Individual _____ Identifier _____ Date _____

Medical Necessity and Level of Care Assessment - Version 3.0

Section A Identification Information

A0310. Type of Assessment

Enter Code

A. Reason for Assessment

01. **Initial assessment**
03. **Annual assessment**
04. **Significant change in status assessment**

A0500. Legal Name of Individual

A. First name:

B. Middle initial:

C. Last name:

D. Suffix:

A0600. Social Security and Medicare Numbers

A. Social Security Number:

B. Medicare number (or comparable railroad insurance number):

A0700. Medicaid Number – Enter "+" if pending, "N" if not a Medicaid recipient

A0800. Gender

Enter Code

1. **Male**
2. **Female**

A0900. Birth Date

Month Day Year

A1000. Race/Ethnicity

Check all that apply

- ☐ **A. American Indian or Alaska Native**
- ☐ **B. Asian**
- ☐ **C. Black or African American**
- ☐ **D. Hispanic or Latino**
- ☐ **E. Native Hawaiian or Other Pacific Islander**
- ☐ **F. White**

Section A Identification Information

A1100. Language

Enter Code

A. Does the individual need or want an interpreter to communicate with a doctor or health care staff?

0. **No**
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine**

B. Preferred language:

A1300. Optional Individual Items

B. Room number:

A1550. Conditions Related to IDD Status

If the individual is 22 years of age or older, complete only if A0310A = 01
If the individual is 21 years of age or younger, complete always

↓ **Check all conditions that are related to IDD status** that were manifested before age 22, and are likely to continue indefinitely

	IDD With Organic Condition
☐	**A. Down syndrome**
☐	**B. Autism**
☐	**C. Epilepsy**
☐	**D. Other organic condition related to IDD**
	IDD Without Organic Condition
☐	**E. IDD with no organic condition**
	No IDD
☐	**Z. None of the above**

A2300. Assessment Date

Observation end date:

Month – Day – Year

Look back period for all items is 7 days unless another time frame is indicated

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code

Persistent vegetative state/no discernible consciousness

0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to GG0115. Functional Limitation in Range of Motion

B0200. Hearing

Enter Code

Ability to hear (with hearing aid or hearing appliances if normally used)

0. **Adequate** – no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** – difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** – speaker has to increase volume and speak distinctly
3. **Highly impaired** – absence of useful hearing

B0300. Hearing Aid

Enter Code

Hearing aid or other hearing appliance used in completing B0200, Hearing

0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code

Select best description of speech pattern

0. **Clear speech** – distinct intelligible words
1. **Unclear speech** – slurred or mumbled words
2. **No speech** – absence of spoken words

B0700. Makes Self Understood

Enter Code

Ability to express ideas and wants, consider both verbal and non-verbal expression. Enter '-' Dash if unable to assess.

0. **Understood**
1. **Usually understood** – difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** – ability is limited to making concrete requests
3. **Rarely/never understood**

B0799. Modes of Expression

Check all used by individual to make needs known

- ☐ A. **Speech**
- ☐ B. **Writing messages to express or clarify needs**
- ☐ C. **American sign language or Braille**
- ☐ D. **Signs/ Gestures/ Sounds**
- ☐ E. **Communication Board**
- ☐ F. **Voice Modulator**
- ☐ G. **Other**
- ☐ Z. **None of the above**

B0800. Ability To Understand Others

Enter Code

Understanding verbal content, however able (with hearing aid or device if used). Enter '-' Dash if unable to assess.

0. **Understands** – clear comprehension
1. **Usually understands** – misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** – responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code

Ability to see in adequate light (with glasses or other visual appliances)

0. **Adequate** – sees fine detail, such as regular print in newspapers/books
1. **Impaired** – sees large print, but not regular print in newspapers/books
2. **Moderately impaired** – limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** – object identification in question, but eyes appear to follow objects
4. **Severely impaired** – no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1200. Corrective Lenses

Enter Code

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision

0. **No**
1. **Yes**

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? – Attempt to conduct interview with the individual

Enter Code

0. **No** (individual is rarely/never understood) **OR** individual is less than 7 years of age**,** skip to and complete C0700-C1000, Caregiver Assessment for Mental Status
1. **Yes** →Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Ask individual: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words." Enter '-' Dash if unable to assess.

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the individual's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code

Ask individual: "Please tell me what year it is right now." Enter '-' Dash if unable to assess.

A. Able to report correct year

0. **Missed by > 5 years or no answer**
1. **Missed by 2–5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code

Ask individual: "What month are we in right now?" Enter '-' Dash if unable to assess.

B. Able to report correct month

0. **Missed by >1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code

Ask individual: "What day of the week is today?" Enter '-' Dash if unable to assess.

C. Able to report correct day of the week

0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Ask individual: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. Enter '-' Dash if unable to assess.

Enter Code

A. Able to recall "sock"

0. **No** – could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code

B. Able to recall "blue"

0. **No** – could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code

C. Able to recall "bed"

0. **No** – could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes**, **no cue required**

C0500. BIMS Summary Score

Enter Score

The sum of the scores for questions C0200–C0400. The sum should be a number (00–15)
A score of 99 indicates that the individual was unable to complete the interview

Section C Cognitive Patterns

C0600. Should the Caregiver Assessment for Mental Status (C0700-C1000) be Conducted?

