

2016

HCBS Assessment Manual



Bureau of TennCare
Long Term Services and Supports
7/1/2016

INTRODUCTION:

Persons who will be assessed through this process are individuals who have applied for home and community based services through the CHOICES program and are not currently located in a Nursing Facility. This also includes persons applying for Employment and Community First (ECF) CHOICES which is a program for individuals with intellectual and/or developmental disabilities. CHOICES program offers individuals who are eligible for Long-Term Care services the choice to receive those services in the community as an alternative to nursing facility placement.

The Bureau of TennCare has many partners that are contracted to conduct assessments and interviews to assist in determining an individual's appropriate level of care need. This level of care need is determined through the pre-admission evaluation (PAE) process. The documents contained herein will be required medical documentation to be submitted in conjunction with the PAE.

This process is very important as it ensures an independent, conflict-free method of gathering and synthesizing information to be used as medical evidence in support of completed Pre-Admission Evaluation (PAE) submitted to TennCare for purposes of establishing eligibility for reimbursement of Long Term Services and Supports (LTSS), including Nursing Facility (NF) services and Home and Community Based Services (HCBS) received as an alternative to NF services. When approved, a PAE may also result in approval of Medicaid institutional eligibility and in a capitation payment to the Managed Care Organization (MCO) as well as payment of claims for physical and behavioral health, pharmacy and LTSS. It is therefore critical that the information submitted on a PAE and the supporting medical evidence is complete and accurate, and does not result in payments being inappropriately authorized to an MCO or to the NF or other health care providers. Finally, the assessment you conduct enables the Bureau of TennCare to meet its fiscal and clinical imperatives of ensuring that persons are matched to the most appropriate and least resource intensive levels of care to meet their needs.

LTSS HCBS Qualified Assessor: TennCare LTSS will only accept the HCBS PAEs assessed by individuals who have been deemed a HCBS CHOICES Qualified Assessor or an HCBS ECF Qualified Assessor (regardless of TPAES submitter). This qualification will be assigned by LTSS for each individual that meets the LTSS HCBS CHOICES Qualified Assessor and LTSS HCBS ECF Qualified Assessor requirements and will be given a unique assessor code. This code must be documented on the PAE with the Assessor Certification signature. LTSS requirements for HCBS CHOICES Qualified Assessors and HCBS ECF Qualified Assessors are as follows:

- Must complete the HCBS CHOICES Qualified Assessor Training or HCBS ECF Qualified Assessor Training and pass the test given at the training. Online trainings will be offered monthly or on an as needed basis.
- An annual online refresher test is required to renew HCBS CHOICES Qualified Assessor and HCBS ECF Qualified Assessor status and codes. If annual refresher test is failed, the individual must complete the HCBS CHOICES Qualified Assessor Training or HCBS ECF Qualified Assessor Training and pass the test to receive ongoing assessor status and code.
- Codes will be tracked at TennCare, per assessor, and will be reviewed to ensure correct usage.

ASSESSMENT COMPONENTS AND INSTRUCTIONS:

- The documentation provided on the assessment tools should be considered documentation by exception. This means that it would be understood to be a variation in the "norm" in each area if documented on the tool.

- Print legibly. All errors are to be corrected with single line, error and initials. Do not use whiteout. Do not write over an error.
- Do not leave blanks. Note "N/A".
- Ask the applicant to have medication bottles ready for you.
- Ask the applicant to have any person who provides them assistance with care present at the time of the interview. If the applicant has a conservator or guardian, ask if they can be present at the interview. In the case that is not convenient, please ask that they have current contact information for those who are not available.
- You should not read the questions verbatim but ask them in such a way that the applicant and collaterals understand exactly what is being asked. Use layperson terminology as appropriate to avoid any confusion or misunderstanding.

Each HCBS CHOICES and PACE PAE application must include:

- 1) The Applicant Interview Tool (att 1): to be used for information gathering from the applicant only;
- 2) The Collateral Interview Tool (att 2): to be used when gathering information from any relevant party other than the applicant;
- 3) A recent history and physical or current medical records that includes a diagnosis to support the Applicant's functional and/or skilled nursing or rehabilitative needs, as reflected in the PAE. Medical records or a history and physical performed within 365 calendar days of the PAE Submit Date may be used if the Applicant's condition has not significantly changed;
- 4) For requested skilled services the appropriate required documentation for each skilled service (att 3); and
- 5) If applicable, the safety determination request form (att 4).

Each ECF PAE application must include:

- 1) The Applicant Interview Tool (att 1): to be used for information gathering from the applicant only;
- 2) The Collateral Interview Tool (att 2): to be used when gathering information from any caregiver or other relevant party (other than the applicant);
- 3) The Life Skills Assessment (att 5);
- 4) For applicants with intellectual disabilities, a psychological examination with IQ score or other supporting documentation;
- 5) For requested skilled services the appropriate required documentation for each skilled service (att 3); and
- 6) If applicable, the ECF safety determination request form (att 6) and ICAP Maladaptive Behavioral Assessment and score.

Interview Tips

- A good clinical interviewer is also always on the lookout for both themes and discrepancies. Themes help you note and describe patterns across time. These patterns may be critical to understanding both how to leverage the person's strengths and to understanding how best to support the person to prevent patterns of difficulties. You should never "lead" respondents toward a particular answer, but you are encouraged to ask for descriptions and clarifications that will help the respondent or you to resolve discrepancies. Being on the lookout for discrepancies ensures that you note and get clarification when information "just doesn't add up".

- It is important that you avoid using ‘buzz words’, generalizations, or reporting opinions instead of descriptions and observations. It is important on the Collateral Interview Tool, that you describe each item to the collateral respondents, and accurately report their report of the individual’s functional and medical status. In your commentary, you are to provide objective, extensive and clear descriptions of the person’s medical, functional and behavioral status. When describing behavioral symptoms, remember that the same behavioral symptoms can present very differently for each person. One person’s experience of “agitated” can involve violent or aggressive behaviors, while another person’s experience may involve irritability, lack of sleep and extreme restlessness. It is important to describe in detail what behaviors, support needs, etc. look like *for that person*. Tell the story of their current presentation.
- Review the document with the respondent or ask the collateral to read over what you have documented on the Collateral Interview Tool. Have the respondent/collateral sign the Collateral Interview Tool and date it. After this signature is obtained, you cannot go back and change any information within the document.
- If the respondent/collateral/caregiver is giving the interview by phone, review with them what you have documented on the Collateral Interview Tool and then sign that you received their acceptance of all information contained within the document.
- When interviewing licensed staff, note their title and/or credentials. At times you are interviewing contracted staff representing an agency. It is the responsibility of the interviewer to assure that information recorded on the interview form reflects an accurate picture of the individual’s needs. Please query and clarify respondent reports if it appears that information given may reflect respondent or agency bias rather than the individual’s objective needs.
- When interviewing licensed staff, note their title and/or credentials.
- Think about it. Does the assessment form provide a clear, detailed and consistent picture of the individual’s functional status?
- The best advice for a great clinical interview is to collect individualized, detailed information from a variety of sources to ensure that the individual’s unique needs and characteristics are reflected. The quality of this process is directly correlated to the quality of your clinical interview.

Applicant Interview Tool

Section A: Demographics

Applicant’s Name- The applicant’s **legal** last name, first name and middle initial. **Ensure spelling accuracy.** The applicant last name and first initial at the top of the form should match.

Date of Birth- Provide full date of birth, Month/Day/Year.

SSN- Full social security number

Age- Actual age of the applicant. Verify with medical records or caregiver interview.

Gender- Male or Female

Assessment Date-Month/Day/Year

Assessment Time- Time of assessment, please indicate am or pm

Applicant's Address: Identify where the individual lives.

County: County of residence. Clarify the county, as cities overlap counties, i.e. Goodlettsville is in both Davidson and Sumner counties.

Where is the Applicant currently located? Please mark the appropriate box

With whom does the applicant live? Please mark the appropriate box

Present during interview: Please mark the appropriate box or document other

Describe how you were contacted and the services requested by applicant/ family member- Describe the initial contact and what services are being sought.

Medical Records to be submitted with the PAE- Reference what records you will submit with the assessment.

Note: It is extremely important when interviewing the applicant that you record only the applicant's responses and your direct observations of the individual. There should be no documentation of comments and/or information given by anyone other than applicant on the Applicant Interview Tool. Anything noteworthy said by someone else (family, caregiver, professional), should be documented on the Collateral Interview Tool.

Section B: Functional Assessment

It is important to remember when completing the functional assessment that we are looking at the need for assistance. Answer all questions, leave no blanks. You must use the TennCare interpretation provided below when soliciting a response. Remember that the need for assistance at least one time in a day counts as assistance required for that day. TennCare definition and interpretation of response options for these items are as follows:

- ❖ Always: Always performs function independently
- ❖ Usually: requires assistance only 1-3 days per week
- ❖ Usually Not: requires assistance 4 or more days per week
- ❖ Never: Never performs function independently

Please note: For the area of Behaviors the definition listed above is reversed meaning:

- ❖ Always: Always requires intervention (daily)
- ❖ Usually: Usually requires intervention 4 or more days per week
- ❖ Usually Not: requires intervention only 1-3 days per week
- ❖ Never: Never requires intervention

1. TRANSFER

Interview Questions:

- **Are you able to:**

**Sit down and get up from a chair by yourself? Get in and out of bed by yourself?
Get on/off the toilet by yourself?**

Comments: If the answer is not "Always" and the applicant lives alone – how do they manage when

no one else is there?

- **Do you require physical assistance with any of the above?** Mark the response the applicant gives.
- **Who provides this assistance?**
- **Describe how the person assists you**
- **If physical assistance from another person is indicated; how many days per week?**

Supporting Medical Condition(s)

Transfer Observations: Document what you see and hear in the observations section. For example, an applicant may report that they can get in and out of bed by themselves, but they are not able to sit up by themselves. An applicant may say they cannot get in and out of bed by themselves but they met you at the door and walked to the living room with you.

2. MOBILITY

Interview Questions:

- **Are you able to walk (with or without assistive devices)?**
- **Are you able to use a wheelchair independently (manual or electric)?**

Mark exactly what the applicant tells you.

- **Do you require physical assistance from another person with mobility?**
- **Who provides assistance?**
- **Describe how the person assists you**
- **If physical assistance from another person is indicated; how many days per week?**

Assessor observation of applicant's gait: document what you observe, if you observe the mobility of the applicant.

Supporting Medical Condition(s)

Mobility Observations: Provide your observations to clarify the functional abilities of the individual (e.g., the applicant may tell you they never leave home except on Saturday when they drive to the store to get groceries. This would be very important information to help clarify the individual's capabilities). Conversation with the applicant can yield important descriptions about the individual's capabilities and inabilities. Note assistive devices utilized or available and not utilized.

3. EATING

Interview Question:

- **Are you able to eat prepared meals by yourself? If No, do you require assistance?**
- **Who provides assistance?**
- **What kind of assistance does this person provide?**
- **If assistance from another person is indicated; how many days per week?**
- **Do you have a feeding tube? If yes, are you able to administer tube feedings independently?**
Please do not assume that just because someone has a feeding tube they are dependent upon someone else for tube management. **If no, how many days per week for you require physical assistance with your tube feedings?**

When asking these questions encourage the applicant to tell his/her story. Never answer for him/her or give prompts. You are specifically inquiring about whether the person can apply food to a fork/spoon and raise the fork/spoon to his/her mouth and eat. Can they functionally eat?

Supporting Medical Condition(s)

Eating Observations: Document any additional information which you feel would be appropriate in describing the functional ability for this applicant to eat. Particularly identify any contradictions in reported information.

4. TOILETING

Interview Questions:

- ***Are you able to clean yourself, including adjusting clothing, after toileting?***

If No, number of days per week. If no, who provides this assistance?

Describe how the person assists you

You will add additional information in the observations section.

Continence Support: Mark all that are applicable. The identified items are routinely used incontinence supplies. If you find the person is performing self-catheterization, you may add in the comments section how often they self cath.

- ***Do you have bowel incontinence?***

This is a yes or no question and should include frequency of incontinence.

- ***Do you have bladder incontinence?***

This is a yes or no question and should include frequency of incontinence. If increased incontinence at a particular time you would add to this section (e.g., "I urinate when I cough"). This may be helpful documentation as this would be described as stress incontinence episodes.

