



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 DIVISION OF REGULATION AND LICENSURE
INITIAL ASSESSMENT - SOCIAL AND MEDICAL

FSD CO. NO.	<input type="checkbox"/> CASH
LOAD NO.	<input type="checkbox"/> XIX

All questions on this form must be answered – write N/A if not applicable. Blank areas will result in return of document and delay in payment.

A. SOCIAL ASSESSMENT

1. PERSON'S NAME (LAST, FIRST, MI)		2. DCN	3. DOB	4. SOCIAL SECURITY NUMBER
5. SEX	9. CURRENT LOCATION (ADDRESS)			
6. RACE	10. NAME OF PROPOSED NURSING FACILITY PLACEMENT, PHONE #			
7. EDUCATION LEVEL <input type="checkbox"/> GRADE SCHOOL <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> COLLEGE <input type="checkbox"/> OTHER	11. DATE ADMITTED TO NF	12. PERSON'S LEGAL GUARDIAN <input type="checkbox"/> OR DESIGNATED CONTACT PERSON <input type="checkbox"/> NAME _____ STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____		
8. OCCUPATION				

B. MEDICAL ASSESSMENT

Attach additional sheets of information if necessary.

1. HEIGHT	2. WEIGHT	6. RECENT MEDICAL INCIDENTS (i.e., CVA, SURGERY, FRACTURE, HEAD INJURY, ETC., AND GIVE DATE)	
3. B/P	4. PULSE	RESIDUAL EFFECTS: _____	
5. DATE OF LAST MEDICAL EXAM	7. SPECIAL LAB TESTS AND FREQUENCY		
8. PRESCRIPTION DRUGS (DOSAGE AND FREQUENCY, INCLUDING PRNS; SHOULD CORRELATE WITH DIAGNOSES)			
1. _____ 4. _____ 7. _____			
2. _____ 5. _____ 8. _____			
3. _____ 6. _____ 9. _____			
9. LIST ALL DIAGNOSES (SHOULD CORRELATE WITH MEDICATIONS) (INCLUDE PSYCH DX)		10. POTENTIAL PROBLEM AREAS AND/OR ADDITIONAL COMMENTS	11. STABILITY
1. _____ 6. _____		_____	<input type="checkbox"/> 1. IMPROVING
2. _____ 7. _____			<input type="checkbox"/> 2. STABLE
3. _____ 8. _____			<input type="checkbox"/> 3. DETERIORATING
4. _____ 9. _____			<input type="checkbox"/> 4. UNSTABLE
5. _____ 10. _____			

12. LEVEL OF CARE REQUESTED BY PERSON'S PHYSICIAN (CHECK ONE) NF RCF ICFMR MH SUPPLEMENTAL NC HOME CARE

13. MENTAL STATUS (CHECK ALL THAT APPLY)	14. BEHAVIORAL INFORMATION (CHECK ONE BOX FOR EACH)	15. FUNCTIONAL IMPAIRMENT (CHECK ALL THAT APPLY AND GIVE RATIONALE)
<input type="checkbox"/> ORIENTED TO: <input type="checkbox"/> person, <input type="checkbox"/> place, <input type="checkbox"/> time <input type="checkbox"/> THINKS CLEARLY <input type="checkbox"/> LETHARGIC <input type="checkbox"/> ALERT <input type="checkbox"/> MEMORY: <input type="checkbox"/> good, <input type="checkbox"/> fair, <input type="checkbox"/> poor	NONE MIN MOD MAX <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CONFUSED <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> WITHDRAWN <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> HYPERACTIVE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> WANDERS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> SUSPICIOUS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> COMBATIVE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> SUPERVISED FOR SAFETY <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CAUSES MGT. PROBLEMS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CONTROLLED WITH MEDICATION(S)	<input type="checkbox"/> VISION _____ <input type="checkbox"/> HEARING _____ <input type="checkbox"/> SPEECH _____ <input type="checkbox"/> AMBULATION _____ <input type="checkbox"/> MANUAL DEXTERITY _____ <input type="checkbox"/> TOILETING _____ <input type="checkbox"/> PATH TO SAFETY _____

16. ASSESSED NEEDS (CHECK APPROPRIATE BOX FOR EACH; GIVE RATIONALE PLUS AMOUNT OF STAFF ASSISTANCE NEEDED. (YOU MUST USE GUIDE #1 ON BACK.))