Enter Code

0. **No** (Individual was able to complete Brief Interview for Mental Status) Skip to C1310, Signs and Symptoms of Delirium
1. **Yes** (Individual was unable to complete Brief Interview for Mental Status OR individual is less than 7 years of age) Continue to C0700, Short-term Memory OK

Caregiver Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200–C0500) was completed

C0700. Short-term Memory OK

Enter Code

Seems or appears to recall after 5 minutes. Enter '-' Dash if unable to assess OR individual is less than 2 years of age.

0. **Memory OK**
1. **Memory problem**

C0800. Long-term Memory OK

Enter Code

Seems or appears to recall long past. Enter '-' Dash if unable to assess OR individual is less than 2 years of age.

0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

Check all that the individual was normally able to recall

- ☐ **A. Current season**
- ☐ **B. Location of own room**
- ☐ **C. Caregiver names and faces**
- ☐ **D. That he or she is in their own home/room**
- ☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code

Made decisions regarding tasks of daily life

0. **Independent** – decisions consistent/reasonable
1. **Modified independence** – some difficulty in new situations only
2. **Moderately impaired** – decisions poor; cues/supervision required
3. **Severely impaired** – never/rarely made decisions

Delirium

C1310. Signs and Symptoms of Delirium (from CAM©)

Code after completing Brief Interview for Mental Status or Caregiver Assessment, and reviewing medical record

A. Acute Onset Mental Status Change

Enter Code

Is there evidence of an acute change in mental status from the individual's baseline?"

0. **No**
1. **Yes**

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

Enter Codes in Boxes

- ☐ **B. Inattention** - Did the individual have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
- ☐ **C. Disorganized Thinking** - Was the individual's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
- ☐ **D. Altered Level of Consciousness** - Did the individual have altered level of consciousness, as indicated by any of the following criteria?
  - 7 **vigilant** - startled easily to any sound or touch
  - 7 **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
  - 7 **stuporous** - very difficult to arouse and keep aroused for the interview
  - 7 **comatose** - could not be aroused

Section D Mood

D0100. Should Individual Mood Interview be Conducted? – Attempt to conduct interview with the individual

Enter Code

0. **No** (Individual is rarely/never understood) **OR** individual is less than 7 years of age Skip to and complete D0500 -D0600, Caregiver Assessment of Individual Mood(PHQ-9-OV)
1. **Yes** → Continue to D0200, Individual Mood Interview (PHQ-9©)

D0200. Individual Mood Interview (PHQ-9©)

Say to individual: "Over the last 2 weeks, have you been bothered by any of the following problems? **"**

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the individual: "About how often have you been bothered by this?"
Read and show the individual a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2–6 days** (several days)
2. **7–11 days** (half or more of the days)
3. **12–14 days** (nearly every day)

		1. Symptom Presence	2. Symptom Frequency
		↓ Enter Scores in Boxes ↓	
A.	Little interest or pleasure in doing things	☐	☐
B.	Feeling down, depressed, or hopeless	☐	☐
C.	Trouble falling or staying asleep, or sleeping too much	☐	☐
D.	Feeling tired or having little energy	☐	☐
E.	Poor appetite or overeating	☐	☐
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐
G.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐
H.	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐
I.	**Thoughts that you would be better off dead, or of hurting yourself in some way**	☐	☐

D0300. Total Severity Score

Enter Score ☐☐

The sum of the scores for all frequency responses in Column 2, Symptom Frequency. The sum should be a number (00-27) A score of 99 indicates that the individual was unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

Section D Mood

D0500. Caregiver Assessment of Individual Mood (PHQ-9-OV*)

Do not conduct if Individual Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the individual have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)

2. Symptom Frequency
0. **Never or 1 day**
1. **2–6 days** (several days)
2. **7–11 days** (half or more of the days)
3. **12–14 days** (nearly every day)

		1. Symptom Presence	2. Symptom Frequency
		↓ Enter Scores in Boxes ↓	
A.	**Little interest or pleasure in doing things**	☐	☐
B.	**Feeling or appearing down, depressed, or hopeless**	☐	☐
C.	**Trouble falling or staying asleep, or sleeping too much**	☐	☐
D.	**Feeling tired or having little energy**	☐	☐
E.	**Poor appetite or overeating**	☐	☐
F	**Indicating that s/he feels bad about self, is a failure, or has let self or family down**	☐	☐
G.	**Trouble concentrating on things, such as reading the newspaper or watching television**	☐	☐
H.	**Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that s/he has been moving around a lot more than usual**	☐	☐
I.	**States that life isn't worth living, wishes for death, or attempts to harm self**	☐	☐
J.	**Being short-tempered, easily annoyed**	☐	☐

D0600. Total Severity Score

☐☐ Enter Score

The sum of the scores for all frequency responses in Column 2, Symptom Frequency. The sum should be a number (00-30).

Section E Behavior

E0100. Potential Indicators of Psychosis

↓ Check all that apply

- ☐ A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
- ☐ B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- ☐ Z. **None of the above**

Behavioral Symptoms

E0200. Behavioral Symptom – Presence & Frequency

Note presence of symptoms and their frequency

Coding:

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

↓ Enter Codes in Boxes

- ☐ A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
- ☐ B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
- ☐ C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0300. Overall Presence of Behavioral Symptoms

Enter Code ☐

Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?