- ***Are you able to clean yourself, including adjusting clothing, after an incontinence episode without physical assistance from another person?***

If No, who provides the assistance? Describe how the person assists you

- ***Do you use a catheter?***
- ***Do you have an ostomy?***
- ***If yes to either catheter/ostomy, can you manage without physical assistance from another person?***
- ***Who provides this assistance? Describe how the person assists you***

Supporting Medical Condition(s)

Toileting Observations: Use this section to add any information you have observed that may help "paint the picture" by what the applicant has told you. Remember this interview is only for information given by the applicant. You should not be documenting anything other than what the applicant tells you and what you have observed.

5. ORIENTATION

Prior to starting the orientation portion of this interview, inform the applicant that some of the questions may seem unnecessary but are a required part of the interview. Keep in mind this is not a behavioral health interview, you are looking strictly at functional abilities. It is important to build rapport to help the individual remain comfortable and candid. Many times someone with an orientation issue becomes skilled at covering up confusion. Ensure that anyone else present is informed that *these are questions just for the Applicant*. Always remember to be thoughtful and give the applicant time to respond to questions. If there are any questions which are not applicable, you should always write N/A. This will reflect that you have addressed all questions.

Interview Question:

- ***Person***

What is your full name? Document exactly what the person tells you. Indicate if this is correct or incorrect

Can you name the other people in the room or can you name the people from photographs in the room? Document exactly what the person tells you. Indicate if this is correct or incorrect

Information confirmed with (must be confirmed)? It is always important to confirm the information the applicant gives you with someone who knows whether or not the responses are correct.

- **Place**

What city/ town are you in? Write exactly what the applicant gives as a response. If s/he does not know, document that. Indicate if this is correct or incorrect.

Can you tell me where you live? Write exactly what the applicant gives as a response. If s/he does not know, document that. Indicate if this is correct or incorrect.

Information confirmed with? It is always important to confirm the information the applicant gives you with someone who knows whether or not the responses are correct.

- **Event/Situation**

Describe what you would do in case of an emergency

Information confirmed with (information must be confirmed)?

Is assistance required with orientation? If yes, number of days per week?

Who provides this assistance? Describe how this person assists you

Supporting medical condition(s) specific to orientation?

Orientation Observations: Use this section to add any information you have observed that may help “paint the picture” by what the applicant has told you. Remember this interview is only for information given by the applicant. You should not be documenting anything other than what the applicant tells you and what you have observed.

6. COMMUNICATION

In this section your focus will be to interview and observe the applicant’s communication abilities. You will be asking for a demonstration of these skills.

Interview Question:

Can you make people understand when you need something? Ask the applicant to respond yes or no. If the individual provides further information which you find useful in clarifying the individual’s capabilities and/or limitations, add that information to the communication observations section at the end of Section 6.

Speech Impairment: This is strictly from your observation.

Hearing: Hearing is assessed from your observations. Consider your efforts to communicate with the individual when responding to this section (e.g., Have you had to make your voice louder throughout the interview to successfully communicate?).

Vision: Select the appropriate box.

Give applicant a simple command within their functional ability (raise right hand, touch nose, point to your pen) and document their ability to follow this simple command. This is assessing both the individual’s receptive communication and his/her ability to respond to simple commands.

Does the applicant say at least ten words that can be understood by someone who knows him/her or as observed during the interview process? Do not ask the applicant to repeat ten words, this question should be completed by observations during the interview process.

Did there appear to be any communication deficits while completing this interview?

Did the applicant use communication assistive device(s) (e.g., Ipad, picture board)? If yes, list type

Supporting Medical Condition(s)

Communication Observations: Use this area to document any observations which you feel would help provide an accurate picture of the individual's status and needs (e.g., Applicant was observed with slurred, slow speech which at times required that the assessor's understanding of responses to be confirmed with the individual).

7. BEHAVIOR

Assessor Observed Behavior: Briefly describe in the *behavioral observations* section why you marked the box (es). We ask that you document your objective observations versus your opinions. It is easy to document an opinion regarding what you see versus an observation. Be sure to be objective and specific regarding the behavior you observe and record. For example, if an applicant gives consistent short answers, one interpretation might be that the individual was "angry/irritable", and another might be that the individual was very private and reluctant to answer questions. Ensure that the individual's actions, verbal content, body language, cultural considerations and other factors are objectively reviewed when recording your observations of the individual's behavior.

Level of consciousness: Please be sure to accurately assess the level of consciousness as observed.

Is there a diagnosis which would lead to a cognitive impairment? If yes, list the diagnosis

Remember that this is not a mental health evaluation; it is strictly to document the functional abilities of the applicant. This is a medically focused interview questionnaire.

Behavioral Observations: Comments about social situations should not be included. E.g. prior living conditions, future living arrangements, financial issues, etc. This is a physical assessment, not a social assessment.

8. MEDICATIONS

Medications (includes: PO, IV, IM, Enteral, optics, topicals, inhalers, continuous SQ pain pump). This section refers to chronic medications only and not short term or acute medications. **NOTE: Refusal or medication noncompliance is not be interpreted as being mentally incapable. You are documenting only what you observe, you are not making a determination.**

Interview Question:

Are you physically or cognitively able to self-administer physician prescribed medications by the routes listed below at the time prescribed? Self-administration does not include reminding when to take medications, encouragement to take, reading medication labels, opening bottles, having them handed to the applicant, and/or reassurance of the correct dose). ***If not, please indicate the prescribed medication on the line provided. If none prescribed via that route, please mark NA as appropriate.***

Document the exact response the applicant gives you. This is **not** the item in which to note your observations. If not applicable, mark NA to reflect that you addressed this area.

- *Pills/Tablets* Yes, No or NA
- *Eye drops* Yes, No or NA
- *Inhaler/Nebulizer* Yes, No or NA

- *Topicals/Patches* Yes, No or NA
- *Injections (excluding SS insulin)* Yes, No or NA
- *Meds via Tube (G Tube, J tube, NG tube...)* Yes, No or NA

If yes to any of the above; what assistance is provided?

Who provides the assistance?

If No to any of the above, who provides this assistance? Number of days per week?

Describe assistance required

Supporting Medical Condition(s)

Medication Observations: Document your observations. Be specific in reporting what you observed, while remembering that you are not writing your opinion. E.g., you might write: While the applicant reported she was prescribed eye drops there were none in the house and when the daughter arrived to assist with medications, she did not administer any drops.

Are you receiving any treatments that are ordered by a physician to be performed by a licensed Nurse/ Therapist? Please respond yes or no and describe the services in the space provided. This would be any kind of service in the home that the applicant would like to have considered when looking at approval for Choices services (PT, OT, tracheal suctioning, ventilator services...)

** For services listed here, if you have attached the required documentation, a collateral interview with the persons providing the service(s) will not be required.

Section C: Applicant or Designee Signature

I HEREBY ATTEST THAT I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED ON THIS DOCUMENT AND IT ACCURATELY REFLECTS THE RESPONSES I HAVE GIVEN DURING THIS ASSESSMENT. I ALSO UNDERSTAND THAT THE COMMENTS AND OBSERVATIONS ARE THOSE OF THE QUALIFIED ASSESSOR.

The assessment must be completed while you are in the home. Review what you have written with the applicant or designee prior to them signing. Be sure the date is the same date as the interview.

Section D: Assessor Credentials and Signature

You are attesting that: BY MY SIGNATURE, I AGREE THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION MAY BE USED TO DETERMINE MEDICAID ELIGIBILITY AND MAY ALSO BE USED BY A JUDGE TO MAKE A HEARING DECISION. I FURTHER UNDERSTAND THAT PEOPLE WHO LIE AND PROVIDE FALSE INFORMATION THAT WOULD POTENTIALLY RESULT IN A PERSON OBTAINING TENNCARE SERVICES TO WHICH HE/SHE IS NOT ENTITLED IS CONSIDERED AN ACT OF FRAUD AND MAY BE FINED OR SENT TO JAIL.

The assessment must be completed while you are in the home. Review what you have written with the applicant prior to signing. Your signature should always be legible and in black ink. If you cannot read it, no one else can. Print your name above your signature. Be sure you are putting the same date you are doing the assessments. There should be no conflicts of dates. Always provide your unique

Assessor Code on the interview tool; tool may be refused without this code. Remember “if you did not document it, you did not do it.” Reread the document prior to signing. This will ensure all areas have been addressed.

Collateral Interview Tool

The more knowledgeable your interview sources are the more accurate and reliable the outcomes of the interview will be; information from multiple respondents who know an individual well lead to more reliable and accurate findings than information from a single interview source. You must always complete a collateral interview with **anyone** identified as a provider of assistance/ care on the applicant tool. We ask that you make every attempt to contact knowledgeable collateral sources if permitted by the individual or designee. Failed attempts must be well documented.

While interviews with the applicant must be conducted in person, collateral source interviews may be conducted in person or by phone. You may need to call at a time other than normal work hours in order to conduct and/or schedule an interview.

Key considerations associated with the caregiver/ healthcare professional collateral interview:

When interviewing licensed staff, note their title and/or credentials. At times you are interviewing contracted staff representing an agency. It is the responsibility of the interviewer to assure that information recorded on the interview form reflects an accurate picture of the individual’s needs. Please query and clarify respondent reports if it appears that information given may reflect respondent or agency bias rather than the individual’s objective needs.

RESPONSE DEFINITION AND INTERPRETATION

You must use the TennCare interpretation provided below. Explain these criteria to the caregiver. If the caregiver experiences difficulty among response options, ask that they select the answer that best reflects the individual’s overall ability. Mark exactly what the caregiver answers. Once you have provided explanations, **do not lead the respondent toward a particular answer in any way**. You may repeat the description of the item and of all item responses, but you may not suggest one answer over another answer in any way. TennCare definition and interpretation of response options for these items are as follows:

- ❖ Always: Always performs function independently
- ❖ Usually: requires assistance only 1-3 days per week
- ❖ Usually Not: requires assistance 4 or more days per week
- ❖ Never: Never performs function independently

Please note: For the area of Behaviors the definition listed above is reversed meaning:

- ❖ Always: Always requires intervention (daily)
- ❖ Usually: Usually requires intervention 4 or more days per week
- ❖ Usually Not: requires intervention only 1-3 days per week
- ❖ Never: Never requires intervention

Who should be interviewed?

- Family member providing care
- Care attendants

- Paid hands on caregivers, i.e., nurses, techs, PT/ OT...
- POA or designee
- ✓ All of the above

How should the interview be conducted?

- Either in person or telephonically
- If interviewing a paid professional, in person, allow them to fill out the form themselves, clarify any discrepancies with them and ensure they sign the form.
- If interviewing a paid professional telephonically, make sure you read back all responses to ensure accuracy and fill out the attestation appropriately.

If interviewing a family member, neighbor, son, daughter, layperson, complete the interview tool for them ensuring they understand all the questions and terms. Clarify any discrepancies and ensure they sign the form.

SECTION I: TRANSFER/ MOBILITY

Choose the response that matches what the collateral reports. You may repeat the description of the item and of all item responses, but you may not suggest one answer over another answer in any way. Answer all questions in this section using the check boxes provided.

Is He/She able to:

- *Rise from a chair independently?*
- *Get on and off the toilet independently?*
- *Get in and out of bed independently?*
- *Walk independently without physical assistance from another person? If UN or N, can he/she use a wheelchair independently, either manual or electric?*

Usual method of mobility?

Assistive devices?

Gait Description (pace, steadiness) Ask the Caregiver to describe how the applicant walks (e.g., slow, steady or unsteady, holds to furniture for support, etc.).

Is this applicant able to walk or operate wheelchair without physical assistance from another person? If no, # of days per week physical assistance is required and share additional information in the comments section.

What medical condition(s) does he/she have to support the need for physical assistance with Transfer/Mobility?

Transfer/Mobility Comments: Address any information the caregiver may share regarding the mobility and transfer abilities of the applicant that are not defined by the questions. This should be written using comments of the respondent. You may also document any comments you assess to be helpful in “painting the picture” of the applicant. Note assistive devices utilized or available and not utilized.

SECTION II: EATING/TOILETING

Document exactly what the caregiver answers. You may ask the caregiver to describe the individual's ability to perform a skill. However, do not guide or influence the caregiver's answer.

