DEMOGRAPHIC INFORMATION

Assessment Date				**Medicaid Number:**		
Recipient Name: (first, middle, last)						**MCO:**
Age:	DOB:	Ethnicity:	Gender:	Gender Expression:	Marital Status:	SSN:

Legal Status (if applicable; please include court order):
□ **None** □ **Judicial Civil** □ **Judicial Civil 648B** □ **NGBRI**
□ **Parole** □ **Probation** □ **Charges Pending** □ **AOT** □ **Judicial**
□ **Court Ordered outpatient Treatment** □ **Legal Detainer**
□ **Other: (list)**

Power of Attorney (POA): select □ **Medical** □ **Financial** □ **Both**
Phone Number of POA:_____
Curator: select **Name:**_____
Phone Number:_____

If available, please attach a copy of legal documentation including Legal status, Power of Attorney, or Interdiction

Past Judicial Status:
□ **None** □ **DWI** □ **Prior Arrests** □ **History of Sexual Offense** □ **History of Elderly Abuse** □ **Prior Incarcerations**_____
□ **History of Aggressive Behavior: (describe)** _____

LOCUS: (date and score) **PRIMARY DIAGNOSIS (from Psych Eval):**

Facility/Agency/Individual Requesting Placement (please include contact person, phone#, and fax to send determination):

Current Location of the Individual:

Type of Referral: □ **Pre-admission;** □ **Resident Review;** □ **Extension Request**

DOCUMENTS REVIEWED/INDIVIDUAL INTERVIEWS

Federal regulations require that the following items are reviewed as part of this evaluation and must be submitted to the Level II Authority with the PASRR Level II Independent Behavioral Health Comprehensive Evaluation. **The Evaluation will not be considered as complete until this information is provided to OBH.** (attach all records reviewed):
□ Medical H&P □ Functional Assessment □ Psychiatric Evaluation or Psychiatric Consult □ Psychosocial Evaluation □ Comprehensive Medications
□ Psychological Testing Results □ Progress Notes(most recent) □ Additional Labs or Consults:_____
□ Other_____

The following individuals were interviewed:
□ Individual □ Family/significant other (specify name)_____
□ Legal representative/Guardian/Conservator (specify name) _____
□ NF/Hospital Staff (specify name/discipline)_____ /_____
□ Other agency for interdisciplinary coordination (specify/organization) _____
□ Other_____

Was the Individual able to participate in the interview? □ Yes □ No If no, please explain why: _____
_____

BEHAVIORAL HEALTH HISTORY

I. CHIEF COMPLAINT ACCORDING TO THE RECIPIENT (the person's viewpoint of their needs.)

II. FAMILY OR SIGNIFICANT OTHER'S DESCRIPTION OF THE PROBLEM

Person Providing Information: _____ **Relationship to Applicant:** _____

III. PRESENTING PROBLEM/HISTORY OF PRESENT ILLNESS: (Including recipient's reason for seeking services, precipitating factors, symptoms, behavioral and functioning impacts, onset/course of issues, *current behavioral health providers,* services sought and recipient expectation, include information on medicaid and medicare-funded services, as well as services provided through alternate funding.)

IV. CURRENT BEHAVIORAL HEALTH PROVIDER/PRESCRIBER: **□ check if N/A**

AGENCY NAME:_____
PHONE NUMBER:_____
DATE SERVICES BEGAN:_____
LAST APPOINTMENT:_____
NAME OF MENTAL HEALTH PROFESSIONAL:_____

SERVICES RENDERED BY PROVIDER:
Check if medication management only:
□ **YES** □ **NO**

Are services funded through Medicare? □ YES □ NO

Describe current behavioral health services beyond medication management including the level of engagement recipient had with services:

V. PAST PSYCHIATRIC HISTORY (First onset of illness, past diagnostic and treatment history, medications, hospitalizations-date, length, reasons, & facility):

Within the last two (2) years, experienced Prior Outpatient Mental Health Treatment: (excluding medication management only) □ No; □ Yes; Please check all that apply:
□ LGE □ IOP □ Individual Counseling with LMHP □ PSR (Psychosocial Rehabilitation)
□ Crisis Intervention □ Community Psychiatric Support and Treatment (CPST)
□ Assertive Community Treatment (ACT) □ Partial Hospitalization/Day Treatment
□ Other (Describe)