0. **No** → Skip to E0800, Rejection of Care
1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

E0500. Impact on Individual

Did any of the identified symptom(s):

Enter Code ☐ **A. Put the individual at significant risk for physical illness or injury?**

0. **No**
1. **Yes**

Enter Code ☐ **B. Significantly interfere with the individual's care?**

0. **No**
1. **Yes**

Enter Code ☐ **C. Significantly interfere with the individual's participation in activities or social interactions?**

0. **No**
1. **Yes**

E0600. Impact on Others

Did any of the identified symptom(s):

Enter Code ☐ **A. Put others at significant risk for physical injury?**

0. **No**
1. **Yes**

Enter Code ☐ **B. Significantly intrude on the privacy or activity of others?**

0. **No**
1. **Yes**

Enter Code ☐ **C. Significantly disrupt care or living environment?**

0. **No**
1. **Yes**

E0800. Rejection of Care – Presence & Frequency

Enter Code ☐

Did the individual reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the individual's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the individual or family), and determined to be consistent with individual values, preferences, or goals.

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

Section E Behavior

E0900. Wandering – Presence & Frequency

Enter Code

Has the individual wandered?

0. **Behavior not exhibited** → Skip to E1100, Change in Behavior or Other Symptoms
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

E1000. Wandering – Impact

Enter Code

A. Does the wandering place the individual at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the residence/facility)?

0. **No**
1. **Yes**

Enter Code

B. Does the wandering significantly intrude on the privacy or activities of others?

0. **No**
1. **Yes**

E1100. Change in Behavior or Other Symptoms – Consider all of the symptoms assessed in items E0100 through E1000.

Enter Code

How does individual's current behavior status, care rejection, or wandering **compare to prior assessment?**

0. **Same**
1. **Improved**
2. **Worse**
3. **N/A** because no prior assessment

Section GG Functional Abilities

GG0115. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed individual at risk of injury in the last 7 days.

Coding:

0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

Enter Code in Boxes

☐	**A. Upper extremity** (shoulder, elbow, wrist, hand)
☐	**B. Lower extremity** (hip, knee, ankle, foot)

GG0120. Mobility Devices

Check all that were normally used in the last 7 days

☐	**A. Cane / crutch**
☐	**B. Walker**
☐	**C. Wheelchair** (manual or electric)
☐	**D. Limb prosthesis**
☐	**Z. None of the above** were used

GG0130. Self-Care (Assessment period is the A2300. Assessment Date plus 2 previous calendar days)

Code the individual's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance** - If caregiver assistance is required because individual's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Individual completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Caregiver sets up or cleans up; individual completes activity. Caregiver assists only prior to or following the activity.
04. **Supervision or touching assistance** - Caregiver provides verbal cues and/or touching/steadying and/or contact guard assistance as individual completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Caregiver does LESS THAN HALF the effort. Caregiver lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Caregiver does MORE THAN HALF the effort. Caregiver lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Caregiver does ALL of the effort. Individual does none of the effort to complete the activity. Or, the assistance of 2 or more caregivers is required for the individual to complete the activity.

If activity was not attempted, code reason:

07. **Individual refused**
09. **Not applicable** - Not attempted and the individual did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

Enter Code in Boxes

☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the individual.
☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

Section GG Functional Abilities

	E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
	F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
	I. Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/ drying face and hands (excludes baths, showers, and oral hygiene).

GG0170. Mobility (Assessment Period is the A2300. Assessment Date plus 2 previous calendar days)

Code the individual's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance** - If caregiver assistance is required because individual's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Individual completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Caregiver sets up or cleans up; individual completes activity. Caregiver assists only prior to or following the activity.
04. **Supervision or touching assistance** - Caregiver provides verbal cues and/or touching/steadying and/or contact guard assistance as individual completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Caregiver does LESS THAN HALF the effort. Caregiver lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Caregiver does MORE THAN HALF the effort. Caregiver lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Caregiver does ALL of the effort. Individual does none of the effort to complete the activity. Or, the assistance of 2 or more caregivers is required for the individual to complete the activity.

If activity was not attempted, code reason:

07. **Individual refused**
09. **Not applicable** - Not attempted and the individual did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

Enter Code in Boxes ↓

	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support.
	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
	F. Toilet transfer: The ability to get on and off a toilet or commode.
	FF. Tub/shower transfer: The ability to get in and out of a tub/shower.
	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If performance in the last 7 days is coded 07, 09, 10, or 88 → Skip to GG0170Q5, Does the individual use a wheelchair and/or scooter?

Section GG Functional Abilities

☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
	Q5. Does the individual use a wheelchair and/or scooter? ☐ **Coding:** **1. No** → Skip to H0100, Appliances **2. Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	RR5. Indicate the type of wheelchair or scooter used. ☐ **Coding:** **1. No** → Manual **2. Yes** → Motorized
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	SS5. Indicate the type of wheelchair or scooter used. ☐ **Coding:** **1. No** → Manual **2. Yes** → Motorized

Section H Bladder and Bowel

H0100. Appliances

↓ **Check all that apply**

- ☐ **A. Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
- ☐ **B. External catheter**
- ☐ **C. Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ **D. Intermittent catheterization**
- ☐ **Z. None of the above**

H0200. Urinary Toileting Program

Enter Code

C. Current continence promotion program or trial – Is an individualized continence promotion program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the individual's urinary continence?