Is He/She able to:

- **Eat prepared meals without assistance from others? If no, number of days per week?**
- **Administer tube feedings independently? If no, number of days per week?**

If assistance is indicated, describe the type of assistance provided

What medical condition(s) does he/she have to support the need for physical assistance, constant one-on-one observation and verbal assistance?

Is He/She able to:

Toilet Independently? If no, number of days per week? Can they perform the function needed?

Maintain continence of bladder? Yes or No question, ask frequency if no.

Maintain continence of bowel? Yes or No question, ask frequency if no.

Clean self after incontinence episode? Does the applicant change incontinence supplies his/herself or does s/he require some level of assistance.

Does applicant use a catheter?

Does applicant have an ostomy? If yes, how often is assistance required?

Eating/Toileting Comments: If partial assistance required or unable to perform, describe the required assistance and number of days per week. Write any comments which the caregiver had made to help in "painting the picture" of the applicant. Do not make judgments; rather, simply state facts of observations, caregiver's reports, etc.

SECTION III: ORIENTATION/COMMUNICATION/ BEHAVIOR (INTERPRETIVE CRITERIA)

Describe any episodes of confusion or disorientation – are there specific times of day, if so how many days per week? Describe specific behaviors.

Orientation

Is He/She:

- **Oriented to name?**
- **Able to identify family members?**
- **Oriented to place?**
- **Aware of current circumstances in order to make decisions that prevent risk of harm?**

If any answer other than Always, please provide specific examples

Orientation Comments: As with the Applicant Interview Tool, the comment sections are for you to provide objective or observational information gained from your collateral interview. These sections are strictly for recording comments and observations that arose from the collateral interview. Do not use the comment section of the Collateral Interview Tool to reiterate information already recorded on the Applicant Interview Tool. You are to document on the Collateral Interview Tool, information from collateral interview only.

Communication

Is He/She:

- Able to follow simple directions?
- Communicate basic needs with or without assistive aid?

Communication Comments: As with the Applicant Interview Tool, the comment sections are for you to provide objective or observational information gained from your collateral interview. These sections are strictly for recording comments and observations that arose from the collateral interview. Do not use the comment section of the Collateral Interview Tool to reiterate information already recorded on the Applicant Interview Tool. You are to document on the Collateral Interview Tool, information from collateral interview only.

Behavior

Does the applicant require persistent behavioral intervention/supervision?

Describe the established and persistent behaviors which are not primarily related to a mental health condition or substance abuse disorder

Describe the persistent staff or caregiver intervention/supervision required/provided

If behavioral intervention/supervision is indicated, who is presently providing this intervention?

Behavior Comments: As with the Applicant Interview Tool, the comment sections are for you to provide objective or observational information gained from your collateral interview. These sections are strictly for recording comments and observations that arose from the collateral interview. Do not use the comment section of the Collateral Interview Tool to reiterate information already recorded on the Applicant Interview Tool. You are to document on the Collateral Interview Tool, information from collateral interview only.

SECTION IV: MEDICATIONS

Interview collateral about the ability of the applicant to take his/her medications and assistance needed, if any. Do not lead or answer for the collateral. Please make sure to always obtain information regarding medications from the individual responsible for dispensing those medications as appropriate. Please provide their identifying information including credentials, if applicable, in the space provided. In addition, the person supplying information regarding medications if this person is not the same as the person providing the rest of the information, will need to sign the last page of the tool on the line that reads, "Signature of person providing **medication** information".

Is He/She able to take prescribed medication (pills) from a medcup/hand, get them to their mouth, and swallow them (refusal doesn't indicate inability) on the appropriate schedule?

Is He/She receiving any injections (not including sliding scale insulin), topicals, eye drops, or inhalers? If yes, are they able to self-administer? If no, number of days per week assistance is required

If no to any of the above, describe intervention(s)

Medication Comments: If unable to self-administer, describe physical limitations and number of days physical assistance is needed. Include any additional information the caregiver may give during this interview regarding medication administration

SECTION V: SIGNATURE

BY MY SIGNATURE, I AGREE THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION MAY BE USED TO DETERMINE MEDICAID ELIGIBILITY AND MAY ALSO BE USED BY A JUDGE TO MAKE A HEARING DECISION. I FURTHER UNDERSTAND THAT PEOPLE WHO LIE AND PROVIDE FALSE INFORMATION THAT WOULD POTENTIALLY RESULT IN A PERSON OBTAINING TENNCARE SERVICES TO WHICH HE/SHE IS NOT ENTITLED IS CONSIDERED AN ACT OF FRAUD AND MAY BE FINED OR SENT TO JAIL.

The assessment must be completed while you are interviewing the respondent(s). Review the document with the respondent or ask the collateral to read over what you have documented on the Collateral Interview Tool. Reiterate the attestation statement. Have the respondent/collateral sign the Collateral Interview Tool and date it. After this signature is obtained, you cannot go back and change any information within the document. Remember, this is a signed legal document. If the respondent/collateral/caregiver is giving the interview by phone, review with them what you have documented on the Collateral Interview Tool and then sign that you received their acceptance of all information contained within the document. As the assessor you must sign and include your credentials and qualified assessor code at the bottom of the form.

Using the tools to complete the PAE

Once you have completed the applicant tool and collateral tools with all individuals who provide care and have obtained a recent H&P, you should have a very clear clinical picture of this individual's functional abilities and are now ready to complete the PAE. You should thoroughly review all the gathered documentation to make sure there are no areas of question; all discrepancies should have been remediated during the assessment process. If there are pieces of conflicting information, those areas should be clarified either by obtaining additional documentation or by completing additional collateral interviews. Once you have clear and concise information you will assimilate the information and mark the functional assessment on the PAE using the documentation as your guide. For every response you mark on the functional assessment, ask yourself the question, "Does my documentation support this response?" If the answer is no, then chances are that TennCare will think the same.

When you have completed your onsite assessment, you should have a very good idea of how the individual will score on the functional assessment. Mark the responses on the PAE which reflect the functional abilities as you observed and as reflected in the documentation. Rely on your skilled clinical knowledge, effective observation and assessment skills and the preponderance of the documentation to assist you in completing the PAE. Upload and attach all of the documents to the PAE prior to submitting to TennCare. Please label each attachment clearly. It is important to make certain that your unique assessor code is on the documents along with your signature and this information is also reflected on the certification tab in TPAES.

Attachment 1

Applicant Interview Tool

APPLICANT INTERVIEW



SECTION A: DEMOGRAPHICS

Applicant's Name _____ Date of Birth ____ / ____ / ____

SSN _____ Age _____ Gender: Male Female Assessment Date ____ / ____ / ____

Applicant's Address _____ Assessment Time ____ : ____ am / pm

City _____ State _____ Zip _____ County _____

Where is Applicant currently located?

<input type="checkbox"/> Hospital	<input type="checkbox"/> Nursing Facility
<input type="checkbox"/> Home alone	<input type="checkbox"/> Home with family
<input type="checkbox"/> Group Home	<input type="checkbox"/> ICF/IID
<input type="checkbox"/> Assisted Care Living Facility	<input type="checkbox"/> Other CBRA
<input type="checkbox"/> Other: _____	

Where does applicant live?

<input type="checkbox"/> Home alone	<input type="checkbox"/> Home with parents
<input type="checkbox"/> Home with other family	<input type="checkbox"/> Group Home
<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> ICF/IID
<input type="checkbox"/> Assisted Care Living Facility	<input type="checkbox"/> Other CBRA
<input type="checkbox"/> Other: _____	

Present during interview: Family Individual Caregiver Home Health Guardian Other: _____

Describe how you were contacted and the services requested by applicant/ family member:

Medical Records to be submitted with assessment: None Home Health Records Hospital Records MD Records
 NF Chart ICAP maladaptive behavior assessment and score
 TABI Psychological Exam or other related documentation to support ID diagnosis
 Other _____

Section B: Functional Assessment

LEGEND

With the exception of behaviors (behaviors using the opposite scale) the following applies:

Always = Applicant can always perform the function without assistance.

Usually = Applicant requires assistance 1-3 days per week.

Usually not = Applicant requires assistance 4 or more days per week.

APPLICANT INTERVIEW



Never = Applicant can never perform the function without assistance.

1. TRANSFER

Interview Questions:

Are you able to:

Sit down and get up from a chair by yourself? Always Usually Usually Not Never

Get in and out of the bed by yourself? Always Usually Usually Not Never

Get on/off toilet by yourself? Always Usually Usually Not Never

Do you require **physical assistance from another person** with any of the above? Yes No

Who provides this assistance? _____ Describe the assistance needed/ provided: _____

If physical assistance from another person is indicated; how many days per week? 1-3 4-6 7 NA

Supporting Medical Condition(s): _____

Transfer Observations: _____

2. MOBILITY

Interview Questions:

Are you able to walk (with or without assistive devices)? Yes No With Without

Are you able to use a wheelchair independently (manual or electric)? Yes No

Do you require **physical assistance** from another person with mobility? Yes No

Who provides assistance? _____ Describe how the person assists you _____

If physical assistance from another person is indicated; how many days per week? 1-3 4-6 7 NA

Assessor observation of applicant's gait:

Steady Shuffling Limp Unsteady Balance problems not observed

Deformities (specify) _____ Limb loss (specify) _____

Prosthesis (specify type and if used or not) _____

Supporting Medical Condition(s): _____

Mobility Observations: _____

APPLICANT INTERVIEW



3. EATING

Interview Question:

Are you able to eat prepared meals by yourself? Yes No

If no, do you require assistance? Yes No Who provides assistance? _____

What kind of assistance does this person provide? Physical feeding Verbal assistance one on one observation

If assistance from another person is indicated; how many days per week? 1-3 4-6 7 NA

Do you have a feeding tube? No Yes if yes, are you able to administer tube feedings independently? Yes No

If no, how many days per week do you require **physical assistance** with your tube feedings? 1-3 4-6 7 NA

Supporting Medical Condition(s): _____

Eating Observations: _____

4. TOILETING

Interview Questions:

Are you able to clean yourself, including adjusting clothing, after toileting? Yes No

If no, # days per week: 1-3 4-6 7

If no, who provides this assistance? _____

Describe how the person assists you: _____

Maintain continence of bladder? No Yes if no, # days per week: 1-3 4-6 7

Maintain continence of bowel? No Yes if no, # days per week: 1-3 4-6 7

Are you able to clean yourself, including adjusting clothing, after an incontinence episode without physical assistance from another person? Yes No

If no, who provides this assistance? _____ Describe how the person assists you: _____

Do you use a catheter? Yes No NA

Do you have an ostomy? Yes No NA

If yes to either catheter/ostomy, can you manage without physical assistance from another person? Yes No

Who provides this assistance? _____ Describe how the person assists you: _____

Supporting Medical Condition(s): _____

Toileting Observations: _____

APPLICANT INTERVIEW

5. ORIENTATION

Interview Questions:

Person

What is your full name? _____ Correct Yes No

Can you name the other people in the room? Yes No NA Correct? Yes No NA

OR

Can you name the people from photographs in the room? Yes No NA Correct? Yes No NA

Information confirmed with: _____

Place

Can you tell me where you are? _____ Correct Yes No

What is your street address/ room number? _____ Correct Yes No

What city/ town are you in? _____ Correct Yes No

Information confirmed with: _____

Event/Situation

Describe what you would do in case of an emergency: _____

Information (must be confirmed) confirmed with: _____

Is assistance required with orientation? Yes No If yes, # of days per week 1-3 4-6 7

If yes, who provides this assistance? _____

Describe how this person assists you: _____

Supporting medical condition(s) specific to orientation: _____

Orientation Observations: _____

6. COMMUNICATION

Interview Questions:

Can you make people understand when you need something? Yes No **Speech Impairment:** Yes No

Hearing : Adequate with/without devices Not Adequate with/without devices

Vision: Adequate with/without corrective lens Not adequate with/without corrective lens

Give applicant a simple command within their functional ability (raise right hand, touch nose, point to your pen) and document ability to follow simple command: _____

Does the applicant say at least ten words that can be understood by someone who knows him/her or as observed during the interview process?

