

Bureau of Long Term Care
Significant Change/Modification Request Form

Participant Name _____

MID # _____

Justification for Changes [] Decrease in unmet needs [] Increase in unmet needs

Please document what has caused the participant's change in functioning, when the change began, and the anticipated length of time the change in function is expected to continue. Include in this area any changes to Available Supports when applicable. Describe the change in the participant's specific ability in the appropriate box. **Only fill out the area in which a change in function has occurred.** The supervision score is calculated based on Section 4; please look to see how it was scored on the previous UAI to determine if there are any changes. (Attach additional sheet if need more room.)

Meal Preparation	Bathing
<u>Comments</u>	<u>Comments</u>
Eating Meals	Shopping or Transportation
<u>Comments</u>	<u>Comments</u>
Toileting	Laundry
<u>Comments</u>	<u>Comments</u>
Mobility	Housework
<u>Comments</u>	<u>Comments</u>
Transferring	Night Needs
<u>Comments</u>	<u>Comments</u>
Personal Hygiene	Medication
<u>Comments</u>	<u>Comments</u>
Dressing	Supervision
<u>Comments</u>	<u>Comments</u>

Requesting Provider _____

Date of Request _____

Provider Signature/Date _____

Participant Signature/Date _____

Provider RN Signature/Date _____

[] Approval [] Denial Reason for Denial _____

BLTC Reviewer Signature/Date _____

(Signed form must be attached to the care plan in the home and care plan updated to reflect the approved changes)

Participant Zip Code _____

Participant DOB _____

Instructions for completing Significant Change /Modification Request Form

Purpose

These instructions are intended to assist our agencies providing A&D Waiver services and PCS to adults to identify significant changes in participant functioning that result in an increase or decrease in the UAI Unmet needs. IDAPA 16.03.23.010.06. Significant Change in Client's Condition. A major change in the client's status that affects more than one area of the client's functional or health status, and requires review or revision of the care plan or negotiated service agreement. The Medicaid nurse reviewer will use this information to approve or deny significant change requests.

Instructions

1. Verify the participant has had a change in functioning that is significant enough to warrant a change in the participant's amount of help they need in any areas found in Section Two of the most recent UAI. (This should be on file in the agency office.) Review Section Two of the UAI, refer to the guideline definitions, and determine if there has been a change in any of the functioning areas.
2. Provider supervising personnel should visit the participant to assess what functioning areas have been impacted. Only in emergency situations will the regional reviewer consider a modification request without a provider visit to the participant's home.
3. If a change has occurred in any of the functioning areas, describe the participant's specific ability in the appropriate box. **Only fill out those areas in which a change has occurred.**
4. Under "Justification for Change" at the top of the form, please note what has caused the participant's change in functioning, when the change began, and the anticipated length of time the change in functioning will continue. Include in this area any changes to Available Supports when applicable.
5. If non-medical transportation services are approved, services will need to be specified in the care plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge or public transit provider will be utilized.
6. Attach additional documentation that supports your observations if applicable and available. This may include attendant progress notes, supervising visit notes, the physician's history and physical, or office visit notes.
7. The Provider Supervising personnel (if completed the request), Provider RN and the participant or the participant's representative must sign and date the request.
8. If the change is approved by the BLTC Reviewer. The care plan must be updated to reflect the change and a copy of the significant change form attached. (For CFH the updated care plan does not need to be sent to the BLTC Reviewer. The significant change form attached to the approved care plan will constitute the plan change approval.

UAI Directions/Guidelines. Section 2 Functional Abilities

All Functional Areas except Night Needs and Medications

None: No help or caregiver support needed.

Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance.

Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity.

Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support.

Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.

Night Needs

Requires documentation for approval.

None: Needs no assistance from another person during the night.

Minimal: Requires hands on or standby assistance 1-2 times per night for care.

Moderate: Requires hands on or standby assistance 3-4 times per night for care.

Extensive: Requires hands on or standby assistance 5 or more times per night for care.

Total: Requires continuous hands on or standby assistance throughout the night for care.

Medication

None: Can self-administer medication without assistance.

Minimal: Requires minimal assistance (i.e. open containers or use a mediset); understands medication routine.

Moderate: Requires occasional assistance or cueing to follow medication routine or timely medication refills.

Extensive: Requires daily assistance or cueing; must be reminded to take medications; does not know medication routine; may not remember if took medications.

Total: Requires licensed nurse to administer and/or assess the amount, frequency, or response to medication or treatment. A treatment is defined as an in home skilled nursing treatment.

Supervision

Based on Section 4 assessment of cognitive functioning.

Disorientation 3 pts Wandering 4 pts

Memory 2 pts Disruptive 4 pts

Judgment 3 pts Assaultive 4 pts

Hallucinations 1 pt Danger to Self 4 pts

Anxiety 1 pt Alcohol/Drug 1 pt

Depression 1 pt Vulnerability 4 pts

None: 0-15 pts

Minimal: 16-30 pts

Moderate: 31-45 pts

Extensive: 46-60 pts

Total: 61-100 pts

Orientation

0. Oriented to person, place, time and/or situation.

1. Current or history of occasional disorientation to person, place, time, or situation that does not interfere with functioning in familiar surroundings. Requires some direction and reminding from others. May have behavior management plan in place.

2. Current or history of frequent disorientation to person, place, time or situation, even if in familiar surroundings and requires supervision and oversight for safety. May have behavior management plan in place.

3. Always disoriented and requires constant supervision and oversight for safety. Extensive intervention needed to manage behavior.