0. **No**
1. **Yes**

H0300. Urinary Continence

Enter Code

Urinary continence – Select the one category that best describes the individual

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence,but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated**, individual had a catheter (indwelling, condom), urinary ostomy, or no urine output for entire 7 days

H0400. Bowel Continence

Enter Code

Bowel continence – Select the one category that best describes the individual

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** individual had an ostomy or did not have a bowel movement for the entire 7 days

H0500. Bowel Continence Program

Enter Code

Is an individualized continence promotion program currently being used to manage the individual's bowel continence?

0. **No**
1. **Yes**

H0600. Bowel Patterns

Enter Code

Constipation present?

0. **No**
1. **Yes**

Section I Active Diagnoses

Active Diagnoses in the last 7 days – Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Cancer

- ☐ **I0100. Cancer** (with or without metastasis)

Heart/Circulation

- ☐ **I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
- ☐ **I0300. Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias)
- ☐ **I0400. Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
- ☐ **I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
- ☐ **I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
- ☐ **I0700. Hypertension**

  I0799a. Blood Pressure ☐☐☐ ☐☐☐
- ☐ **I0800. Orthostatic Hypotension**
- ☐ **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
- ☐ **I0999. Peripheral Edema**

Gastrointestinal

- ☐ **I1100. Cirrhosis**
- ☐ **I1200. Gastroesophageal Reflux Disease** (**GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)
- ☐ **I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

Genitourinary

- ☐ **I1400. Benign Prostatic Hyperplasia (BPH)**
- ☐ **I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)**
- ☐ **I1550. Neurogenic Bladder**
- ☐ **I1650. Obstructive Uropathy**

Infections

- ☐ **I1700. Multidrug-Resistant Organism (MDRO)**
- ☐ **I2000. Pneumonia**
- ☐ **I2100. Septicemia**
- ☐ **I2200. Tuberculosis**
- ☐ **I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
- ☐ **I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
- ☐ **I2500. Wound Infection** (other than foot)

Metabolic

- ☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)

  I2999. Blood Sugar Range ☐☐☐ — ☐☐☐
- ☐ **I3100. Hyponatremia**
- ☐ **I3200. Hyperkalemia**
- ☐ **I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
- ☐ **I3400. Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Section I Active Diagnoses

Active Diagnoses in the last 7 days – Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Musculoskeletal

- ☐ **I3700. Arthritis** (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
- ☐ **I3800. Osteoporosis**
- ☐ **I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
- ☐ **I3999. Contractures**
- ☐ **I4000. Other Fracture**
- ☐ **I4099. Scoliosis**

Neurological

- ☐ **I4200. Alzheimer's Disease**
- ☐ **I4300. Aphasia**
- ☐ **I4400. Cerebral Palsy**
- ☐ **I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ **I4800. Non-Alzheimer's Dementia** (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
- ☐ **I4900. Hemiplegia or Hemiparesis**
- ☐ **I5000. Paraplegia**
- ☐ **I5100. Quadriplegia**
- ☐ **I5199. Tremors**
- ☐ **I5200. Multiple Sclerosis (MS)**
- ☐ **I5250. Huntington's Disease**
- ☐ **I5299. Muscular Dystrophy**
- ☐ **I5300. Parkinson's Disease**
- ☐ **I5350. Tourette's Syndrome**
- ☐ **I5399. Hydrocephalus**
- ☐ **I5400. Seizure Disorder or Epilepsy**

I5499. Type of Seizure

↓ Check all that apply

- ☐ **A. Localized** (partial or focal)
- ☐ **B Generalized** (absence, myclonic, clonic, tonic and atonic)

I5499C. Average Frequency of Seizures in the last 7 days

Enter Code ☐

- **0. No seizures**
- **1. Less than 1 seizure/week**
- **2. 1-6 seizures/week**
- **3. 1 seizure/day**
- **4. 2-5 seizures/day**
- **5. 6-12 seizures/day**
- **6. More than 12 seizures/day**

- ☐ **I5500. Traumatic Brain Injury (TBI)**
- ☐ **I5599. Spina Bifida**

Section I Active Diagnoses

Active Diagnoses in the last 7 days – Check all that apply

Nutritional

- ☐ **I5600. Malnutrition** (protein or calorie) or at risk for malnutrition
- ☐ **I5699. At risk for dehydration**

Psychiatric/Mood Disorder

- ☐ **I5700. Anxiety Disorder**
- ☐ **I5800. Depression** (other than bipolar)
- ☐ **I5900. Bipolar Disorder**
- ☐ **I5950. Psychotic Disorder** (other than schizophrenia)
- ☐ **I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ **I6100. Post Traumatic Stress Disorder (PTSD)**
- ☐ **I6199. ADHD Syndrome**

Pulmonary

- ☐ **I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ **I6299. Cystic Fibrosis**
- ☐ **I6300. Respiratory Failure**

Vision

- ☐ **I6500. Cataracts, Glaucoma, or Macular Degeneration**

None of Above

- ☐ **I7900. None of the above active diagnoses** within the last 7 days

Other

I8000. Additional active diagnoses

Enter diagnosis description and ICD code.