APPLICANT INTERVIEW



Did there appear to be any communication deficits while completing this interview? _____

Did applicant use communication assistive device (e.g., Ipad, picture board)? Yes No

If yes, list type: _____

Supporting Medical condition(s): _____

Communication Observations: _____

7. BEHAVIOR

Assessor Observed Behavior:

- Cooperative
- Angry/irritable
- Withdrawn

- Uncooperative
- Sociable

Level of Consciousness:

- Awake Drowsy Alert
- Oriented to: Person Place

Is there a diagnosis which would lead to a cognitive impairment? Yes No If yes, list the diagnosis: _____

Behavioral Observations: _____

8. MEDICATIONS (INCLUDES: PO, IV, IM, ENTERAL, OPTICS, TOPICALS, INHALER, AND CONTINUOUS SQ PAIN)

Interview Questions:

Are you physically or cognitively able to self-administer physician prescribed medications by the routes listed below at the time prescribed? (Self-administration does not include reminding when to take medications, encouragement to take, reading medication labels, opening bottles, having them handed to you and/ or reassurance of the correct dose.) **If no, please indicate the prescribed medication on the line provided. If none prescribed via that route, please mark NA as appropriate.**

Pills/Tablets Yes No NA _____

Eye drops Yes No NA _____

Inhaler/Nebulizer Yes No NA _____

Topicals/Patches Yes No NA _____

Injections Yes No NA _____

Meds via Tube (G Tube, J tube, NG tube...) Yes No NA

If no to above, who provides this assistance? _____ # days per week 1-3 4-6 7 NA

APPLICANT INTERVIEW



Describe assistance required: Reminders Encouragement Reading Labels Opening Bottles
 Someone hands them to me preparation of medication box Other: _____

Supporting Medical Condition(s): _____

Medication Observations: _____

Are you receiving any treatments that are ordered by a physician to be performed by a licensed Nurse/ Therapist?

Yes No NA

If yes, please describe the services being requested and attach the appropriate additional required documentation: _____

Section C: APPLICANT OR DESIGNEE SIGNATURE

I HEREBY ATTEST THAT I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED ON THIS DOCUMENT AND IT ACCURATELY REFLECTS THE RESPONSES I HAVE GIVEN DURING THIS ASSESSMENT. I ALSO UNDERSTAND THAT THE COMMENTS AND OBSERVATIONS ARE THOSE OF THE QUALIFIED ASSESSOR.

Applicant Signature: _____ Date: ____/____/____

Section D: ASSESSOR CREDENTIALS AND SIGNATURE

BY MY SIGNATURE, I AGREE THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION MAY BE USED TO DETERMINE MEDICAID ELIGIBILITY AND MAY ALSO BE USED BY A JUDGE TO MAKE A HEARING DECISION. I FURTHER UNDERSTAND THAT PEOPLE WHO LIE AND PROVIDE FALSE INFORMATION THAT WOULD POTENTIALLY RESULT IN A PERSON OBTAINING TENNCARE SERVICES TO WHICH HE/SHE IS NOT ENTITLED IS CONSIDERED AN ACT OF FRAUD AND MAY BE FINED OR SENT TO JAIL.

Printed Name: _____

Signature: _____ Credentials: _____

Date: _____ Assessor Code : _____

Attachment 2

Collateral Interview Tool

COLLATERAL INTERVIEW



Applicant Last _____ First Initial _____

RESPONDENT INFORMATION

Name: _____ Relationship to Applicant: _____

Title (if applicable): _____ Agency (if applicable): _____

Date of Interview: _____ Location of Interview: _____

Hands-on caregiver? Yes No, # of days per week _____ for _____ months / years

LEGEND

With the exception of behaviors (behaviors using the opposite scale) the following applies:

Always = Applicant can always perform the function without assistance.

Usually = Applicant requires assistance 1-3 days per week.

Usually not = Applicant requires assistance 4 or more days per week.

Never = Applicant can never perform the function without assistance.

I. TRANSFER/ MOBILITY

Rise from a chair independently? Always Usually Usually Not Never

Get on and off the toilet independently? Always Usually Usually Not Never

Get in and out of bed independently? Always Usually Usually Not Never

If this applicant requires physical assistance with transfer, # days per week physical assistance is required:

1-3 4-6 7 N/A

Walk independently without physical assistance from another person ?

Always Usually Usually Not Never NA

If answered UN or N, can he/she use a wheelchair independently, either manual or electric?

Always Usually Usually Not Never NA

Usual method of mobility? Walk Wheelchair

Assistive devices: Cane/Quad Cane Walker Lift Chair Wheelchair Gait belt

Other(specify): _____

Gait Description, if observed(pace, steadiness):

Is this applicant able to walk or operate wheelchair without **physical assistance** from another person? Yes No

If no, # days per week assistance required 1-3 4-6 7 NA

What medical condition(s) does he/she have to support the need for physical assistance with Transfer/ Mobility?

Transfer/Mobility Comments: _____

COLLATERAL INTERVIEW



Applicant Last _____ First Initial _____

II. EATING/TOILETING

Is He/She able to:

Eat prepared meals without assistance from others? Yes No If no, # days per week: 1-3 4-6 7

Administer tube feeding independently? Yes No If no, # days per week: 1-3 4-6 7 NA

If assistance is indicated, describe the type of assistance provided: _____

What medical condition(s) does he/she have to support the need for physical assistance, constant one-on-one observation and verbal assistance? _____

Toilet Independently? Yes No, If no,# days per week: 1-3 4-6 7

Maintain continence of bladder? Yes No If no, # days per week: 1-3 4-6 7 NA

Maintain continence of bowel? Yes No If no,# days per week: 1-3 4-6 7 NA

Clean self after incontinence episode? Yes No N/A

Does applicant use a catheter? Yes No N/A

Does applicant have an ostomy? Yes No N/A

If yes, how often is assistance required? Always Usually Usually Not Never

Eating/Toileting Comments: _____

III. Orientation

Is He/She able to:

Oriented to name? Always Usually Usually Not Never

Able to identify family members? Always Usually Usually Not Never

Oriented to place? Always Usually Usually Not Never

Aware of current circumstances in order to make decisions that prevent risk of harm? Always Usually Usually Not Never

If any answer other than Always, please provide **specific** examples: _____

Orientation Comments: _____

IV. COMMUNICATION

Follow simple directions? Always Usually Usually Not Never

Communicate basic needs with or without assistive aid? Always Usually Usually Not Never

COLLATERAL INTERVIEW



Applicant Last _____ First Initial _____

Communication Comments: _____

V. BEHAVIOR

Does applicant require persistent behavioral intervention/supervision? Yes No NA

Describe the established and persistent behaviors which are not primarily related to a mental health condition or substance abuse disorder: _____

Describe the persistent staff or caregiver intervention/supervision required/provided _____

If behavioral intervention/supervision is indicated, who is presently providing this intervention? _____

Behavior Comments: _____

VI. MEDICATION

****Please get this information from person responsible for dispensing medications****

Information obtained from? _____

Is He/She able to take pills from a medcup/hand, get them to their mouth, and swallow them (refusal doesn't indicate inability) on the appropriate schedule? Yes No

Is He/She receiving any injections (not including sliding scale insulin), topicals, eye drops, or inhalers? Yes No

If yes, are they able to self-administer? Yes No

If no, # of days per week assistance is required: 1-3 4-6 7 NA

If no, to any of the above, describe intervention(s): _____

Medication Comments: (If unable to self-administer, describe limitations and number of days assistance is needed)

VII. SIGNATURE

BY MY SIGNATURE, I AGREE THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION MAY BE USED TO DETERMINE MEDICAID ELIGIBILITY AND MAY ALSO BE USED BY A JUDGE TO MAKE A HEARING DECISION. I FURTHER UNDERSTAND THAT PEOPLE WHO LIE AND PROVIDE FALSE INFORMATION THAT WOULD POTENTIALLY RESULT IN A PERSON OBTAINING TENNCARE SERVICES TO WHICH HE/SHE IS NOT ENTITLED IS CONSIDERED AN ACT OF FRAUD AND MAY BE FINED OR SENT TO JAIL.

Signature of person providing information: _____ Date: _____

Signature of person providing **medication** information: _____ Date: _____

COLLATERAL INTERVIEW



Applicant Last _____ First Initial _____

If by telephone, I _____ certify that I have conducted this interview with _____ and have read back the responses to all questions and have obtained permission to sign this document on their behalf. Signature: _____ Date: _____

Printed Name: _____

Signature: _____ Credentials: _____

Date: _____ Assessor Code: _____

Attachment 3

Additional Requirements for Skilled Services

Skilling Service	Supporting Documentation Required	Instructions	Approval Period
Ventilator (Does not include vent weaning services)	Physician order for ventilator. and Must have an invasive patient end of circuit.	Documentation which supports ventilator services provided by registered/ licensed nurse and/ or respiratory therapist. And Does not meet requirements for enhanced respiratory reimbursement for chronic ventilator services	3-6 month increments
Nasopharyngeal suctioning	Physician order. and Nursing notes indicating care	Treatment plan must be signed by the treating physician and contain a plan for services to be performed by a registered or licensed nurse and/ or respiratory therapist.	3-6 month increments
Infrequent tracheal suctioning	Physician order. and Nursing notes indicating care.	Patient must have a functioning tracheostomy requiring suctioning through the tracheostomy multiple times per day at less frequent intervals, e.g., < every 4 hours.	30 day increments.
Total Parenteral Nutrition	Physician order. Medical Administration Record (optional).	Documentation must contain duration and frequency of treatment.	30 day increments.
Complex wound care (e.g., infected wounds, dehisced wounds, 3 or more stage 3 and/or stage 4 wounds)	Physician order. and Wound assessment (describing characteristics, type and measurements).	. Documentation must support the following: 1. Infected or dehisced wound 2. Three (3) or more stage 3and/or stage 4 wounds 3. Wound vac Wound type and severity to be determined based upon documentation received.	3-6 month increments

Wound care for stage 3 or 4 decubitus	Physician order. and Wound assessment (describing characteristics and measurements).	Documentation must support there is a stage 3 and/or stage 4 wound. Stage 3 – Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to but not through, underlying fascia. Stage 4 – Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (tendon, joint, capsule). Undermining and sinus tracts may be present.	3-6 month increments.
Peritoneal Dialysis	Physician order.		Open ended.
Tube feeding, enteral	Physician order including type of feeding, amount and/or rate.	Tube feeding must constitute 50% or greater of the nutritional/ caloric intake. Documentation should indicate if patient is NPO or taking PO foods/ liquids.	6 months unless determined that tube feeding will be required long term, in which case, approval may be open ended.
Intravenous fluid administration	Physician Order (must include frequency and duration). Medical Administration Record (optional).	Can be approved for one day only.	Exact number of days ordered. If continuous, 30-60 day increments.
Injections, sliding scale	Physician order. and Sliding scale insulin log or medication record	See separate protocol	14 day increments. Maximum of 60 days per incidence

<p>Injections, other IV, IM</p>	<p>Physician Order. (must include frequency and duration).</p> <p>Medical Administration Record (optional)</p>	<p>Do not bill for one day, one time orders. Does not include scheduled insulin doses.</p>	<p>Exact number of days ordered.</p>
<p>Isolation precautions</p>	<p>Physician order for isolation.</p> <p>and</p> <p>Diagnosis to support need for isolation.</p> <p>or</p> <p>Lab report indicating organism (opt.)</p>		<p>30 day increments.</p>
<p>PCA pump</p>	<p>Physician order. (must include duration of therapy).</p> <p>and</p> <p>Diagnosis to support treatment.</p> <p>or</p> <p>Medical Administration Record (optional)</p>		<p>30 day increments. Terminal pain management up to 3 months.</p>

Occupational therapy by OT or OT assistant	Physician order (must be 5x per week aggressive therapy). or Therapist notes and evaluation.	Must be new/acute event or condition, not an old condition, e.g. new CVA, amputation, fracture, etc. May be approved for 30 days when admitting from hospital after acute care of diagnosis directly related to therapy need (total hip replacement, rotator cuff repair...) Chronic conditions such as generalized weakness are not approvable.	As indicated by the physician/therapist certification, but not more than 90 days.
Physical therapy by PT or PT assistant	Physician order (must be 5x per week aggressive therapy). or Therapist notes and evaluation.	Must be new/acute event or condition, not an old condition, e.g. new CVA, amputation, fracture, etc. May be approved for 30 days when admitting from hospital after acute care of diagnosis directly related to therapy need (total hip replacement, rotator cuff repair...) Chronic conditions such as generalized weakness are not approvable.	As indicated by the physician/therapist certification, but not more than 90 days.
Teaching catheter/ostomy care	Physician order. and Documentation of teaching plan requiring at least one week of instruction.	Ensure patient is functionally and mentally able to learn and perform the specific task(s). Documentation should include the patient's capability to provide self-care adequately.	30 day increments.
Teaching self-injection	Physician order. and Documentation of teaching plan requiring at least one week of instruction.	Ensure patient is functionally and mentally able to learn and perform the specific task(s). Documentation should include the patient's capability to provide self-care adequately.	30 day increments.