NONE	MIN	MOD	MAX	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. MOBILITY _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. DIETARY _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. RESTORATIVE SERVICES _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. MONITORING _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. MEDICATION _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. BEHAVIOR/MENTAL COND. _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. TREATMENTS _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. PERSONAL CARE _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. REHAB. SERVICES _____

17. POTENTIAL FOR REHAB GOOD FAIR POOR

18. PATIENT REFERRED BY NAME OF INDIVIDUAL OR AGENCY	19. FORM COMPLETED BY SIGNATURE OF INDIVIDUAL	CENTRAL OFFICE USE ONLY	
ADDRESS	TELEPHONE NUMBER	LEVEL OF CARE DETERMINATION BY DIVISION HSL CENTRAL OFFICE	
TELEPHONE	FAX NUMBER	<input type="checkbox"/> 1 NF <input type="checkbox"/> 2 IMR <input type="checkbox"/> 3 MH <input type="checkbox"/> 4 SNC <input type="checkbox"/> 5 NONE	
	DATE	NEXT EVALUATION DATE	SIGNATURE DATE
		STATE MEDICAL CONSULTANT	

GUIDE #1 - ASSESSED NEEDS:

1. **MOBILITY** - individual's ability to move from place to place. Do they require assistive device, physical assist with transfer, mobile only with physical assist or unable to ambulate and/or totally dependent?
2. **DIETARY** - individual's nutritional requirements and need for assist and/or supervision with meals. Do they have a special diet, require tray set up, cueing, feeding or on tube feedings or IV fluids?
3. **RESTORATIVE** - specialized services provided to help individual obtain/maintain optimal function potential. Is individual receiving ROM, B & B program, RO, frequency, and amount of assistance required?
4. **MONITORING** - Observation and assessment of individual's physical and mental condition. This may include routine lab work, I & O, clinitest, acetest, weights and other routine procedures.
5. **MEDICATION** - A drug regimen of all physician ordered legend and non-legend drugs for which a physician has ordered monitoring due to complexity of drug or condition of individual.
6. **BEHAVIORAL** - individual's social or mental activities. Does individual require supervision/guidance or assist due to their behavior? Are they alert, oriented, disoriented, uncooperative, abusive or incapable of self-direction?
7. **TREATMENTS** - a systematized course of nursing procedures ordered by the attending physician. What is the treatment and how often is it ordered? Is the treatment non-routine and preventive, require daily attention by a professional or require extensive direct supervision?
8. **PERSONAL CARE** - activities of dailing living, including hygiene, personal grooming (dressing, bathing, oral hygiene, hair and nail care, shaving), and bowel and bladder functions. Does daily care require supervision, close supervision or total care?
9. **REHABILITATION** - restoration of former or normal state of health through medically ordered therapeutic services either directly provided by or under the supervision of a qualified professional, which may include PT, OT, ST and audiology. What type of rehab is individual receiving and how often do they receive it?

NOTE: Refer to State of Missouri Long-Term Care Facility Licensure Law and Rules book, 19 CSR 30-81.030(4)(G) for complete details of point count system.

GUIDE #2 - INSTRUCTIONS (for Pre-Admission Screenings):

A. NURSING FACILITY ADMISSIONS FROM HOSPITALS—

1. If the person is hospitalized and will or MAY seek placement in a Medicaid certified bed within a skilled or intermediate nursing facility upon discharge, the hospital completes the Level One (I) Screening (DA-124C form) as soon as possible. If a Level Two (II) Screening is then indicated, the hospital also completes the DA-124A/B form (**all questions must be answered**). Submit both forms to: DHSS, SLCR/COMRU, P.O. BOX 570, JEFFERSON CITY, MO 65102. NOTE: The hospital must take immediate action since the Level II Screening process takes 7-9 working days to complete. The person or their legal guardian must sign & date the DA-124C form whenever a Level II Screening is indicated. If the person does not have a legal guardian but is unable to sign, make notation 'PT UNABLE TO SIGN' and have 2 witnesses sign and date. The physician's signature, discipline, license number and date are ALWAYS required.