A. _____ ☐☐☐☐☐☐☐☐

B. _____ ☐☐☐☐☐☐☐☐

C. _____ ☐☐☐☐☐☐☐☐

D. _____ ☐☐☐☐☐☐☐☐

E. _____ ☐☐☐☐☐☐☐☐

F. _____ ☐☐☐☐☐☐☐☐

G. _____ ☐☐☐☐☐☐☐☐

H. _____ ☐☐☐☐☐☐☐☐

I. _____ ☐☐☐☐☐☐☐☐

J. _____ ☐☐☐☐☐☐☐☐

Section J Health Conditions

J0100. Pain Management – Complete for the individual, regardless of current pain level

At any time in the last 5 days, has the individual:

Enter Code

A. Received scheduled pain medication regimen?
0. **No**
1. **Yes**

Enter Code

B. Received PRN pain medications OR was offered and declined?
0. **No**
1. **Yes**

Enter Code

C. Received non-medication intervention for pain?
0. **No**
1. **Yes**

J0200. Should Pain Assessment Interview be Conducted?– Attempt to conduct interview with the individual.
If individual is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code

0. **No** (individual is rarely/never understood **OR** individual is less than 3 years of age)→ Skip to J0800, Indicators of Pain or Possible Pain
1. **Yes** →Continue to J0300, Pain Presence

Pain Assessment Interview

J0300. Pain Presence

Enter Code

Ask individual: "Have you had pain or hurting at any time in the last 5 days?"
0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0400, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0400. Pain Frequency

Enter Code

Ask individual: "How much of the time have you experienced pain or hurting over the last 5 days?"
1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

J0500. Pain Effect on Function

Enter Code

A. Ask individual: "Over the past 5 days, has pain made it hard for you to sleep at night? "
0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code

B. Ask individual: "Over the past 5 days, have you limited your day-to-day activities because of pain? "
0. **No**
1. **Yes**
9. **Unable to answer**

J0600. Pain Intensity – Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating

A. Numeric Rating Scale (00–10)
Ask individual: "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine." (Show individual 00 -10 pain scale)
Enter two-digit response. Enter 99 if unable to answer.

Enter Code

B. Verbal Descriptor Scale
Ask individual: "Please rate the intensity of your worst pain over the last 5 days." (Show individual verbal scale)
1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

Section J Health Conditions

J0700. Should the Caregiver Assessment for Pain be Conducted?

Enter Code ☐

0. **No** (J0400=1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
1. **Yes** (J0400=9) → Continue to J0800, Indicators of Pain or Possible Pain

Caregiver Assessment for Pain

J0800. Indicators of Pain or Possible Pain in the last 5 days

↓ **Check all that apply**

- ☐ **A. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
- ☐ **B. Vocal complaints of pain** (e.g., that hurts, ouch, stop)
- ☐ **C. Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- ☐ **D. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- ☐ **Z. None of these signs observed or documented** If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code ☐

Frequency with which individual complains or shows evidence of pain or possible pain

1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

- ☐ **A. Shortness of breath** or trouble breathing **with exertion** (e.g. walking, bathing, transferring)
- ☐ **B. Shortness of breath** or trouble breathing **when sitting at rest**
- ☐ **C. Shortness of breath** or trouble breathing **when lying flat**
- ☐ **Z. None of the above**

J1400. Prognosis

Enter Code ☐

Does the individual have a condition or chronic disease that may result in a **life expectancy of less than 6 months**?

0. **No**
1. **Yes**

J1550. Problem Conditions

↓ **Check all that apply**

- ☐ **A. Fever**
- ☐ **B. Vomiting**
- ☐ **C. Dehydrated**
- ☐ **D. Internal bleeding**
- ☐ **E99. Syncope**
- ☐ **Z. None of the above**

Section J Health Conditions

J1700. Fall History

Enter Code	**A.** Did the individual have a fall any time in the **last month**? 0. **No** 1. **Yes** 9. **Unable to determine**
Enter Code	**B.** Did the individual have a fall any time in the **last 2–6 months**? 0. **No** 1. **Yes** 9. **Unable to determine**
Enter Code	**C.** Did the individual have any **fracture related to a fall in the last 6 months**? 0. **No** 1. **Yes** 9. **Unable to determine**

J1900. Number of Falls in the last 6 months with or without injury

Complete only if J1700A or J1700B = 1

Coding:
0. **None**
1. **One**
2. **Two or more**

#**Enter Codes in Boxes**	
☐	**A. No injury** – no evidence of any pain, injury or change in the individual's behavior after the fall as reported by the individual/ caregiver.
☐	**B. Injury (except major)** – skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the individual to complain of pain
☐	**C. Major injury** – bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J2000. Prior Surgery

Enter Code ☐	Did the individual have major surgery during the 100 days prior to **this assessment**? 0. **No** 1. **Yes** 8. **Unknown**

Section K Swallowing/Nutritional Status

K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder

↓ **Check all that apply**

- ☐ **A. Loss of liquids/solids from mouth when eating or drinking**
- ☐ **B. Holding food in mouth/cheeks or residual food in mouth after meals**
- ☐ **C. Coughing or choking during meals or when swallowing medications**
- ☐ **D. Complaints of difficulty or pain with swallowing**
- ☐ **Z. None of the above**

K0200. Height and Weight – While measuring, if the number is X.1 – X.4, round down; X.5 or greater round up

☐☐ inches

A. Height (in inches). Record most recent height measure.

☐☐☐

B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.). Enter '-' Dash if unable to assess.