Location(s) / Date(s): *include additional pages as necessary*

Location:_____/ Date(s)_____

Location:_____/ Date(s)_____

Within in the last two (2) years experienced Psychiatric Hospitalizations:
□ No; □ Yes; If yes, was the hospitalization due to a Neurocognitive diagnosis? □ No; □ Yes

Location(s) / Date(s): *include additional pages as necessary*

Location:_____/Date(s)_____

Location:_____/Date(s)_____

Location:_____/Date(s)_____

ADDITIONAL COMMENTS REGARDING BEHAVIORAL HEALTH TREATMENT: (reason for hospitalization/treatment, types of treatment provided, psychiatric complications to treatment, order of protective custody/legal commitment, etc.)

Within the last three (3) to six (6) months, has the individual had an episode of significant decline to their psychiatric status resulting in one of the following: □ legal/judicial involvement □ loss of housing □ crisis intervention □ bizarre behavior (ex: hallucinations, delusions, excessive spending, aggressive behavior) □ other (please describe):

VI. SUBSTANCE USE/DEPENDENCE (Past use of primary, secondary & tertiary current substance, incl. type, frequency, method & age of first use.)

Check any/all that apply in past 12 months:

□ Alcohol Use; □ Illegal Drug Use; □ Injected Drug Use ; □ Tobacco Product Use; □ Prescription Drugs Abuse; □ Non-Prescription (OTC) abuse; □ Alcohol and/or Drug Overdose; □ Alcohol and/or Drug Withdrawal; □ Problems caused by gambling; □ Trouble stopping any substance; □ Denies □ Other/Describe:

Substance Use Treatment History: □ None; □ Outpatient; □ Intensive Outpatient; □ Residential/Inpatient; □ Detox; □ Other/Describe:

SUBSTANCE TYPE Include all use in last 30 days.	AGE OF 1ST USE	YEARS IN LIFETIME	DAYS IN PAST 30	DAYS SINCE LAST USE	AMOUNT	ROUTE OF ADMINISTRATION
						□ Oral; □ Nasal; □ Smoking; □ Non-IV Injxn; □ IV
						□ Oral; □ Nasal; □ Smoking; □ Non-IV Injxn; □ IV
						□ Oral; □ Nasal; □ Smoking; □ Non-IV Injxn; □ IV
						□ Oral; □ Nasal; □ Smoking; □ Non-IV Injxn; □ IV

PHYSICAL/MEDICAL HISTORY

VII. CURRENT MEDICAL CONDITIONS (Check all that apply; supporting documentation must be attached)

Meets Medical Eligibility for NF placement as determined by the Level I Authority □ Yes □ No

□ Pregnant	Due date:	Prenatal care:		
□ None Reported	□ Congestive Heart Failure **Date of onset:**	□ Asthma **Date of onset:**	□ Seizure **Date of onset:**	□ Sexually Transmitted Dz **Date of onset:**
□ High Blood Pressure **Date of onset:**	□ Stroke **Date of onset:**	□ Emphysema **Date of onset:**	□ Cirrhosis **Date of onset:**	□ Chronic Pain **Date of onset:**
□ Heart Disease (specify): **Date of onset:**	□ Diabetes □ Insulin **Date of onset:**	□ Epilepsy **Date of onset:**	□ Digestive Problems **Date of onset:**	□ Thyroid Disease **Date of onset:**
□ Cancer (specify type): **Date of onset:** Life expectancy of less than 6 months? □ Yes □ No	□ Dementia □ Early Stage □ Late Stage **Date of onset:** **Must provide proof of dx and complete dementia addendum**	□ Underweight □ Overweight **Date of onset:**	□ COPD □ Oxygen □ No oxygen **Date of onset:**	Chronic Kidney Disease □ Stage 1 □ Stage 2 □ Stage 3 □ Stage 4 **Date of onset:**

□ Other/Describe:

List source of medical conditions noted above:

VIII. Allergies:

IX. CURRENT MEDICATIONS (Including non-psychotropic prescribed medications for last 12 months) *include additional pages as necessary*