The following chart provides additional clinical requirements and timelines for enhanced respiratory reimbursement approval.

Ventilator	<p>Physician order – ventilator dependent at least 12 hours per day.</p> <p>and</p> <p>Must have an invasive patient end of circuit (e.g., tracheostomy cannula).</p> <p>and</p> <p>Detailed treatment plan.</p>	<p>Treatment plan must be developed with input and participation from a pulmonologist or physician with experience in ventilator care, signed by the treating physician or a licensed respiratory professional who will oversee the intensive respiratory care.</p>	3-6 month increments
Frequent tracheal suctioning	<p>Physician order.</p> <p>and</p> <p>Detailed treatment plan.</p> <p>and</p> <p>Nursing notes indicating care.</p>	<p>Patient must have a functioning tracheostomy requiring suctioning through the tracheostomy at a minimum, multiple times per 8-hour shift. (6 times over a 24 hour period)</p> <p>Treatment plan must be signed by the treating physician, licensed registered nurse, or licensed respiratory professional who will oversee the intensive respiratory care and must contain the following elements:</p> <ol style="list-style-type: none"> 1. Nursing care plan for services to be performed by a registered or licensed nurse and/ or respiratory therapist. 2. Plan for care to be rendered by family members, with documentation of their ability to perform such care. 	3-6 month increments.

Attachment 4

Safety Determination Request Form



Safety Determination Request Form

Applicant Name: _____ SSN: _____ DOB: _____

This form is to be used only by an entity submitting a PAE for NF LOC and requesting a Safety Determination in accordance with requirements set forth in TennCare Rule. This form must be completed in its entirety and included with the PAE submission, along with all required documentation as specified below. An incomplete Safety Determination Request Form, or a Safety Determination Form submitted without documentation as specified below, will be denied.

Total Acuity Score of PAE as submitted: _____

Current Living Arrangements:

Applicant residence (if applicant currently resides in a NF, housing status prior to admission):

- Lives in own home/apt (alone)
- Lives in own home/apt (with spouse/partner)
- Lives in own home/apt (with others)—specify relationship _____
- Lives in other's home—specify relationship _____
- Assisted living facility
- Other community-based residential (i.e., group home) setting—specify _____
- Other—specify _____

If the applicant would not be able to return to or continue living in this residence, please explain why:

Justification for Safety Determination Request:

Please note that documentation as specified below may consist of, but is not limited to, narrative descriptions or explanations from submitter, caregivers, or family members; hospital notes, therapy notes, MD visits, ADL flow sheets, encounter notes from nurses, therapists, or physicians; and any other documents which would demonstrate the safety concern(s) for the applicant.

Please check and complete **all** that apply. (While a single justification is sufficient for review of a Safety Determination request, it is critical that TennCare has benefit of all available information pertaining to safety concerns that could impact the applicant's ability to be safely served in the community.)

- The applicant has an approved acuity score of at least five (5) but no more than eight (8) and safety concerns impacting the applicant's ability to be safely served in CHOICES Group 3 exist.
 - Provide a detailed description of the safety concern and include sufficient evidence showing that the necessary intervention and supervision needed by the applicant cannot be safely provided within the array of services and supports that would be available if the applicant was enrolled in Choices Group 3.



Safety Determination Request Form

Applicant Name: _____ SSN: _____ DOB: _____

(Attach additional explanation if needed and any other documentation which would support the safety concerns detailed below. Label attachment(s) as “**Score 5-8 with Safety Concerns.**”)

Description of documentation attached: _____

- The applicant has an individual acuity score of at least 3 for the mobility or transfer measures **and** the absence of frequent intermittent assistance for mobility or transfer needs would result in imminent and serious risk to the applicant’s health and safety.
 - Describe how often mobility and/or transfer assistance is needed by the member and the availability of paid and unpaid caregivers to provide such assistance, including any recent changes in the applicant’s needs and/or availability of caregivers to meet such needs. (Attach additional explanation if needed and any other documentation which would support safety concerns pertaining to the applicant’s mobility or transfer deficit. Label attachment(s) as “**Mobility or Transfer Deficit.**”)

Description of documentation attached: _____

- The applicant has an individual acuity score of at least 2 for the toileting measure, **and** the absence of frequent intermittent assistance for toileting needs would result in imminent and serious risk to the applicant’s health and safety.
 - Describe how often toileting assistance is needed by the member and the availability of paid and unpaid caregivers to provide such assistance, including any recent changes in the applicant’s needs and/or availability of caregivers to meet such needs. (Attach additional explanation if needed and any other documentation which would support safety concerns pertaining to the applicant’s toileting deficit. Label attachment(s) as “**Toileting Deficit.**”)

Description of documentation attached: _____

- The applicant has an individual acuity score of at least 3 for the Orientation measure **and** the absence of frequent intermittent or continuous intervention and supervision would result in imminent and serious risk of harm to the applicant and/or others.



Safety Determination Request Form

Applicant Name: _____ SSN: _____ DOB: _____

- Provide a detailed description of how orientation deficits impact the applicant’s safety, including information or examples that would support and describe the imminence and seriousness of risk. (Attach additional explanation if needed and any other documentation which would support safety concerns pertaining to the applicant’s orientation deficit. Label attachment(s) as “**Orientation Deficit.**”)

Description of documentation attached: _____

- The applicant has an individual acuity score of at least 2 for the Behavior measure **and** the absence of intervention and supervision for behaviors at the frequency specified in the PAE would result in imminent and serious risk of harm to the Applicant and/or others.
 - Provide a detailed description of the specific behavior(s), the frequency of each behavior, and information and/ or examples which support and describe the imminence and seriousness of risk resulting from the behavior(s). (Attach additional explanation if needed and any other documentation which would support safety concerns pertaining to the applicant’s behavior deficit. Label attachment(s) as “**Behavior Deficit.**”)

Description of documentation attached: _____

- The applicant** has experienced a significant change in physical or behavioral health or functional needs.
 - Provide a detailed description of the change(s), and how such changes impact the applicant’s need for assistance. (Attach additional explanation if needed and any other documentation which would support that these change(s) occurred and/or concerns pertaining to the applicant’s safety as a result of the change(s). Label attachment(s) as “**Change in Needs.**”)

Description of documentation attached: _____



Safety Determination Request Form

Applicant Name: _____ SSN: _____ DOB: _____

- Applicant's **primary caregiver** has experienced a significant change in physical or behavioral health or functional needs which impacts the availability of needed assistance for the applicant.
 - Provide a detailed description of the change(s), and how such changes impact the availability of needed assistance for the applicant. (Attach additional explanation if needed and any other documentation which would support that these changes occurred and/or concerns pertaining to the applicant's safety as a result of the change(s). Label attachment(s) as "**Change in Primary Caregiver Status.**")

Description of documentation attached: _____

- Applicant has a pattern of recent falls resulting in injury or with significant potential for injury or a recent fall under circumstances indicating a significant potential risk for further falls.
 - Provide a detailed description of the fall(s) including the date of each incident, circumstances surrounding each fall, injury sustained as a result of the fall (if applicable) or significant potential for injury or risk for further falls, treatment received (if applicable), and interventions implemented to mitigate the risk of falls and injury from falls, and whether these interventions have been successful. (Attach additional explanation if needed and any other documentation pertaining to fall(s), including documentation of any treatment received. TennCare developed Fall Form may be used to assist. Label attachment(s) as "**Documentation of Falls.**")

Description of documentation attached: _____

- Applicant has an established pattern of recent emergent hospital admissions or emergency department utilization for emergent conditions or a recent hospital or NF admission or episode of treatment in a hospital emergency department under circumstances sufficient to indicate that the person may not be capable of being safely maintained in the community (not every hospital or NF admission or ER episode will be sufficient to indicate such).
 - Document below and provide detailed explanation of any circumstances pertaining to such inpatient admission(s) or ER visit(s) which indicate that the person may not be capable of being safely maintained in the community, along with records from each admission or ER visit, e.g., discharge papers. Label attachment(s) as "**Inpatient Admissions/ER Visits.**"



Safety Determination Request Form

Applicant Name: _____ SSN: _____ DOB: _____

Recent (last 365 days) hospital admissions		
Admit Date	Discharge Date	Reason for Admission

Recent (last 365 days) ER visits (for emergent condition <i>only</i>)	
Date	Reason for ER visit

Recent (last 365 days) nursing facility admissions		
Admit Date	Discharge Date	Reason for admission

Description of documentation attached: _____

- The applicant's behaviors or a pattern of self-neglect has created a risk to personal health, safety and/or welfare requiring involvement by law enforcement or Adult Protective Services.

- Provide a detailed description of the behaviors and/or pattern of self-neglect, the frequency of each such behavior or self-neglect, the risk to personal health, safety and/or welfare, the date of involvement by law enforcement or Adult Protective Services, and any actions taken by such agency to ensure the person's safety. Attach supporting documentation, including the APS/ Police reports, where available. Label attachment(s) as "**APS/Police Involvement.**"

Description of documentation attached: _____



Safety Determination Request Form

Applicant Name: _____ SSN: _____ DOB: _____

- The applicant has recently been discharged from a community-based residential alternative setting (or such discharge is pending) because the applicant’s needs can no longer be safety met in that setting.
 - Document below and attach documentation detailed description of the circumstances leading to discharge, including documentation from the CBRA. Include explanation regarding any other previous settings from which the applicant has been discharged due to safety concerns, including the date(s) of such admissions and discharge. Label attachment(s) as “**CBRA Discharge.**”

Name of CBRA facility: _____

Date of discharge: _____

Safety concerns leading to discharge _____

Description of documentation attached: _____

- The applicant has diagnosed complex acute or chronic medical conditions which require frequent, ongoing skilled and / or rehabilitative interventions and treatment by licensed professional staff.
 - Document below (attach additional explanation if needed) and attach current (last 365 days) medical records documenting each condition, including ongoing treatment prescribed, and the name, professional title, and contact information of the primary treating practitioner for each such condition:

Medical Condition	Acute or Chronic	Intervention Required	Licensed staff required

Description of documentation attached: _____

- The applicant requires post- acute inpatient treatment for a specified period of time to allow for stabilization, rehabilitation or intensive teaching in order to facilitate a safe transition into the community.

Acute event: _____

Treatment required: _____

Duration of time needed: _____



Safety Determination Request Form

Applicant Name: _____ SSN: _____ DOB: _____

- The applicant's MCO has determined, upon enrollment into Group 3 based on a PAE submitted by another entity, that the applicant's needs cannot be safely met within the array of services and supports available if enrolled in Group 3.
- None of the criteria above have been met, but other safety concerns which impact the applicant being safely served in CHOICES Group 3 exist.
 - Provide a detailed description of the safety concern and include sufficient evidence showing that the necessary intervention and supervision needed by the applicant cannot be safely provided within the array of services and supports that would be available if the applicant was enrolled in Choices Group 3. (Attach additional explanation if needed and any other documentation which would support the safety concerns detailed below. Label attachment(s) as "**Other Safety Concerns.**")

Description of documentation attached: _____

- The applicant is a current CHOICES Group 1 or 2 member or PACE member enrolled on or after 7/1/2012 and has been determined upon review to no longer meet NF LOC requirements based on a total acuity score of 9 or above, but because of specific safety concerns, still requires the level of care currently being provided. Safety justification and associated documentation must be represented in at least one of the areas listed above.