K0300. Weight Loss

☐

Loss of 5% or more in the last month or loss of 10% or more in last 6 months

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

K0310. Weight Gain

☐

Gain of 5% or more in the last month or gain of 10% or more in last 6 months

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-gain regimen
2. **Yes, not on** physician-prescribed weight-gain regimen

K0510. Nutritional Approaches

↓ **Check all of the following nutritional approaches that were performed during the last 7 days**

- ☐ **A. Parenteral/IV feeding**
- ☐ **B. Feeding-tube** – nasogastric or abdominal (PEG)
- ☐ **C. Mechanically altered diet** – require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- ☐ **D. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)
- ☐ **Z. None of the above**

K0710. Percent Intake by Artificial Route – Complete K0710 only if K0510A or K0510B is checked

Enter ☐ Code

A. Proportion of total calories the individual received through parenteral or tube feeding during entire 7 days

1. **25% or less**
2. **26–50%**
3. **51% or more**

Enter ☐ Code

B. Average fluid intake per day by IV or tube feeding during entire 7 days

1. **500 cc/day or less**
2. **501 cc/day or more**

Section L Oral/Dental Status

L0200. Dental	
↓ Check all that apply	
☐	**A. Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
☐	**B. No natural teeth or tooth fragment(s)** (edentulous)
☐	**C. Abnormal mouth tissue** (ulcers, masses, oral lesions, including under denture or partial if one is worn)
☐	**D. Obvious or likely cavity or broken natural teeth**
☐	**E. Inflamed or bleeding gums or loose natural teeth**
☐	**F. Mouth or facial pain, discomfort or difficulty with chewing**
☐	**G. Unable to examine**
☐	**Z. None of the above were present**

Section M Skin Conditions

Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse"stage

M0100. Determination of Pressure Ulcer/Injury Risk

↓ **Check all that apply**

- ☐ **A. Individual has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device**
- ☐ **B. Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☐ **C. Clinical assessment**
- ☐ **Z. None of the above**

M0150. Risk of Pressure Ulcers/Injuries

Enter Code ☐

Is this individual at risk of developing pressure ulcers/injuries?

0. **No**
1. **Yes**

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code ☐

Does this individual have one or more unhealed pressure ulcers/injuries?

0. **No** → skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Enter Number ☐

A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

1. Number of Stage 1 pressure injuries

Enter Number ☐

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

1. Number of Stage 2 pressure ulcers - If 0 → **skip to M0300C, Stage 3**

Enter Number ☐

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

1. Number of Stage 3 pressure ulcers

Enter Number ☐

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

1. Number of Stage 4 pressure ulcerso- If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device

Enter Number ☐

E. Unstageable – Non-removable dressing/device: Known but not stageable due to non-removable dressing/device

1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable e -Slough and/or eschar

Enter Number ☐

F. Unstageable – Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar

Enter Number ☐

G. Unstageable – Deep tissue injury:

1. Number of unstageable pressure injuries presenting as deep tissue injury - If 0 → Skip to M1030, Number of Venous and Arterial Ulcers

Section M Skin Conditions

M1030. Number of Venous and Arterial Ulcers

Enter Number	
☐	**Enter the total number of venous and arterial ulcers present**

M1040. Other Ulcers, Wounds and Skin Problems

↓ **Check all that apply**

	Foot Problems
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other open lesion(s) on the foot**
	Other Problems
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**E. Surgical wound(s)**
☐	**F. Burn(s)** (second or third degree)
☐	**G. Skin tear(s)**
☐	**H. Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
☐	**Z. None of the above** were present

Section M Skin Conditions

M1200. Skin and Ulcer/Injury Treatments	
↓ Check all that apply	
☐	**A. Pressure reducing device for chair**
☐	**B. Pressure reducing device for bed**
☐	**C. Turning/repositioning program**
☐	**D Nutrition or hydration intervention** to manage skin problems
☐	**E. Pressure ulcer/injury care**
☐	**F. Surgical wound care**
☐	**G. Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	**H. Applications of ointments/medications** other than to feet
☐	**I. Application of dressings to feet** (with or without topical medications)
☐	**Z. None of the above** were provided

Section N Medications

N0300. Injections	
Enter Days ☐	Record the **number of days that injections of any type were received** during the last 7 days If 0 → Skip to N0410, Medications Received
N0350. Insulin	
Enter Days ☐	**A. Insulin injections – Record the number of days that insulin injections were received** during the last 7 days
Enter Days ☐	**B. Orders for insulin – Record the number of days the physician (or authorized assistant or practitioner) changed the individual's insulin orders** during the last 7 days
N0410. Medications Received	
↓ **Indicate the number of DAYS the individual received the following medications by pharmacological classification, not how it is used, during the last 7 days.** Enter "0" if medication was not received by the individual during the last 7 days.	
Enter Days ☐	**A. Antipsychotic**
Enter Days ☐	**B. Antianxiety**
Enter Days ☐	**C. Antidepressant**
Enter Days ☐	**D. Hypnotic**
Enter Days ☐	**E. Anticoagulant** (e.g., warfarin, heparin, or low-molecular weight heparin)
Enter Days ☐	**F. Antibiotic**
Enter Days ☐	**G. Diuretic**
Enter Days ☐	**H. Opioid**

