Transportation					
Homemaker					
Expanded Home Health*					
Home Delivered Meals					
In-Home Respite					
In-Home Nursing Respite					
Institutional Respite					
Medication Admin/Oversight					
Personal Care					
Programming					
Intermittent Skilled Nursing					
Specialized Equipment/Supplies					
Transition Services					
Transportation					

\* Expanded Home Health can include: Home Health Aide, Skilled Nurse, Physical Therapy and Speech Therapy

Comments:



**MISSISSIPPI DIVISION OF MEDICAID**  
**Application for Long Term Care**

Person Name: \_\_\_\_\_

Date: \_\_\_\_\_

**IX. LEVEL II DETERMINATION**

- This section is to be completed on all persons being considered for placement in a Nursing Facility
- Complete Part A to determine if person is exempt from Level II evaluation due to medical diagnosis or other qualifying factor. Yes answers must be supported by data entered in previous PAS sections, as indicated.
- Complete Part B to document if person has a mental illness or is mentally retarded/developmentally disabled (Part B must be completed if one of the exemption criteria are marked in Part A)
- Referrals must be made even if physician certifies that, in his/her opinion, a Level II evaluation is not indicated at this time (physician finding will be considered by DOM when making final determination regarding the person's need for an evaluation)

**A. Exemption Criteria**

Criteria	As Documented in:	Yes	No
1. Person has diagnosis of Alzheimer's Disease or other Dementia	Section V.A		
2. Person is in need of nursing care for a terminal illness with a life expectancy of six (6) months or less	Section V.A		
3. Person has severe physical illness such as coma, functioning at brain stem level or diagnosis such as severe COPD, Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis and Severe Congestive Heart Failure	Section V.A and ICD-9 portion of physician certification form		
4. Person is ventilator dependent	Section V.B		
5. Person needs respite care for 10 days or less			
6. Person needs short term convalescent care (likely to be less than 30 days) and is being admitted directly from a hospital			
7. Person needs provisional admission pending further assessment in an emergency situation requiring protective services with placement in a nursing facility not to exceed 7 days			

*If any question in Part A has been answered "Yes", person is exempt from Level II evaluation. (Part B must still be completed)*

**MISSISSIPPI DIVISION OF MEDICAID**  
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Person Name: \_\_\_\_\_ Date: \_\_\_\_\_

**IX. LEVEL II DETERMINATION - *continued***

**B. Level II Referral**

Criteria	As Documented in:	Yes	No
1. Person has diagnosis of Mental Retardation	Section V.A		
2. Person has a history of, or presents any evidence of cognitive or behavior functions that indicate the need for an MR evaluation	Section V.C		
3. Person has a diagnosis of a major mental illness	Section V.A and ICD-9 portion of physician certification form		
4. Person has a recent history of a mental illness	Section IV.B.7 (score of 1, 2, 3 or H)		
5. Person takes, or has a history of taking, psychotropic medication(s)	Section V.C		

# MISSISSIPPI DIVISION OF MEDICAID

## Application for Long Term Care

### X. PAS SUMMARY & PHYSICIAN CERTIFICATION (Electronic PAS)

*Hard copy signature instructions: If physician is certifying in hard copy, print this page and the following page after completing the electronic PAS and obtain ICD-9 diagnosis data and physician signature. Check box below and retain certification in your records.*

*Electronic signature instructions: If physician is certifying electronically, forward the completed electronic PAS and obtain ICD-9 data and electronic signature. Instruct physician to return to you electronically*

Physician has certified by signing hard copy form. Certification has been retained for DOM review (if requested)