Additional Required Documentation:

In addition to the information specified above to support each of the safety concerns identified, you must attach:

- ✓ A comprehensive needs assessment, including:
 - ✓ an assessment of the applicant's physical, behavioral, and psychosocial needs not reflected in the PAE;
 - ✓ the specific tasks and functions for which assistance is needed by the Applicant;
 - ✓ the frequency with which such tasks must be performed; and
 - ✓ the Applicant's need for safety monitoring and supervision

Label attachment(s) as "**Comprehensive Needs Assessment.**"

- ✓ A detailed description of the Applicant's living arrangements and the services and supports the Applicant has received during the six (6) months prior to submission of the Safety Determination request, including unpaid care provided by family members and other caregivers, paid services and supports the Applicant has been receiving regardless of payer (e.g., non-CHOICES HCBS available through TennCare such as home health and services



Safety Determination Request Form

Applicant Name: _____ SSN: _____ DOB: _____

available through Medicare, private insurance or other funding sources); and any anticipated change in the availability of such care or services from the current caregiver or payer

Label attachment(s) as “**Prior 6 Months.**”

- ✓ A detailed explanation regarding any recent significant event(s) or circumstances that have impacted the Applicant’s need for services and supports, including how such event(s) or circumstances impact the Applicant’s ability to be safely supported within the array of covered services and supports that would be available if the Applicant were enrolled in CHOICES Group 3

Label attachment(s) as “**Recent Events.**”

- ✓ A person-centered plan of care developed by the MCO Care Coordinator, NF, or PACE Organization (i.e., the entity submitting the Safety Determination request) which specifies the tasks and functions for which assistance is needed by the Applicant, the frequency with which such tasks must be performed, the Applicant’s need for safety monitoring and supervision; and the amount (e.g., minutes, hours, etc.) of paid assistance that would be necessary to provide such assistance; and that would be provided by such entity upon approval of the Safety Determination. (A plan of care is not required for a Safety Determination submitted by the AAAD.) In the case of a Safety Determination request submitted by an MCO or AAAD for a NF resident, the plan of care shall be developed in collaboration with the NF, as appropriate. To the extent that all of the required information is not specified in a NF Plan of Care, please attach the Plan of Care along with additional documentation regarding tasks and functions, frequency, etc., that will help to describe why the person’s needs cannot be safely met in CHOICES Group 3, and why the higher level of care is appropriate.

✓ Label attachment(s) as “**Plan of Care.**”

- ✓ A detailed explanation regarding why the array of covered services and supports, including CHOICES HCBS up to the Expenditure Cap of \$15,000 and non- CHOICES HCBS (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers would not be sufficient to safely meet the applicant’s needs in the community

Label attachment(s) as “**Safety Explanation.**”

Submitting Entity Attestation

Completed Attestation, printed name, signature, credentials and date of form completion are required.

Please read and check at least one of the statements below (check all that apply):

- I do **not** believe this individual can be safely served in the community in CHOICES Group 3.
- I believe this individual **can** be safely served in the community in CHOICES Group 3.



Safety Determination Request Form

Applicant Name: _____ SSN: _____ DOB: _____

This safety determination form was completed at the request of the applicant/representative.

By signing below, I, as a licensed professional, take responsibility for the information provided in this Safety Determination request and attest that I have personally reviewed the information provided in this Safety Determination Request and it is accurate and true to the best of my knowledge. I understand that this information will be used to determine the applicant's eligibility and/or reimbursement for long-term care services. I understand that any intentional act or omission on my part to provide false information or give a false impression that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled may be considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent may be subject to federal and state civil and criminal penalties.

Printed Name of person making this decision

Signature of person making this decision

Credentials

Date



Safety Determination Request Form

Applicant Name: _____ SSN: _____ DOB: _____

Please use this form when the justification for a safety determination request is related to a recent fall(s). Provide any available information for falls occurring within the last 6 months. Most recent fall should be listed first. All fields are not required, but providing all the details available will help ensure that the correct LOC is approved for this person.

Fall #	Date of fall:	Time of Fall:	AM / PM
Location of Fall:			
What was applicant doing prior to fall?			
List factors contributing to fall (environment, meds, etc...)			
Was an injury sustained related to fall? YES / NO		If yes, describe:	
What mechanisms are in place to prevent falls?			
Why were these prevention mechanisms unsuccessful?			
Fall #	Date of fall:	Time of Fall:	AM / PM
Location of Fall:			
What was applicant doing prior to fall?			
List factors contributing to fall (environment, meds, etc...)			
Was an injury sustained related to fall? YES / NO		If yes, describe:	
What mechanisms are in place to prevent falls?			
Why were these prevention mechanisms unsuccessful?			
Fall #	Date of fall:	Time of Fall:	AM / PM
Location of Fall:			
What was applicant doing prior to fall?			
List factors contributing to fall (environment, meds, etc...)			
Was an injury sustained related to fall? YES / NO		If yes, describe:	
What mechanisms are in place to prevent falls?			
Why were these prevention mechanisms unsuccessful?			
Fall #	Date of fall:	Time of Fall:	AM / PM
Location of Fall:			
What was applicant doing prior to fall?			
List factors contributing to fall (environment, meds, etc...)			



Safety Determination Request Form

Applicant Name: _____ SSN: _____ DOB: _____

Was an injury sustained related to fall? YES / NO	If yes, describe:
What mechanisms are in place to prevent falls?	
Why were these prevention mechanisms unsuccessful?	

Attachment 5

Life Skills Assessment



Cover Sheet

APPLICANT NAME:
PRIMARY INFORMANT'S NAME:
PRIMARY INFORMANT'S RELATIONSHIP TO APPLICANT:
OTHER INFORMANTS' NAMES AND RELATIONSHIP TO APPLICANT
QUALIFIED ASSESSOR NAME:
QUALIFIED ASSESSOR CODE:
MCO NAME OR DIDD REGIONAL OFFICE:
LOCATION OF INTERVIEW:
LANGUAGE USED*:
DATE OF INTERVIEW:
* Assessment must be conducted in applicant and informant's primary language(s)



Personal Data Sheet

Please fill in each of the boxes below. If you cannot write, someone will write your answers for you. This task helps us find out if you can do three important things. First, it helps tell us if you can read and follow directions. Second, it helps tell us if you can respond in writing to requests for information. Third, it tells us if you can provide personal data when needed, like when you apply for a job or visit a doctor. Thank you for your help.

Your name

Your date of birth

Your sex (check one):

Male

Female

The address where you get your mail

City

State

Zip code

Your telephone number (include area code)

Your Social Security Number

The highest level of education you have completed:

Grade school or middle school

High school

Some college

Associate degree

Bachelor degree

Master degree

Doctorate degree

Tell us about your current or most recent job.

PAGE 1

Tell us about your disability and how it affects your life.

ABOVE DATA FILLED IN BY THE

APPLICANT QUALIFIED ASSESSOR



STATE OF TENNESSEE, HEALTH CARE FINANCE & ADMINISTRATION
 BUREAU OF TENNCARE, LONG TERM SERVICES & SUPPORTS
 TENNESSEE LIFE SKILLS ASSESSMENT (LSA)

MAJOR LIFE ACTIVITY: CATEGORY I SELF-CARE (Activities of Daily Living)	SOURCE OF INFORMATION								
	OBSERVATION			APPLICANT			INFORMANT		
	Y	N	N-C	Y	N	N-C	Y	N	N-C
1. Applicant bathes or showers independently, including transfer to tub or shower, turning on and adjusting water, scrubbing, washing hair, transfer from tub or shower and drying, without using assistive devices. Comments:	<input type="checkbox"/>								
2. Applicant completes grooming independently, including brushing/combing hair, brushing teeth, shaving, and cleaning and trimming nails, without using assistive devices. Comments:	<input type="checkbox"/>								
3. Applicant independently selects attire appropriate to season and activity and independently dresses and undresses self, including underclothes, outer clothes, socks and shoes, without using adapted clothes or assistive devices. Comments:	<input type="checkbox"/>								
4. Applicant is continent of bowel and bladder, and independently toilets self, including transferring to toilet, wiping self and transferring from toilet, without using assistive devices. If alternative methods of urinary voiding or fecal evacuation are applicable, applicant independently completes entire routine. Comments:	<input type="checkbox"/>								
5. Applicant independently feeds self; including cutting food, lifting food and drink to mouth, chewing and swallowing when served a prepared meal, without using assistive devices. Comments:	<input type="checkbox"/>								
6. Applicant self-administers oral medications, including opening container, obtaining correct dosage, placing medications in mouth, swallowing, and closing container, without using assistive devices. Comments:	<input type="checkbox"/>								
CATEGORY 1 SUBSTANTIAL FUNCTIONAL LIMITATION (Two (2) or more statements marked No under Observation OR under Applicant AND confirmed by Informant OR by multiple Informants/sources.)									
NO SUBSTANTIAL FUNCTIONAL LIMITATION (All statements are marked yes or ? under Observation, and all statements marked ? under Observation are marked Yes under at least one (1) other source of information.)									
POSSIBLE FUNCTIONAL LIMITATION (Neither Substantial Functional Limitation nor No Substantial Functional Limitation.)									
APPLICANT'S NAME:									



STATE OF TENNESSEE, HEALTH CARE FINANCE & ADMINISTRATION
 BUREAU OF TENNCARE, LONG TERM SERVICES & SUPPORTS
 TENNESSEE LIFE SKILLS ASSESSMENT (LSA)

MAJOR LIFE ACTIVITY: CATEGORY II RECEPTIVE AND EXPRESSIVE LANGUAGE	SOURCE OF INFORMATION								
	OBSERVATION			APPLICANT			INFORMANT		
	Y	N	?	Y	N	?	Y	N	?
1. Applicant can hear and comprehend the content of ordinary spoken conversations in the applicant's primary language without using a hearing aid or other assistive device. Comments:	<input type="checkbox"/>								
2. Applicant pays attention and can follow simple directions given to him or her verbally. Comments:	<input type="checkbox"/>								
3. Applicant can communicate basic wants and needs, and answer simple questions in a manner that can be understood by others, without the use of assistive devices. Comments:	<input type="checkbox"/>								
4. Applicant has sufficient vocabulary and intelligible speech or nonverbal communication skills to interact with individuals of casual acquaintance and conduct ordinary business in the community. Comments:	<input type="checkbox"/>								
CATEGORY II SUBSTANTIAL FUNCTIONAL LIMITATION (One (1) or more statements marked No under Observation OR under Applicant AND confirmed by Informant OR by multiple Informants/sources.) NO SUBSTANTIAL FUNCTIONAL LIMITATION (All statements are marked yes or ? under Observation and all statements marked ? under Observation are marked Yes under at least one (1) other source of information.) POSSIBLE FUNCTIONAL LIMITATION (Neither Substantial Functional Limitation nor No Substantial Functional Limitation.)									
APPLICANT'S NAME:									



STATE OF TENNESSEE, HEALTH CARE FINANCE & ADMINISTRATION
 BUREAU OF TENNCARE, LONG TERM SERVICES & SUPPORTS
 TENNESSEE LIFE SKILLS ASSESSMENT (LSA)

MAJOR LIFE ACTIVITY: CATEGORY III LEARNING	SOURCE OF INFORMATION								
	OBSERVATION			APPLICANT			INFORMANT		
	Y	N	N-C	Y	N	N-C	Y	N	N-C
1. Applicant is able to provide complete and accurate personal data, including name, date of birth, place of residence (street address, city, and state), telephone number, etc. without using assistive devices. Comments:	<input type="checkbox"/>								
2. Applicant is able to read and understand items such as personal mail, labels on food or other common domestic products, menus in restaurants, and signs in the community. Comments:	<input type="checkbox"/>								
3. Applicant is able to do simple addition and subtraction, identify basic units of money—pennies, nickels, dimes, quarters, \$1, \$5, \$10 and \$20, calculate the value of combinations of these items and make change up to \$5.00. Comments:	<input type="checkbox"/>								
4. Applicant is able to tell the time of day, including A.M. and P.M. (or morning, afternoon and evening) using a time-keeping device, use a calendar to tell the day of the week and month of the year, and associate activities with the appropriate time of day or year, without using assistive devices. Comments:	<input type="checkbox"/>								
5. Applicant is able to write his or her name, a note for self or someone else, send an email or text message, and complete basic forms. Comments:	<input type="checkbox"/>								
6. Applicant is able to complete a task involving at least three steps that are presented verbally at the beginning of the task (stand up, take the tray to the other side of the room, and set it on the blue table). Comments:	<input type="checkbox"/>								
CATEGORY III SUBSTANTIAL FUNCTIONAL LIMITATION (Two (2) or more statements marked No under Observation OR under Applicant AND confirmed by Informant OR by multiple Informants/sources.) NO SUBSTANTIAL FUNCTIONAL LIMITATION (All statements are marked yes or? under Observation and all statements marked? under Observation are marked Yes under at least one (1) other source of information.) POSSIBLE FUNCTIONAL LIMITATION (Neither Substantial Functional Limitation nor No Substantial Functional Limitation.)									
APPLICANT'S NAME:									