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last 14 days

	Check all that apply ↓
Cancer Treatments	
A. Chemotherapy	☐
B. Radiation	☐
Respiratory Treatments	
C. Oxygen therapy	☐
D. Suctioning	☐
E. Tracheostomy care	☐
F. Invasive Mechanical Ventilator (ventilator or respirator)	☐
G. Non-Invasive Mechanical Ventilator (BiPAP/CPAP)	☐
Other	
H. IV medications	☐
I. Transfusions	☐
J. Dialysis	☐
K. Hospice care	☐
L. Respite care	☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	☐
N99. Psychiatric care	☐
None of the Above	
Z. None of the above	☐

Section O Special Treatments, Procedures, and Programs

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the individual **individually** in the last 7 days

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the individual **concurrently with one other individual** in the last 7 days

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as **part of a group of individuals** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B, Occupational Therapy

Enter Number of Minutes

3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the individual in co-treatment sessions in the last 7 days

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the last assessment) started

Month – Day – Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the last assessment) ended - enter dashes if therapy is ongoing

Month – Day – Year

B. Occupational Therapy

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the individual **individually** in the last 7 days

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the individual **concurrently with one other individual** in the last 7 days

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as **part of a group of individuals** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C, Physical Therapy

Enter Number of Minutes

3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the individual in co-treatment sessions in the last 7 days

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the last assessment) started

Month – Day – Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the last assessment) ended - enter dashes if therapy is ongoing

Month – Day – Year

O0400 continued on next page

Section O — Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

C. Physical Therapy

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

1. **Individual minutes** - record the total number of minutes this therapy was administered to the individual **individually** in the last 7 days
2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the individual **concurrently with one other individual** in the last 7 days
3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as **part of a group of individuals** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400D, Respiratory Therapy

3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the individual in co-treatment sessions in the last 7 days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
5. **Therapy start date** - record the date the most recent therapy regimen (since the last assessment) started — Month – Day – Year
6. **Therapy end date** - record the date the most recent therapy regimen (since the last assessment) ended - enter dashes if therapy is ongoing — Month – Day – Year

D. Respiratory Therapy

Enter Number of Minutes

Enter Number of Days

1. **Total minutes** - record the total number of minutes this therapy was administered to the individual in the last 7 days
   If zero, → skip to O0400E, Psychological Therapy
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

E. Psychological Therapy (by any licensed mental health professional)

Enter Number of Minutes

Enter Number of Days

1. **Total minutes** - record the total number of minutes this therapy was administered to the individual in the last 7 days
   If zero, → skip to O0400F, Recreational Therapy
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

F. Recreational Therapy (includes recreational and music therapy)

Enter Number of Minutes

Enter Number of Days

1. **Total minutes** - record the total number of minutes this therapy was administered to the individual in the last 7 days
   If zero, → skip to O0420, Distinct Calendar Days of Therapy
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

Section O Special Treatments, Procedures, and Programs

O0420. Distinct Calendar Days of Therapy

Enter Number of Days ☐

Record the number of calendar days that the individual received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

Number of Days	Technique
☐	**A. Range of motion (passive)**
☐	**B. Range of motion (active)**
☐	**C. Splint or brace assistance**
Number of Days	**Training and Skill Practice In:**
☐	**D. Bed mobility**
☐	**E. Transfer**
☐	**F. Walking**
☐	**G. Dressing and/or grooming**
☐	**H. Eating and/or swallowing**
☐	**I. Amputation/prostheses care**
☐	**J. Communication**

O0600. Physician Examinations

Enter Days ☐☐

Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the individual?**

O0700. Physician Orders

Enter Days ☐☐

Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) change the individual's orders?**

Section P Restraints and Alarms

P0100. Physical Restraints

Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the individual's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body

Coding:
0. **Not used**
1. **Used less than daily**
2. **Used daily**

↓ **Enter Codes in Boxes**

	Used in Bed
☐	**A. Bed rail**
☐	**B. Trunk restraint**
☐	**C. Limb restraint**
☐	**D. Other**
	Used in Chair or Out of Bed
☐	**E. Trunk restraint**
☐	**F. Limb restraint**
☐	**G. Chair prevents rising**
☐	**H. Other**

P0200. Alarms

An alarm is any phyiscal or electronic device that monitors an individual's movement and alerts when movement is detected.

Coding:
0. **Not used**
1. **Used less than daily**
2. **Used daily**

↓ **Enter Codes in Boxes**

☐	**A. Bed alarm**
☐	**B. Chair alarm**
☐	**C. Floor mat alarm**
☐	**D. Motion Sensor alarm**
☐	**E. Wander/elopement alarm**
☐	**F. Other alarm**

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code ☐

A. Individual participated in assessment
0. **No**
1. **Yes**

Enter Code ☐

B. Family or significant other participated in assessment
0. **No**
1. **Yes**
9. **No family or significant other available**

Enter Code ☐

C. Guardian or legally authorized representative participated in assessment
0. **No**
1. **Yes**
9. **No guardian or legally authorized representative available**

Q0300. Individual's Overall Expectation

Complete only if A0310A = 01

Enter Code ☐

A. Select one for individual's overall goal established during assessment process
1. Expects to be **discharged to the home** (i.e. currently in ALF)
2. Expects to **remain in the home**
3. Expects to be **transferred to a facility/institution**
9. **Unknown or uncertain**

Enter Code ☐

B. Indicate information source for Q0300A
1. **Individual**
2. If not individual, then **family or significant other**
3. If not individual, family, or significant other, then **guardian or legally authorized representative**
9. **Unknown or uncertain**