Medication Name	Dose	Freq.	Route	Current	COMMENTS (Reason Prescribed/Response/Side effects/Interactions, etc.)
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	

X. PRIMARY CARE PHYSICIAN	NAME	PHONE	FAX

XI. **a)** Does the individual has a history of non-compliance with medication? □ Yes □ No (if Yes describe)

b) Does the individual has the ability to administer his/her medication without supervision? (provide detailed rationale for answer) □ Yes □ No (If no describe how medication compliance can be accomplish)

XII. **ADDITIONAL MEDICAL HISTORY INCLUDING DATES OF ONSET** (Diagnosis, Pertinent injuries (head trauma), Illnesses; Hospitalizations, Surgery, Labs Values, Status of Conditions, Neurological Assessment reviewing motor function, gait, communication, etc.)

a) Does person participate in: □ Speech Therapy □ Occupational Therapy □ Physical Therapy □ Wound Care

If checked, explain:

SOCIAL HISTORY

XIII. FAMILY HISTORY (relationship status with relatives, family involvement in treatment, and living status of significant relatives):

Current Adverse Circumstances: □ N/A; □ Poverty; □ Criminal Behavioral; □ Mental Illness; □ Substance Use; □ Abuse; □ Neglect; □ Domestic Violence; □ Violence; □ Trauma/Describe: _____

□ Other/Describe: _____

Current Family Stress: □ Low Stress; □ Mildly Stressful; □ Moderately Stressful; □ Highly Stressful; □ Extremely Stressful

□ Other/Describe: _____

Current Family Supports: □ Highly Supportive; □ Supportive; □ Limited Support; □ Minimal Support; □ No Support

□ Other/Describe: _____

Additional Comments:

XIV. TRAUMA HISTORY

History of Trauma: □ None; □ By History □ Experienced; □ Witnessed;
TYPE: □ Abuse; □ Neglect; □ Violence; □ Sexual Assault; □ Related to Military experience
□ Other/Describe:

XV. LIVING SITUATION (Current status and functioning)

a. Primary Residence: □ Own Home; □ Apartment; □ Relative's Home; □ Group Home; □ Homeless; □ Nursing Facility
□ Other/Describe:

How long at current residence?

Individuals Living in the Home:

Source of meals/food:	**Means of transportation:**

Have you ever been homeless? (if yes give dates and describe living situation**)** □ Yes □ No

Additional Comments: (Include psychological and social adjustments made to disabilities and/or disorders as it relates to housing needs.)

b. Preferences: include things the individual or their family member feels will enhance his/her living situation

c. Abilities/Interests/Strengths –Include strengths, skills, aptitudes that might assist in maintaining or improving living situation; also list assets, service options and resources the person has to meet needs, including available housing options

d. Does the individual want nursing home placement? □ Yes; □ No If yes how long? □ 1-3 months □ 3-9 Months □ 9-12 Months □ Permanently (Describe reason for wanting nursing home placement)

e. Where would you like to live?

f. Prior Community Services Utilized such as: □ Home Health; □ Sitters; □ Waiver Services; □ Adult Day Care;
□ PSH Voucher: Name of PSH Provider: _____
□ Voucher (Type)_____
□ Services through the Office of Citizens with Developmental Disabilities

g. Prior Nursing Home Placement: Date(s) and Names of Facility(ies) *include additional pages as necessary* □ **None**

Name of Facility:_____ **/ Date(s)**_____**/ Reason for Leaving:** _____

Name of Facility:_____ **/ Date(s)**_____**/ Reason for Leaving:** _____

h. Needs – From evaluator's perspective, identify the needs that will allow the individual to remain in the community (Ex. Transportation, personal care attendant day program, outpatient therapy, council on aging, home health, medication management, ACT, CPST, substance abuse treatment housing subsidy, money in savings, care-giver resource assessment, etc.)