STATE OF TENNESSEE, HEALTH CARE FINANCE & ADMINISTRATION
 BUREAU OF TENNCARE, LONG TERM SERVICES & SUPPORTS
 TENNESSEE LIFE SKILLS ASSESSMENT (LSA)

MAJOR LIFE ACTIVITY: CATEGORY IV MOBILITY	SOURCE OF INFORMATION								
	OBSERVATION			APPLICANT			INFORMANT		
	Y	N	N-C	Y	N	N-C	Y	N	N-C
1. Applicant independently and safely moves about within indoor and outdoor environments, without using a wheelchair, crutches, cane, or other assistive device. Comments:	<input type="checkbox"/>								
2. Applicant independently and safely pulls self into a standing position, stands, and transfers self from one surface to another, e.g., bed to chair, chair to bed, onto and off toilet, in and out of bath or shower, etc., without using assistive devices. Comments:	<input type="checkbox"/>								
3. Applicant is able to turn knobs or handles to open a door, lock and unlock doors, and enter and exit the home, without using assistive devices. Comments:	<input type="checkbox"/>								
4. Applicant independently picks up small objects, carries small objects, removes wrappings, opens containers, and pours and stirs, without using assistive devices. Comments:	<input type="checkbox"/>								
CATEGORY IV									
SUBSTANTIAL FUNCTIONAL LIMITATION (One (1) or more statements marked No under Observation OR under Applicant AND confirmed by Informant OR by multiple Informants/sources.)									
NO SUBSTANTIAL FUNCTIONAL LIMITATION (All statements are marked yes or? under Observation and all statements marked? under Observation are marked Yes under at least one (1) other source of information.)									
POSSIBLE FUNCTIONAL LIMITATION (Neither Substantial Functional Limitation nor No Substantial Functional Limitation.)									
APPLICANT'S NAME:									



STATE OF TENNESSEE, HEALTH CARE FINANCE & ADMINISTRATION
 BUREAU OF TENNCARE, LONG TERM SERVICES & SUPPORTS
 TENNESSEE LIFE SKILLS ASSESSMENT (LSA)

MAJOR LIFE ACTIVITY: CATEGORY V SELF-DIRECTION	SOURCE OF INFORMATION								
	OBSERVATION			APPLICANT			INFORMANT		
	Y	N	N-C	Y	N	N-C	Y	N	N-C
1. Applicant makes and implements essentially independent daily personal decisions regarding diet (what to eat, when to eat, where to eat) and schedule of activities, including when to get up, what to do (for example, work, leisure, home chores, etc.) and when to go to bed. Comments:	<input type="checkbox"/>								
2. Applicant makes and implements essentially independent major life decisions such as choice of type and location of living arrangements, marriage, and career choice. Comments:	<input type="checkbox"/>								
3. Applicant possesses adequate social skills to establish and maintain interpersonal relationships with friends, relatives, or coworkers. Comments:	<input type="checkbox"/>								
4. Applicant sets personal goals and makes plans and takes steps to accomplish them. Comments:	<input type="checkbox"/>								
5. Applicant solves problems and takes responsibility for own actions, obeys laws. Comments:	<input type="checkbox"/>								
6. Applicant is able to manage physical and mental health, self-refers for routine medical and dental checkups and treatment, including selecting a doctor, setting appointment and providing a medical history as necessary. Comments:	<input type="checkbox"/>								
CATEGORY V									
SUBSTANTIAL FUNCTIONAL LIMITATION (Two (2) or more statements marked No under Observation OR under Applicant AND confirmed by Informant OR by multiple Informants/sources.)									
NO SUBSTANTIAL FUNCTIONAL LIMITATION (All statements are marked yes or? under Observation and all statements marked? under Observation are marked Yes under at least one (1) other source of information.)									
POSSIBLE FUNCTIONAL LIMITATION (Neither Substantial Functional Limitation nor No Substantial Functional Limitation.)									
APPLICANT'S NAME:									



STATE OF TENNESSEE, HEALTH CARE FINANCE & ADMINISTRATION
 BUREAU OF TENNCARE, LONG TERM SERVICES & SUPPORTS
 TENNESSEE LIFE SKILLS ASSESSMENT (LSA)

MAJOR LIFE ACTIVITY: CATEGORY VI CAPACITY FOR INDEPENDENT LIVING	SOURCE OF INFORMATION								
	OBSERVATION			APPLICANT			INFORMANT		
	Y	N	N-C	Y	N	N-C	Y	N	N-C
1. Applicant generally carries out regular duties and chores (shopping, simple meal preparation, laundry, light housekeeping, etc.) safely and without need for reminders. Comments:	<input type="checkbox"/>								
2. Applicant is aware of a variety of community businesses and resources such as grocery stores, department stores, gas stations and quick stops, banks, post office, libraries, churches, etc. and independently finds and uses services or resources as needed. Comments:	<input type="checkbox"/>								
3. Applicant is able to get around in the neighborhood and community (including safely crossing streets and driving or using public transportation). Comments:	<input type="checkbox"/>								
4. Applicant can be left alone during the day without being considered to be at significant risk. Comments:	<input type="checkbox"/>								
5. Applicant is able to protect self from being taken advantage of, and knows how to ask for help when needed. Comments:	<input type="checkbox"/>								
6. Applicant has hobbies and interests, is aware of community businesses and activities such as restaurants, parks, recreational facilities and programs, sporting events, movies, etc. and independently selects and participates in desired activities on a regular basis. Comments:	<input type="checkbox"/>								
CATEGORY VI SUBSTANTIAL FUNCTIONAL LIMITATION (Two (2) or more statements marked No under Observation OR under Applicant AND confirmed by Informant OR by multiple Informants/sources.) NO SUBSTANTIAL FUNCTIONAL LIMITATION (All statements are marked yes or? under Observation and all statements marked? under Observation are marked Yes under at least one (1) other source of information.) POSSIBLE FUNCTIONAL LIMITATION (Neither Substantial Functional Limitation nor No Substantial Functional Limitation.)									
APPLICANT'S NAME:									



STATE OF TENNESSEE, HEALTH CARE FINANCE & ADMINISTRATION
 BUREAU OF TENNCARE, LONG TERM SERVICES & SUPPORTS
 TENNESSEE LIFE SKILLS ASSESSMENT (LSA)

MAJOR LIFE ACTIVITY: CATEGORY VII ECONOMIC SELF-SUFFICIENCY (not applicable for children under age 16)	SOURCE OF INFORMATION								
	OBSERVATION			APPLICANT			INFORMANT		
	Y	N	N-C	Y	N	N-C	Y	N	N-C
1. Applicant is able to independently manage his or her own money, budget for required living expenses, keep track of financial obligations, and pay bills on time. Comments:	<input type="checkbox"/>								
2. Applicant has post-secondary (upon exiting school) work experience in a competitive, integrated setting, earning at least minimum wage without paid assistance (through VR, etc.) in obtaining or maintaining employment OR if still in school and at least age 16 or older, has part-time work experience or (paid or unpaid) internship experience OR expresses desire and intent to work upon exiting school. Comments:	<input type="checkbox"/>								
3. Applicant is able to demonstrate knowledge of and competence for several traits of a good employee such as being prompt, attending regularly, accepting supervision and getting along with coworkers. (Applicant may be able to talk about school experiences as they relate to this area if no work history has been established.) Comments:	<input type="checkbox"/>								
4. Applicant is able to express a vocational preference and describe with reasonable accuracy the education and skills required. Comments:	<input type="checkbox"/>								
CATEGORY VII									
SUBSTANTIAL FUNCTIONAL LIMITATION (One (1) or more statements marked No under Observation OR under Applicant AND confirmed by Informant OR by multiple Informants/sources.)									
NO SUBSTANTIAL FUNCTIONAL LIMITATION (All statements are marked yes or? under Observation and all statements marked? under Observation are marked Yes under at least one (1) other source of information.)									
POSSIBLE FUNCTIONAL LIMITATION (Neither Substantial Functional Limitation nor No Substantial Functional Limitation.)									
APPLICANT'S NAME:									

Attachment 6

ECF Safety Determination Request Form

Employment and Community First CHOICES Safety Determination Request Form

Applicant Name: _____

SSN: _____ DOB: _____ Age _____

This form is to be used only by an MCO or DIDD submitting a PAE for NF LOC and requesting a Safety Determination in accordance with requirements set forth in TennCare Rule. This form must be completed in its entirety and included with the PAE submission, along with all required documentation as specified below. An incomplete Safety Determination Request Form, or a Safety Determination Form submitted without documentation as specified below, will be denied.

Total Acuity Score of PAE as submitted: _____

Current Living Arrangements:

Applicant residence:

- Lives in own home alone
- Lives in own home with parents
- Lives in own home with other family — specify relationship _____
- Lives at home with others— specify relationship _____
- Lives in other’s home—specify relationship _____
- Lives in a community-based residential setting—specify _____
- Other—specify _____

Justification for Safety Determination Request:

Please note that documentation as specified below may consist of, but is not limited to, narrative descriptions or explanations from submitter, caregivers, or family members; hospital notes, therapy notes, MD visits, ADL flow sheets, encounter notes from nurses, therapists, or physicians; and any other documents which would demonstrate the safety concern(s) for the applicant.

- The applicant has an intellectual or developmental disability and a General Maladaptive Index value of -31 or lower

Please attach copy of Maladaptive Behavior Assessment and Score and label **MBA and MBI**.

STOP: if above box is checked please go directly to Page 9, complete the attestation and submit the ECF CHOICES Safety Determination Form. If the box is not checked, please proceed with the remaining sections of the form.

Please check and complete **all** that apply. While a single justification is sufficient for review of a Safety Determination request, it is critical that TennCare has benefit of all available information pertaining to safety concerns that could impact the applicant’s ability to be safely served in Groups 4 or 5, as applicable.

- The applicant has an intellectual or developmental disability and is under the age of 18 and will not qualify financially for TennCare unless the deeming of the parent’s income to the child is waived, and absent the availability of benefits in ECF CHOICES Group 4, the child is at imminent risk of placement outside the home (DIDD use only).

Employment and Community First CHOICES Safety Determination Request Form

Applicant Name: _____

Please explain how such event(s) or circumstances would impact the Applicant's ability to remain in the family home:

Please explain how benefits in ECF CHOICES Group 4 would help the child stay in the home:

- The applicant has an intellectual or developmental disability and a General Maladaptive Index value of -21 to -30 and other safety concerns.

Please describe the imminence and seriousness of risk resulting from the behavior(s) and how services available in ECF CHOICES Group 6 would mitigate such risks

Please attach copy of Maladaptive Behavior Assessment and Score and label **MBA and MBI**.

- The applicant has an intellectual or developmental disability and a General Maladaptive Index value of -21 or lower and other safety concerns.

Please describe the imminence and seriousness of risk resulting from the behavior(s) and how services available in ECF CHOICES Group 6 would mitigate such risks

- The applicant has an approved acuity score of at least five (5) but no more than eight (8)

- The applicant has an individual acuity score of at least 2 for the Behavior measure **and** the absence of intervention and supervision for behaviors at the frequency specified in the PAE would result in imminent and serious risk of harm to the Applicant and/or others.