Section Z Assessment Administration

Z0500. Signature of RN Completing Assessment

A. Signature

B. Date Assessment Completed:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

LTC Medicaid Information

S1. Medicaid Information

S1a	Medicaid Client Indicator 1. Medicaid	
S1b	Individual Address	
S1c	City	
S1d	State	
S1e	ZIP Code	
S1f	Phone	

S2. Claims Processing Information

S2a	DADS Vendor/Site ID Number	
S2b	Provider Number	
S2c	Service Group 3. CBA 11. PACE 17. CWP 19. Star + Plus 23. CFC	
S2d	NPI Number	
S2e	Region	
S2f	Purpose Code	
S2g	HHA License #	
S2h	HHA License # Expiration Date	

S3. Primary Diagnosis

S3a	Primary Diagnosis ICD Code	
S3b	Primary Diagnosis ICD Description	

S4. For DADS use only

S4a	RN Asssessment Coordinator	
S4b	PDPM LTC	
S4c	Effective Date	
S4d	Expiration Date	
S4e	County	
S4f	DADS RN Signature	
S4g	Signature Date	

S5. Licenses

Certification: To the best of my knowledge, I certify to the accuracy and completeness of this information.

S5a	HHA RN Last Name	
S5b	HHA RN License #	
S5c	HHA RN License State	
S5d	DADS RN Last Name	
S5e	DADS RN License #	
S5f	DADS RN License State	
S5g	DADS RN Signature Date	
DADS RN Signature		
S5h	PACE RN Last Name	
S5i	PACE RN License #	
S5j	PACE RN License State	
S5k	HMO RN Last Name	
S5l	HMO RN License #	
S5m	HMO RN License State	

S6. Additional MN Information

S6a	Tracheostomy Care 1. Less than once a week 2. 1 to 6 times a week 3. Once a day 4. Twice a day 5. 3 - 11 times a day 6. Every 2 hours 7. Hourly / continuous	
S6b	Ventilator/Respirator 1. Less than once a week 2. 1 to 6 times a week 3. Once a day 4. Twice a day 5. 3 - 11 times a day 6. 6 - 23 hours 7. 24-hour continuous	

LTC Medicaid Information

S6c	Number of hospitalizations in the last 90 days	
S6d	Number of emergency room visits in the last 90 days	
S6e	Oxygen Therapy 1. Less than once a week 2. 1 to 6 times a week 3. Once a day 4. Twice a day 5. 3 - 11 times a day 6. 6 - 23 hours 7. 24-hour continuous	
S6f	Special Ports/Central Lines/PICC Y/N/U	
S6g	At what developmental level is the individual functioning? 1. < 1 Infant 2. 1 - 2 Toddler 3. 3 - 5 Pre-School 4. 6 - 10 School age 5. 11 - 15 Young Adolescence 6. 16 - 20 Older Adolescence -. Unknown or unable to assess	
S6h	Enter the number of times this individual has fallen in the last 90 days	
S6i	In how many of the falls listed above was the person physically restrained prior to the fall?	
S6j	In the falls listed in S6h above, how many had the following contributory factors? (More than one factor may apply to a fall. Indicate the number of falls for each contributory factor.)	
1	Environmental (debris, slick or wet floors, lighting, etc.)	
2	Medication(s)	
3	Major Change in Medical Condition (Myocardial Infarction (MI/Heart Attack), Cerebrovascular Accident (CVA/Stroke), Syncope (Fainting), etc.)	
4	Poor Balance/Weakness	
5	Confusion/Disorientation	
6	Assault by Individual or Caregiver	

S7. Physician's Evaluation & Recommendation

S7a	Did an MD/DO certify that this individual requires nursing facility services or alternative community based services under the supervision of an MD/DO? Y/N	
S7b	Did a military physician providing healthcare according to requirements stipulated in 10 US Code 1094 provide the evaluation and recommendation for this individual? Y/N	

S7c	MD/DO Last Name	
S7d	MD/DO License #	
S7e	MD/DO License State	

Indicate Physician Signature on file by checking box [Required for Initial Assessments] ☐

The following MD/DO information is required if MD/DO is **not** licensed in Texas.

S7f	MD/DO First Name	
S7g	MD/DO Address	
S7h	MD/DO City	
S7i	MD/DO State	
S7j	MD/DO ZIP Code	
S7k	MD/DO Phone	

LTC Medicaid Information

S9. Medications

List all medications that the individual received during the last 30 days. Include scheduled medications that are used regularly, but less than weekly.

☐ **Medication Certification:** I certify this individual is taking no medications OR the medications listed below are correct

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. PRN-n

LTC Medicaid Information

S10. Comments

S11. Advance Care Planning

S11a	Does the individual/caregiver report having a legally authorized representative? Y/N	
S11b	Does the individual/caregiver report having a Directive to Physicians and Family or Surrogates? Y/N	
S11c	Does the individual/caregiver report having a Medical Power of Attorney? Y/N	
S11d	Does the individual/caregiver report having an Out-of-Hospital Do Not Resuscitate Order? Y/N	

S12. LAR Address

Required if individual/caregiver has reported having a legally authorized representative.		
S12a	LAR First Name	
S12b	LAR Last Name	
S12c	Address	
S12d	City	
S12e	State	
S12f	ZIP Code	
S12g	Phone	