XVI. LEARNING/WORKING AND FUNCTIONAL STATUS

a. Employment/Education/Rehabilitation Status:

Current source of income:	**Estimated Monthly Income Amount:**
Military income: □ No; □ Yes;	**Military Status:**
Difficulties with Reading/Writing: □ No; □ Yes;	**Estimated Literacy Level:**
Employed within the last year?: □ No; □ Yes	**Type of Work Performed?**

Assistive Devices utilized/required: □ No; □ Yes: □ Hearing Aid □ Wheelchair □ Walker □ Cane
□ Other (describe)

Additional Comments: (Include psychological and social adjustments made to disabilities and/or disorders.)

b. Current Status & Functioning (Assess ability to fulfill responsibilities; interact with others, capacity self-care, etc.)

ADLs/IADLs	Explanation for how Determined	Impairment Expected to improve?	No Impairment	Supervision	Limited Assistance	Extensive Assistance	Total Assistance
Mobility	Select	Select					
Bathing	Select	Select					
Dressing	Select	Select					
Self-Feeding	Select	Select					
Personal hygiene & grooming	Select	Select					
Toilet hygiene	Select	Select					
Housework	Select	Select					
Meal Preparation	Select	Select					
Medication Management	Select	Select					
Managing Finances	Select	Select					
Shopping (groceries or clothing)	Select	Select					
Communication	Select	Select					
Transportation	Select	Select					

Comments – indicate if the impairment is due to the current illness, including individual's reliance on support systems to perform activities in the community

Functional Abilities - Include recipient reported strengths, skills, aptitudes that may help maintain or improve the current level of functioning

CURRENT STATUS

XVII. MENTAL STATUS EXAMINATION *(Circle or Check all that apply)*

a. GENERAL APPEARANCE □ Healthy; □ As stated Age; □ Older Than Stated Age; □ Young-looking; □ Tattoos; □ Disheveled; □ Unkempt; □ Malodorous; □ Thin; □ Overweight; □Obese; □ Other/Describe:

b. BEHAVIOR & PSYCHOMOTOR ACTIVITY □ Normal; □ Overactive; □ Hypoactive; □ Catatonia; □ Tremor; □ Tics; □ Combative; □ Other/Describe:

c. ATTITUDE □ Optimal; □ Constructive; □ Motivated; □ Obstructive; □ Adversarial; □ Inaccessible; □ Cooperative; □ Seductive; □ Defensive; □ Hostile; □ Guarded; □ Apathetic; □ Evasive; □ Other/Explain:

d. SPEECH □ Normal; □ Spontaneous; □ Slow; □ Impoverished; □ Hesitant; □ Monotonous; □ Soft/Whispered; □ Mumbled; □ Rapid; □ Pressured; □ Verbose; □ Loud; □ Slurred; □ Impediment; □ Other/Describe:

e. MOOD □ Dysphoric; □ Euthymic; □ Expansive; □ Irritable; □ Labile; □ Elevated; □ Euphoric; □ Ecstatic; □ Depressed; □ Grief/mourning; □ Alexithymic; □ Elated; □ Hypomanic; □ Manic; □ Anxious; □ Tense; □ Other/Describe:

d. AFFECT □ Appropriate; □ Inappropriate; □ Blunted; □ Restricted; □ Flat; □ Labile; □ Tearful; □ Intense; □ Other/Describe:

g. PERCEPTUAL DISTURBANCES □ None; □ Hallucinations: □ Auditory; □ Visual; □ Olfactory; □ Tactile; □ Other/Describe:

h. THOUGHT PROCESS □ Logical/Coherent; □ Incomprehensible; □ Incoherent; □ Flight of Ideas; □ Loose Associations; □ Tangential; □ Circumstantial; □ Rambling; □ Evasive; □ Racing Thoughts; □ Perseveration; □ Thought Blocking; □ Concrete; □ Other/Describe:

i. THOUGHT CONTENT □ Preoccupations; □ Obsessions; □ Compulsions; □ Phobias; □ Delusions; □ Thought Broadcasting; □ Thought Insertion; □ Thought Withdrawal; □ Ideas of Reference; □ Ideas of Influence □ Other/Describe:

Comments – If checked, please describe:

j. SUICIDAL/HOMICIDAL IDEATION □ Suicidal Thoughts; □ Suicidal Attempts; □ Suicidal Intent; □ Suicidal Plans; □ History of Self-Injurious Behavior; □ Homicidal Thoughts; □ Homicidal Attempts; □ Homicidal Intent; □ Homicidal Plans; □ Other/Describe:

Comments – If checked, please describe:

k. SENSORIUM/COGNITION □ Alert; □ Lethargic; □ Somnolent; □ Stuporous; **Oriented to:** □ Person; □ Place; □ Time; □ Situation; □ Normal Concentration; □ Impaired Concentration; □ Other/Describe:

l. MEMORY Remote Memory: □ Normal; □ Impaired; **Recent Memory:** □ Normal; □ Impaired; **Immediate Recall:** □ Normal; □ Impaired □ Other/Describe:

m. INTELLECTUAL FUNCTIONING (Estimate) □ Above Avg.; □ Normal/Avg.; □ Borderline; Intellectual Disability: □ Mild; □ Moderate; □ Severe □ Other/Describe:

n. JUDGEMENT □ Critical Judgment Intact; □ Impaired Judgment; □ Other/Describe:

o. INSIGHT □ True Emotional Insight; □ Intellectual Insight; □ Some Awareness of Illness/symptoms; □ Impaired Insight; □ Denial; □ Other/Describe:

p. IMPULSE CONTROL □ Recent Impulsive Behavior; □ Impaired Impulse Control; □ Compulsions; □ Other/Describe:

XVIII. Mood and Behavioral Assessment: within the last 3 to 6 Months, has the individual had an episode of significant decline to their psychiatric status resulting in one of the following:

Mood	Within past 30 Days	Within past 31-90 Days	Indicate if present within the last 7 days
Anxiety	□ Yes □ No	□ Yes □ No	□ Yes □ No
Loneliness	□ Yes □ No	□ Yes □ No	□ Yes □ No
Feelings of Hopelessness	□ Yes □ No	□ Yes □ No	□ Yes □ No
Suicidal Thoughts	□ Yes □ No	□ Yes □ No	□ Yes □ No
Suicidal Threats	□ Yes □ No	□ Yes □ No	□ Yes □ No
Lability/Mood Swings	□ Yes □ No	□ Yes □ No	□ Yes □ No
Sadness	□ Yes □ No	□ Yes □ No	□ Yes □ No
Mania	□ Yes □ No	□ Yes □ No	□ Yes □ No
Homicidal Ideation	□ Yes □ No	□ Yes □ No	□ Yes □ No
Suicidal Ideation	□ Yes □ No	□ Yes □ No	□ Yes □ No

A) Has an effective strategy been identified to have helped the individual manage these symptoms in the past? (Please describe your answer)
□ Yes □ No (describe)_____

B) Are there other strategies not currently in place that may assist the individual with managing these symptoms? □ Yes □ No (if yes, please describe)_____
Are there early warning signs that the individual or his/her family/significant other is able to identify prior to the person decompensating?
□ Yes □ No(if yes describe)_____

Comments - Provide a summary of mental status, including details about externalizing and internalizing behaviors, intellectual functioning, cognitive functioning, and reality testing.

XIX. RISK ASSESSMENT: Assess the potential risk of harm to self or others, including patterns of risk behavior and/or risk due to personality factors, substance use, criminogenic factors, exposure to elements, exploitation, abuse, neglect, suicidal or homicidal history, self-injury, psychosis, impulsiveness, etc.

a. Risk of Harm to Self - unintentional or intentional: □ Prior Suicide Attempt; □ Stated Plan/Intent; □ Access to means (weapons, pills, etc.); □ Recent Loss; □ Presence of Behavioral Cues (isolation, giving away possessions, rapid mood swings, etc.); □ Family History of Suicide; □ Terminal Illness; □ Substance Abuse; □ Marked lack of support; □ Psychosis; □ Suicide of friend/acquaintance; □ Other/Describe:

b. Risk of Harm to Others - unintentional or intentional: □ Prior acts of violence; If yes, when was the most recent violent act? _____ □ Destruction of property; □ Arrests for violence; □ Access to means (weapons); □ Substance use; □ Physically abused as child; □ Was physically abusive as a child; □ Harms animals; □ Fire setting; □ Angry mood/agitation; □ Prior hospitalizations for danger to others; □ Psychosis/command hallucinations; If yes, is there a history of acting on any commands to harm others? □ Yes □ No; □ Other/Describe:

c. Risk of Harm to Self or Others Rating: *(From LOCUS Risk of Harm Evaluation Parameters.)* □ **Minimal;** □ **Low;** □ **Moderate;** □ **Serious;** □ **Extreme; as evidenced by:**

d. Recipient Safety & Other Risk Factors: □ Feels unsafe in current living environment; □ Feels currently being harmed/hurt/abused/threatened by someone; □ Engages in dangerous sexual behavior; □ Past involvement with Child or Adult Protective Services; □ Relapse/decompensation triggers; □ Other/Describe:

e. Describe recipient's **preferences and desires** for addressing risk factors, including any Mental Health Advance Directives or plan of response to periods of decompensation/relapse (Ex. Resources recipient feels comfortable reaching out to for assistance in a crisis.):

XX. CULTURAL AND LANGUAGE PREFERENCES (Language, Customs/Values/Preferences)

a. Spiritual Beliefs/Preferences:

b. Cultural Beliefs/Preferences:

c. Language Preferences:

XXI. PRINCIPAL DIAGNOSES (PROVIDE PRINCIPLE BEHAVIORAL, MEDICAL DIAGNOSES, AND DEVELOPMENTAL DISABILITY)

DIAGNOSIS	*SEVERITY, IF APPLICABLE*	*SOURCE OF DIAGNOSIS*

XXII. IDENTIFIED NEEDS

Recipient would benefit from the following services (as indicated by recipient, family, staff, etc):

Living Situation: □ Home □ Independent Living □ Supportive Housing □ Other (describe):

Additional Services:

Medical: □ Home Health □ Evaluation for a diagnosis of dementia □ Audiological evaluation □ Dental evaluation □ Vision evaluation
Personal Care Attendant Assistance in obtaining medical appliances/devices (describe):

Mental Health: □ Short term counseling □ Medication education □ Crisis intervention plan/safety plan □ LGE □ Medication Monitoring
□ Group Counseling □ Family Counseling

Supportive/Recreational: □ Transportation □ Training in ADLs □ Training in independent living skills □ Meals on Wheels □ Interpretive services
□ Services for the visually/hearing impaired □ Reading/writing Training □ Structured leisure activities (day program, council on Aging) □ Employment
□ Skill Training other:

Substance Use: □ AA/NA □ MAT □ Res Tx □ AA □ NA □ Other(describe)

Income: □ Benefits Planning □ Other (describe)

Legal: □ Guardian □ Power of Attorney □ Living Will □ Will □ A guardian/conservator for decisions regarding health and safety

Other: □ Other (describe)

□ Referrals to other agencies or community programs (please specify):

Recipient would benefit from the following services (as indicated by treating medical clinicians/records):

□Rehabilitation services ordered by a medical doctor and provided by a licensed physical, occupational, respiratory, or speech therapist
□Rehabilitation services provided by a technician or aide
□Rehabilitation services following major surgery during a post-operative period
□Treatment for severe and debilitating medical conditions, which require daily care from medical staff and cannot be cared for in the home even with the assistance of home health nursing.
□Oxygen therapy when monitoring the need or regulating flow rate either temporarily or intermittently (do not include those using continuous oxygen who are in stable condition)
□Treatment for chronic skin conditions requiring daily dressing changes with aseptic techniques and use of prescription drugs or when have a co-occurring medical condition (such as diabetes) which can complicate healing (do not include those conditions which can be treated by topical ointments)
□Medication administration requiring close observation and assessment (e.g. IV, NG, gastrostomy, etc)
□Medication monitoring through assistance with medication compliance or routine medication administration
□Clinically required observation, assessment, and documentation of significant nutritional deficit such as parenteral feedings, gastrostomy or NG tubes which are included in a specific treatment plan
□Special diet or assistance with food preparation
□Treatment for dementia, delirium, or another cognitive disorder related to a medical condition
□Nursing treatment for the purpose of maintaining or restoring maximum functioning for individuals with restorative potential
□Care and/or maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other indwelling tubes for a recipient who is unable to self-care
□ Support/training in the self-maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other indwelling tubes for a recipient

Comments – indicate any additional needs of the recipient that speak to the need for community-based or NF placement.