2. In Missouri, Federal & State regulations require that Level II Screenings be completed PRIOR to nursing facility placement EXCEPT when a person qualifies for a SPECIAL ADMISSION CATEGORY (follow directions on DA-124C form). The hospital may contact the COMRU nurse for prior authorization at 573-526-8609. NOTE: COMRU nurse may require copy of History & Physical.

B. NURSING FACILITY ADMISSIONS FROM HOME OR RCF—

1. Skilled/intermediate nursing facilities receiving persons directly from home should assist families in completing the Level I Screening

(DA-124C) with instructions for them to obtain the family physician's signature. If a Level II Screening is indicated, completion of the DA-124A/B follows, as outlined in section A, #1 and 2.

2. **EMERGENCY ADMISSIONS FROM HOME OR RCF**—If the person is a danger to himself or others, or if protective oversight is necessary, call the Elderly Abuse and Neglect Hotline, 1-800-392-0210. Explain the emergency and ask that a DHSS Worker review the client for EMERGENCY admission to a skilled/intermediate nursing facility. Complete the DA-124A/B & C forms and contact COMRU immediately (573-526-8609). If the emergency occurs at night or on a weekend, do the same and contact COMRU at open of next business day before mailing the forms. If the person will require more than 7 days in a nursing facility, notify COMRU immediately.

3. All Medicaid certified beds, including swing beds, within skilled/intermediate nursing facilities MUST have a completed DA-124C form. If the person is PRIVATE PAY and their Level I Screening does NOT indicate the need for a Level II Screening, the DA-124C form is kept in their chart (on file) until they apply for Medicaid. At that time, a current DA-124A/B form is completed, attached to the original DA-124C form, and mailed to the same address as in section A, #1.

C. NURSING FACILITY TRANSFERS—

1. When persons transfer from one skilled/intermediate nursing facility to another, the sending facility furnishes a copy of their DA-124A/B & C forms to the receiving facility. The receiving facility then notifies their local FSD office of the transfer.

2. When persons transfer from one skilled/intermediate nursing facility to another and application for Medicaid is not indicated, the ORIGINAL DA-124C form must follow to the next facility.

D. TRANSFERS FROM A FACILITY TO A HOSPITAL TO ANOTHER FACILITY—

1. When the person transfers from one skilled/intermediate facility to a hospital, then to another skilled/intermediate facility, hospitals must consider the following prior to placement:

a. If the person did not need a Level II Screening prior to placement at the sending facility, no new forms are indicated if this hospital stay does not exceed 60 days (unless a current Level I Screening indicates the need for a Level II Screening).

b. If the person had a Level II Screening prior to placement at the sending facility, but is being hospitalized for acute medical treatment, no new forms are necessary if the hospital stay does not exceed 60 days.

c. If the person had a Level II Screening prior to placement at the sending facility, and this hospitalization involves a change in the person's mental status, the hospital completes a new DA-124C form, and writes CHANGE IN MENTAL STATUS at the top of the form prior to transferring the person back to (or on to the next) skilled/intermediate nursing facility (if the person stays less than 60 days). That nursing facility sends the new form to COMRU, as in section A, #1. NOTE: If the person stays more than 60 days, the HOSPITAL completes new set of DA-124A/B & C forms (as in section A, #1) and waits for completion of the Level II Screening.

E. PERSON IS DISCHARGED HOME BUT UNABLE TO STAY—

1. If person is out of facility less than 60 days, no new forms are required. Notify local FSD office of person's readmission.