<b>Name (Last, First, Middle):</b>			
<b>Medicaid Number:</b>		<b>Medicare Number:</b>	
<b>SSN:</b>	<b>DOB (MM/DD/YR)</b>	<b>Gender (check box)</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Activities of Daily Living/Instrumental Activities of Daily Living – Level of Need for Assistance in past 30 days</b>			
Mobility/Ambulation	Independent	Toileting	Supervision
Community Mobility	Supervision	Bathing	Physical/Hands-On Assist
Transferring	Physical/Hands-On Assist	Dressing	Total Dependence
Eating	Total Dependence	Personal Hygiene	Independent
Meal Preparation	Independent	Medication Management	Supervision
<b>Bladder/Bowel Continence – Frequency of Incontinence</b>			
Bladder Incontinence	Less than weekly	Bowel Incontinence	Complete voluntary control
<b>Sensory – Level of Impairment</b>			
Expressive Communication	Can fully communicate	Vision	Mildly impaired
Ability to Understand Others	Understands (no impairment)	Hearing	Mildly impaired
<b>Level of Orientation to Person, Place &amp; Time (11 question test)</b>			
Incorrect answers (out of 11)	4 incorrect	Screeener Judgment	Mildly/Moderately Impaired
<b>Behaviors – Frequency in past 90 days</b> <i>Occasional = less than weekly; Frequent = less than daily; Constant = daily</i>			
Verbally Aggressive	None	Inappropriate/Unsafe	None
Physically Aggressive	Occasional	Self-Injurious	Occasional
Resistive	Frequent	Other (includes delusional and manic)	Frequent
Wandering/Elopement	Constant		
<b>Active Medical Conditions</b>			
Arthritis/Osteoarthritis	Dementia (not Alzheimer's)	Diabetes – IDDM	Hypertension
Condition 5	Condition 6	Condition 7	Condition 8
<b>Health-Related Services – Currently Receives or Needs</b>			
Drug Administration Service 5	Drug Regulation Service 6	Physical Therapy Service 7	Special Diet Service 8
<b>Federal Pre-Admission Screen &amp; Resident Review (PASARR) – For Nursing Facility Admissions</b>			
<b>Part A – Level II Evaluation Exemption Criteria</b>		<b>Part B – Level II Referral Criteria</b>	
Person has diagnosis of Alzheimer's/Dementia?	Yes	Person has a diagnosis of Mental Retardation?	No
Person is in need of nursing care for terminal illness?	No	Person has a history of, or presents any evidence of cognitive or behavior functions that indicate the need for an MR evaluation?	No
Person has severe physical illness?	No	Person has a diagnosis of a major mental illness?	No
Person is ventilator dependent?	No	Person takes, or has a history of taking, psychotropic medications?	No
Person needs respite care for 10 days or less?	No		
Person needs short term convalescent care (likely to be less than 30 days) and is being admitted directly from hospital?	No		
Person needs provisional admission pending further assessment in an emergency situation requiring protective services with placement not to exceed 7 days?	No		

**MISSISSIPPI DIVISION OF MEDICAID**  
**Application for Long Term Care**

**X. PAS SUMMARY & PHYSICIAN CERTIFICATION (Electronic PAS/Hard Copy Attestation)**

Name (Last, First, Middle):		
Medicaid Number:	Medicare Number:	
SSN:	DOB (MM/DD/YR)	Gender (check box) <input type="checkbox"/> Male <input type="checkbox"/> Female
PAS Date:		

PAS Clinical Score	Determination
50 or higher	Approved - Person meets clinical threshold for long term care
45 - 49.9 or age <12	Pending - Sent for secondary clinical review
Under 45	Denied

***This section to be completed by Physician***

**Hard Copy Version - if completing certification electronically, please turn to next page**

Primary Diagnosis					Secondary Diagnosis				
Description	ICD-9 Code				Description	ICD-9 Code			

***Physician Certification:***

This person is appropriate for Medicaid long term care services. In the event of Nursing Facility placement, a Level II evaluation  IS INDICATED  IS NOT INDICATED at this time (check one)

Signature \_\_\_\_\_ Date \_\_\_\_\_ Printed Name \_\_\_\_\_

License Number \_\_\_\_\_

**MISSISSIPPI DIVISION OF MEDICAID**  
**Application for Long Term Care**

**X. PAS SUMMARY & PHYSICIAN CERTIFICATION (Electronic PAS/Electronic attestation)**

Name (Last, First, Middle):		
Medicaid Number:	Medicare Number:	
SSN:	DOB (MM/DD/YR)	Gender (check box) <input type="checkbox"/> Male <input type="checkbox"/> Female
PAS Date:		

*This section to be completed by Physician*

Enter Primary and Secondary Diagnoses

Primary Diagnosis					Secondary Diagnosis				
Description	ICD-9 Code				Description	ICD-9 Code			
				.					.

Electronic Attestation – Check where indicated and sign below

<input type="radio"/>	I am a doctor of allopathic medicine (M.D.) or osteopathic medicine (O.D.) and am licensed to practice medicine		
<input type="radio"/>	I certify that this person <u>is appropriate</u> for Medicaid long term care services. In the event of a Nursing Facility placement: (check one)		
<input type="radio"/>	A Level II evaluation <u>is</u> indicated at this time	<input type="radio"/>	A Level II evaluation <u>is not</u> indicated at this time
<input type="radio"/>	I understand that typing my name below will constitute my signature and, by doing so, I am attesting to the above information under penalty of perjury.		

Signature (Type Name)	
License Number (Enter)	
Date Signed:	MM/DD/YY field

# MISSISSIPPI DIVISION OF MEDICAID

## Application for Long Term Care

### X. PAS SUMMARY & PHYSICIAN CERTIFICATION (Hard Copy PAS)

Hard copy signature instructions: If physician is certifying in hard copy, print this page and the following page after completing the electronic PAS and obtain ICD-9 diagnosis data and physician signature. Retain in your records.