EVALUATOR SIGNATURE			
PRINTED NAME OF ASSESSOR	**SIGNATURE**	**LICENSE NUMBER**	**DATE**

BY SIGNING THIS DOCUMENT, I CERTIFY THAT I AM INDEPENDENT OF THE OFFICE OF BEHAVIORAL HEALTH MAKING THE DETERMINATIONS AND THAT I HAVE NO DIRECT OR INDIRECT AFFILIATION OR RELATIONSHIP WITH THE NURSING FACILITY.

DEMENTIA ADDENDUM – *Only complete if Dementia suspected or if an indication of Dementia in Section VII of the Evaluation*

A. Interview individuals with direct contact/knowledge of the individual's decline in everyday functioning such as their ability to fulfill responsibilities; interact with others, and their capacity for self-care. This should NOT include anecdotal or third party information. Within the table below, for each behavior, indicate how the person functioned during the listed time-period using the following criteria:

- **No impairment = able to complete independently**
- **Some impairment = needs assistance to complete some aspects of the task, but primarily completes tasks independently,**
- **Major impairment = needs a lot of assistance to complete tasks,**
- **Total impairment = unable to complete any aspect of task on own,**
- **Not applicable = have never completed task even at the best level of functioning**

Behavior	5 + years	3-4 years	1-2 years	6-12 Months
Mobility				
Bathing				
Dressing				
Self-Feeding				
Personal hygiene & grooming				
Toilet hygiene				
Housework				
Meal Preparation				
Medication Management				
Managing Finances				
Shopping (groceries or clothing)				
Communication				
Driving				
Memory (Forgetting simple words/everyday items/activities)				
Wandering				
Behavior (aggressive or bizarre behavior which is unusual to the person)				

B. Describe in detail how the person's current level of function is different from their best-sustained level of functioning:

C. Describe in Detail the timeline of the person's decline in functioning to current level of functioning (tell the story of what happened first to last in the person's ability to function)

Testing that may be required: MRI/CAT SCAN, extensive detailed psychiatric evaluation, neurological exam. If an additional psychiatric evaluation is requested, special emphasis to all aspects of memory and executive functioning should be included. Single word descriptors and checklist evaluations <u>cannot be accepted</u> for diagnostic purposes.

TO BE COMPLETED BY MCO ONLY

□ **MCO HAS REVIEWED THE EVALUATION AND IT IS COMPLETE (incomplete evaluations will be returned to the MCO as not accepted)**
□ **BASED ON THE REVIEW, NURSING FACILITY APPEARS APPROPRIATE (final determination will be made by OBH PASRR)**
□ **BASED ON THE REVIEW, NURSING FACIILTY DOES NOT APPEAR APPROPRIATE; THE PERSON CAN BE SERVED IN:**
□ **A MORE RESTRICTIVE SETTING (INPATIENT PSYCHIATRIC HOSPITAL)** □ **A LESS RESTRICTIVE SETTING**

DOES THE MCO SHOW A HISTORY OF BEHAVIORAL HEALTH CLAIMS IN THE PAST 2 YEARS? □ YES □ NO (CHECK ALL THAT APPLY)
□ INPATIENT □ INTENSIVE OUTPATIENT (ACT/MHR) □ LMHP □ MEDICATION MANAGEMENT

RECOMMENDED SERVICES (PROVIDED THROUGH MCO'S PROVIDER NETWORK)

MH SERVICES:	□ ACT	□ CPST	□ PSR - Individual	□ PSR -Group	□ PSH
	□ PSYCH diag eval	□ Outpt Therapy (Ind)	□ Outpt Therapy (Fam)	□ Outpt Therapy (Group)	
SUD SERVICES:	□ Residential Tx	□ Halfway House	□ IOP	□ Ambulatory Detox	
	□ Outpt Therapy (Ind)	□ Outpt Therapy (Fam)	□ Outpt Therapy (Group)		

OTHER (with explanation)

CASE MANAGEMENT

PLAN FOR PROVISION OF CASE MANAGEMENT:

ADDITIONAL SERVICE RECOMMENDATIONS TO MAINTAIN PERSON IN THE LEAST RESTRICTIVE SETTING:

PRINTED NAME OF MCO STAFF	SIGNATURE	POSITION TITLE	DATE