Employment and Community First CHOICES Safety Determination Request Form

Applicant Name: _____

- Provide a detailed description of the specific behavior(s), the frequency of each behavior, and information and/ or examples which support and describe the imminence and seriousness of risk resulting from the behavior(s). (Attach additional explanation if needed and any other documentation which would support safety concerns pertaining to the applicant’s behavior deficit. Label attachment(s) as “**Behavior Deficit.**”)

Description of documentation attached: _____

- The applicant has an individual acuity score of at least 3 for the Orientation measure **and** the absence of frequent intermittent or continuous intervention and supervision would result in imminent and serious risk of harm to the applicant and/or others.
 - Provide a detailed description of how orientation deficits impact the applicant’s safety, including information or examples that would support and describe the imminence and seriousness of risk. (Attach additional explanation if needed and any other documentation which would support safety concerns pertaining to the applicant’s orientation deficit. Label attachment(s) as “**Orientation Deficit.**”)

Description of documentation attached: _____

- The applicant has an individual acuity score of at least 3 for the mobility or transfer measures **and** the absence of frequent intermittent assistance for mobility or transfer needs would result in imminent and serious risk to the applicant’s health and safety.
 - Describe how often mobility and/or transfer assistance is needed by the member and the availability of paid and unpaid caregivers to provide such assistance, including any recent changes in the applicant’s needs and/or availability of caregivers to meet such needs. (Attach additional explanation if needed and any other documentation which would support safety concerns pertaining to the applicant’s mobility or transfer deficit. Label attachment(s) as “**Mobility or Transfer Deficit.**”)

Description of documentation attached: _____

Employment and Community First CHOICES Safety Determination Request Form

Applicant Name: _____

- The applicant has an individual acuity score of at least 2 for the toileting measure, **and** the absence of frequent intermittent assistance for toileting needs would result in imminent and serious risk to the applicant's health and safety.
- Describe how often toileting assistance is needed by the member and the availability of paid and unpaid caregivers to provide such assistance, including any recent changes in the applicant's needs and/or availability of caregivers to meet such needs. (Attach additional explanation if needed and any other documentation which would support safety concerns pertaining to the applicant's toileting deficit. Label attachment(s) as "**Toileting Deficit.**")

Description of documentation attached: _____

- The applicant** has experienced a significant change in physical or behavioral health or functional needs.
- Provide a detailed description of the change(s), and how such changes impact the applicant's need for assistance. (Attach additional explanation if needed and any other documentation which would support that these change(s) occurred and/or concerns pertaining to the applicant's safety as a result of the change(s). Label attachment(s) as "**Change in Needs.**")

Description of documentation attached: _____

- Applicant's **primary caregiver** has experienced a significant change in physical or behavioral health or functional needs which impacts the availability of needed assistance for the applicant.
- Provide a detailed description of the change(s), and how such changes impact the availability of needed assistance for the applicant. (Attach additional explanation if needed and any other documentation which would support that these changes occurred and/or concerns pertaining to the applicant's safety as a result of the change(s). Label attachment(s) as "**Change in Primary Caregiver Status.**")

Description of documentation attached: _____

Employment and Community First CHOICES Safety Determination Request Form

Applicant Name: _____

- Applicant has a pattern of recent falls resulting in injury or with significant potential for injury or a recent fall under circumstances indicating a significant potential risk for further falls.
 - Provide a detailed description of the fall(s) including the date of each incident, circumstances surrounding each fall, injury sustained as a result of the fall (if applicable) or significant potential for injury or risk for further falls, treatment received (if applicable), and interventions implemented to mitigate the risk of falls and injury from falls, and whether these interventions have been successful. (Attach additional explanation if needed and any other documentation pertaining to fall(s), including documentation of any treatment received. TennCare developed Fall Form may be used to assist. Label attachment(s) as “**Documentation of Falls.**”)

Description of documentation attached: _____

- Applicant has an established pattern of recent emergent hospital admissions or emergency department utilization for emergent conditions or a recent hospital or NF admission or episode of treatment in a hospital emergency department under circumstances sufficient to indicate that the person may not be capable of being safely maintained in the community (not every hospital or NF admission or ER episode will be sufficient to indicate such).
 - Document below and provide detailed explanation of any circumstances pertaining to such inpatient admission(s) or ER visit(s) which indicate that the person may not be capable of being safely maintained in the community, along with records from each admission or ER visit, e.g., discharge papers. Label attachment(s) as “**Inpatient Admissions/ER Visits.**”

Recent (last 365 days) hospital admissions		
Admit Date	Discharge Date	Reason for Admission

Recent (last 365 days) ER visits (for emergent condition <i>only</i>)	
Date	Reason for ER visit

Employment and Community First CHOICES Safety Determination Request Form

Applicant Name: _____

Recent (last 365 days) nursing facility admissions		
Admit Date	Discharge Date	Reason for admission

Description of documentation attached: _____

- The applicant’s behaviors or a pattern of self-neglect has created a risk to personal health, safety and/or welfare requiring involvement by law enforcement or Adult Protective Services.
 - Provide a detailed description of the behaviors and/or pattern of self-neglect, the frequency of each such behavior or self-neglect, the risk to personal health, safety and/or welfare, the date of involvement by law enforcement or Adult Protective Services, and any actions taken by such agency to ensure the person’s safety. Attach supporting documentation, including the APS/ Police reports, where available. Label attachment(s) as **“APS/Police Involvement.”**

Description of documentation attached: _____

- The applicant has recently been discharged from a community-based residential alternative setting (or such discharge is pending) because the applicant’s needs can no longer be safety met in that setting.
 - Document below and attach documentation detailed description of the circumstances leading to discharge, including documentation from the CBRA. Include explanation regarding any other previous settings from which the applicant has been discharged due to safety concerns, including the date(s) of such admissions and discharge. Label attachment(s) as **“CBRA Discharge.”**

Name of CBRA facility: _____

Date of discharge: _____

Safety concerns leading to discharge _____

Description of documentation attached: _____

- The applicant has diagnosed complex acute or chronic medical conditions which require frequent, ongoing skilled and / or rehabilitative interventions and treatment by licensed professional staff.

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- Document below (attach additional explanation if needed) and attach current (last 365 days) medical records documenting each condition, including ongoing treatment prescribed, and the name, professional title, and contact information of the primary treating practitioner for each such condition:

Medical Condition	Acute or Chronic	Intervention Required	Licensed staff required

Description of documentation attached: _____

- The applicant’s MCO has determined, upon enrollment into Group 5 based on a PAE submitted by another entity, that the applicant’s needs cannot be safely met within the array of services and supports available if enrolled in Group 5.
- None of the criteria above have been met, but other safety concerns which impact the applicant being safely served in CHOICES Group 5 exist.
 - Provide a detailed description of the safety concern and include sufficient evidence showing that the necessary intervention and supervision needed by the applicant cannot be safely provided within the array of services and supports that would be available if the applicant was enrolled in Choices Group 5. (Attach additional explanation if needed and any other documentation which would support the safety concerns detailed below. Label attachment(s) as “**Other Safety Concerns.**”)

Description of documentation attached: _____

Additional Required Documentation:

In addition to the information specified above to support each of the safety concerns identified, unless the applicant has a maladaptive score of -31 or lower, you must attach:

- ✓ A comprehensive needs assessment, including:
 - ✓ an assessment of the applicant’s physical, behavioral, and psychosocial needs not reflected in the PAE;
 - ✓ the specific tasks and functions for which assistance is needed by the Applicant;
 - ✓ the frequency with which such tasks must be performed; and
 - ✓ the Applicant’s need for safety monitoring and supervision

Label attachment(s) as “**Comprehensive Needs Assessment.**”

Employment and Community First CHOICES Safety Determination Request Form

Applicant Name: _____

- ✓ A detailed description of the Applicant's living arrangements and the services and supports the Applicant has received during the six (6) months prior to submission of the Safety Determination request, including unpaid care provided by family members and other caregivers, paid services and supports the Applicant has been receiving regardless of payer (e.g., non-CHOICES HCBS available through TennCare such as home health and services available through Medicare, private insurance or other funding sources); and any anticipated change in the availability of such care or services from the current caregiver or payer

Label attachment(s) as "**Prior 6 Months.**"

- ✓ A detailed explanation regarding any recent significant event(s) or circumstances that have impacted the Applicant's need for services and supports, including how such event(s) or circumstances impact the Applicant's ability to be safely supported within the array of covered services and supports that would be available if the Applicant were enrolled in CHOICES Group 5 or for a child under age 18 who has an intellectual or developmental disability, how such event(s) or circumstances would impact the Applicant's ability to remain in the family home.

Label attachment(s) as "**Recent Events.**"

- ✓ A person-centered plan of care or support plan developed by the MCO Care Coordinator or Support Coordinator (i.e., the entity submitting the Safety Determination request) which specifies the tasks and functions for which assistance is needed by the Applicant, the frequency with which such tasks must be performed, the Applicant's need for safety monitoring and supervision; and the amount (e.g., minutes, hours, etc.) of paid assistance that would be necessary to provide such assistance; and that would be provided by such entity upon approval of the Safety Determination. A plan of care or support plan is not required for a Safety Determination submitted by DIDD.)

Label attachment(s) as "**Plan of Care or Support Plan.**"

- ✓ A detailed explanation regarding why the array of covered services and supports, including CHOICES HCBS up to the Expenditure Cap of \$30,000 and one-time emergency assistance up to \$6,000 and non- CHOICES HCBS (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers would not be sufficient to safely meet the applicant's needs in the community or for a child under age 18 who has an intellectual or developmental disability, why the availability of benefits in ECF CHOICES Group 4, including ECF CHOICES HCBS up to the Expenditure Cap of \$15,000, non-ECF CHOICES HCBS available through TennCare (e.g., home health); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and natural supports provided by family members and other caregivers who are willing and able to provide such care, will help to minimize the child's risk of risk of placement outside the home.

Label attachment(s) as "**Safety Explanation.**"

Employment and Community First CHOICES Safety Determination Request Form

Applicant Name: _____

- ✓ If an Emergent Criteria Review Form has been completed and approved by Interagency Committee Review for this Applicant, please attach the completed **Emergent Criteria Review Form** and **Interagency Committee Review Decision Form**.
- ✓ If a Multiple Complex Health Conditions Criteria Review Form has been completed and approved by Interagency Committee Review for this Applicant, please attach the completed **Multiple Complex Health Conditions Criteria Review Form** and **Interagency Committee Review Decision Form**.

Label attachments as “**Interagency Review and Decision.**”

Submitting Entity Attestation

Completed Attestation, printed name, signature, credentials and date of form completion are required.

Please read and check at least one of the statements below (check all that apply):

- I do **not** believe this individual can be safely served in the community in CHOICES Group 4 or 5, as applicable.
- I believe this individual **can** be safely served in the community in CHOICES Group 4 or 5, as applicable.
- This safety determination form was completed at the request of the applicant/representative.

By signing below, I, as a qualified assessor, take responsibility for the information provided in this Safety Determination request and attest that I have personally reviewed the information provided in this Safety Determination Request and it is accurate and true to the best of my knowledge. I understand that this information will be used to determine Medicaid reimbursement for long-term care services and/or the applicant’s Medicaid eligibility. I understand that any intentional act or omission on my part to provide false information or give a false impression that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled may be considered an act of fraud under the state’s TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent may be subject to federal and state civil and criminal penalties.

Printed Name of person making this decision

Signature of person making this decision

Qualified Assessor Code

Date

Employment and Community First CHOICES Safety Determination Request Form

Applicant Name: _____

Fall Form

Please use this form when the justification for a safety determination request is related to a recent fall(s). Provide any available information for falls occurring within the last 6 months. Most recent fall should be listed first. All fields are not required, but providing all the details available will help ensure that the correct LOC is approved for this person.

Fall #	Date of fall:	Time of Fall:	AM / PM
Location of Fall:			
What was applicant doing prior to fall?			
List factors contributing to fall (environment, meds, etc...)			
Was an injury sustained related to fall? YES / NO		If yes, describe:	
What mechanisms are in place to prevent falls?			
Why were these prevention mechanisms unsuccessful?			
Fall #	Date of fall:	Time of Fall:	AM / PM
Location of Fall:			
What was applicant doing prior to fall?			
List factors contributing to fall (environment, meds, etc...)			
Was an injury sustained related to fall? YES / NO		If yes, describe:	
What mechanisms are in place to prevent falls?			
Why were these prevention mechanisms unsuccessful?			
Fall #	Date of fall:	Time of Fall:	AM / PM
Location of Fall:			
What was applicant doing prior to fall?			
List factors contributing to fall (environment, meds, etc...)			
Was an injury sustained related to fall? YES / NO		If yes, describe:	
What mechanisms are in place to prevent falls?			
Why were these prevention mechanisms unsuccessful?			
Fall #	Date of fall:	Time of Fall:	AM / PM
Location of Fall:			
What was applicant doing prior to fall?			
List factors contributing to fall (environment, meds, etc...)			

Employment and Community First CHOICES Safety Determination Request Form

Applicant Name: _____

Was an injury sustained related to fall? YES / NO	If yes, describe:
What mechanisms are in place to prevent falls?	
Why were these prevention mechanisms unsuccessful?	