PAS Score (to be completed by DOM/LTC only) →

Name (Last, First, Middle):												
Medicaid Number:					Medicare Number:							
SSN:					DOB (MM/DD/YR)			Gender (check box) <input type="checkbox"/> Male <input type="checkbox"/> Female				
ADL/IADL Level of Need for Assistance in past 30 days – Mark the appropriate rating <input checked="" type="checkbox"/>												
ADL/IADL	Independent	Supervision	Physical Assist	Total Depend.	ADL/IADL	Independent	Supervision	Physical Assist	Total Depend.			
Mobility/Ambulation	0	1	2	3	Toileting	0	1	2	3			
Community Mobility	0	1	2	3	Bathing	0	1	2	3			
Transferring	0	1	2	3	Dressing	0	1	2	3			
Eating	0	1	2	3	Personal Hygiene	0	1	2	3			
Meal Preparation	0	1	2	3	Medication Management	0	1	2	3			
Bladder/Bowel Continence – Frequency of Incontinence in past 30 days - Mark the appropriate rating <input checked="" type="checkbox"/>												
Incontinence Type	None	<1 per Week	Once per Week	2+ Times per Week	Incontinence Type	None	<1 per Week	Once per Week	2+ Times per Week			
Bladder Incontinence	0	1	2	3	Bowel Incontinence	0	1	2	3			
Insulin Dependence – Mark if Applies <input checked="" type="checkbox"/>					Vision/Hearing – Level of Impairment - Mark the appropriate rating <input checked="" type="checkbox"/>							
Insulin Task	Applies	Sensory Type			None	1	2	3	4	Unk	Unk	
Needs assistance w/finger sticks and/or understanding glucose testing results		Vision			0	1	2	3	4	Unk	Unk	
Needs assistance drawing-up and/or injecting insulin		Hearing			0	1	2	3		Unk	Unk	
Number of ADL Underlying Causes Recorded (Part A only) - Mark the appropriate number <input checked="" type="checkbox"/>												
0	1	2	3	4	5	6	7	8	9	10 or more		
Level of Orientation to Person, Place & Time (11 question test)												
Incorrect answers (out of 11)	0	1	2	3	4	5	Screener Judgment of Impairment Level			None	Mild Moderate	Severe
Mark here if unable to determine <input type="checkbox"/>	6	7	8	9	10	11				0	1	2
Behavior – Frequency in past 90 days requiring intervention – Mark the appropriate rating (Mark "H" as 0) <input checked="" type="checkbox"/>												
Behavior Type	None	Less than Weekly	Less than Daily	Daily	Behavior	None	Less than Weekly	Less than Daily	Daily			
Verbally Aggressive	0	1	2	3	Inappropriate/Unsafe	0	1	2	3			
Physically Aggressive	0	1	2	3	Self-Injurious	0	1	2	3			
Resistive	0	1	2	3	Other: (includes delusions, manic symptoms, mood swings)	0	1	2	3			
Wandering/Elopement	0	1	2	3								
Active Medical Conditions – Record conditions (up to 5)												
Primary Diagnosis/Condition												
Secondary Diagnosis/Condition												
Tertiary Diagnosis/Condition												
Does applicant have Traumatic Brain Injury and/or Spinal Cord Injury? If Yes, mark box →												
Does applicant have severe orthopedic or neurological impairment and possess rehabilitative potential? If yes, mark box →												

**MISSISSIPPI DIVISION OF MEDICAID**  
**Application for Long Term Care**

**X. PAS SUMMARY & PHYSICIAN CERTIFICATION (Hard Copy PAS) - *continued***

Name (Last, First, Middle):		PAS Date:			
<b>Health-Related Services – Currently Receives or Needs (Record up to 6) – Indicate whether Receives today or Needs</b>					
Service	Service Description and frequency (if known)	Receives Today	Needs		
Service 1					
Service 2					
Service 3					
Service 4					
Service 5					
Service 6					
<b>Federal Pre-Admission Screen &amp; Resident Review (PASARR) – For Nursing Facility Admissions – Mark Yes or No</b>					
Part A – Level II Evaluation Exemption Criteria	Yes	No	Part B – Level II Referral Criteria	Yes	No
Person has diagnosis of Alzheimer's/Dementia?			Person has a diagnosis of Mental Retardation?		
Person is in need of nursing care for terminal illness?			Person has a history of, or presents any evidence of cognitive or behavior functions that indicate the need for an MR evaluation?		
Person has severe physical illness?			Person has a diagnosis of a major mental illness?		
Person is ventilator dependent?			Person takes, or has a history of taking, psychotropic medications?		
Person needs respite care for 10 days or less?					
Person needs short term convalescent care (likely to be less than 30 days) and is being admitted directly from hospital?					
Person needs provisional admission pending further assessment in an emergency situation requiring protective services with placement not to exceed 7 days?					

***This section to be completed by Physician***

Primary Diagnosis				Secondary Diagnosis			
Description	ICD-9 Code			Description	ICD-9 Code		

***Physician Certification:***

This person is appropriate for Medicaid long term care services. In the event of Nursing Facility placement, a Level II evaluation  IS INDICATED  IS NOT INDICATED at this time (check one)

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

License Number \_\_\_\_\_