Memory

0. Does not have difficulty remembering and using information. Does not require directions or reminding from others.

1. Current or history of occasional difficulty remembering and using information. Requires some direction and reminding from others. May be able to follow written instructions. May have behavior management plan in place.

2. Current or history of frequent difficulty remembering and using information, and requires direction and reminding from others. Cannot follow written instructions. May have behavior management plan in place.

3. Cannot remember or use information. Requires continual verbal PROMPTS. May have behavior management plan in place.

Judgment

0. Judgment is good. Makes appropriate decisions.

1. Current or history of occasional poor judgment. May make inappropriate decisions in complex or unfamiliar situations. Needs monitoring and guidance in decision-making. May have behavior management plan in place.

2. Current or history of frequent poor judgment. Needs protection and supervision because participant makes unsafe or inappropriate decisions. May have behavior management plan in place.

3. Judgment is always poor. Cannot make appropriate decisions for self or makes unsafe decisions and needs intense supervision. (Intense supervision is needed to prevent danger to self or others). May have behavior management plan in place.

Hallucinations

0. No history of hallucinations.

1. Current or history of occasional hallucinations which interfere with functioning, but currently well controlled, may be taking medication. May have behavior management plan in place.

2. Current or history of frequent hallucinations which interfere with functioning and may require medication and routine

3. Presently has a hallucination(s) which significantly impairs ability for self-care, may or may not be taking medication. May have behavior management plan in place.

Delusions

0. No history of delusions.

1. Current or history of occasional delusions which interfere with functioning, but currently well controlled, may be taking medication. May have behavior management plan in place.

2. Current or history of frequent delusions which interfere with functioning and may require medication and routine monitoring by a behavioral health professional. May have behavior management plan in place.

3. Presently has delusion(s) which significantly impair the ability for self-care, may or may not be taking medication. May have behavior management plan in place.

Anxiety

0. No history of anxiety.

1. Current or history of occasional anxiety which interferes with functioning, but currently well controlled, may be taking medication. May have behavior management plan in place.

2. Current or history of frequent anxiety which interferes with functioning and may require medication and routine monitoring by behavioral health

<p>professional. May have behavior management plan in place.</p> <p>3. Presently displays anxiety which significantly impairs the ability for self-care, may require medication or may need routine monitoring by behavioral health professional. May have behavior management plan in place.</p>
<p style="text-align: center;">Depression</p> <p>0. No history of depression.</p> <p>1. Current or history of occasional depression which interferes with functioning but currently well controlled, may be taking medication. May have behavior management plan in place.</p> <p>2. Current or history of frequent depression which interferes with functioning and may require medication and routine monitoring by behavioral health professional. May have behavior management plan in place.</p> <p>3. Presently displays depression which significantly impairs the ability for self-care, may or may not be taking medication. May have behavior management plan in place.</p>
<p style="text-align: center;">Wandering</p> <p>0. No history of wandering.</p> <p>1. Current or history of wandering within the residence or facility and may wander outside, but does not jeopardize health or safety (of self or others). May have behavior management plan in place.</p> <p>2. Current or history of wandering within the residence or facility. May wander outside; health or safety may be jeopardized, but participant is not combative about returning and does not require professional consultation or intervention. May have behavior management plan in place.</p> <p>3. Wanders outside and leaves immediate area. Has consistent history of leaving immediate area, getting lost, or being combative about returning. Requires constant supervision, a professionally-authorized behavioral management program, and/or professional consultation and intervention. May have behavior management plan in place.</p>
<p style="text-align: center;">Disruptive/Socially Inappropriate</p> <p>0. No history of disruptive, aggressive, or socially inappropriate behavior.</p> <p>1. Current or history of occasional disruptive, aggressive, or socially inappropriate behavior, either verbally or physically threatening. May require special tolerance or staff training. May have behavior management plan in place.</p> <p>2. Current or history of frequent disruptive, aggressive, or socially inappropriate behavior. May require professional consultation or staff training. May have behavior management plan in place.</p> <p>3. Is dangerous or physically threatening and requires constant supervision, a professionally authorized behavioral management program, and/or professional consultation and intervention. May have behavior management plan in place.</p>
<p style="text-align: center;">Assaultive/Destructive</p> <p>0. No history of combative or destructive behaviors.</p> <p>1. Current or history of occasional combative or destructive behaviors. Requires special tolerance or staff training, but does not require professional consultation and/or intervention. May have behavior management plan in place.</p> <p>2. Current or history of frequent combative or destructive behaviors, and may require professional consultation or staff training. May have behavior management plan in place.</p> <p>3. Is assaultive, and requires constant supervision, a professionally authorized behavioral management program, and/or professional consultation and intervention. May have behavior management plan in place.</p>
<p style="text-align: center;">Danger to Self</p> <p>0. No history of self-injurious behavior.</p> <p>1. Current or history of self-injurious behavior (i.e., self-mutilation, suicidal ideation/plans, and suicide gestures), but can be redirected away from these behaviors. May have behavior management plan in place.</p> <p>2. Current or history of self-injurious behavior, self-neglect, head banging, suicidal thoughts, self-mutilation, and behavioral control. Intervention and/or medication may be required to manage behavior. May have behavior management plan in place.</p> <p>3. Displays self injurious behavior and requires constant supervision, with behavioral control intervention and/or medication. (Requires an assessment and/or referral for help.) May have behavior management plan in place.</p>
<p style="text-align: center;">Alcohol/Drug Abuse</p> <p>0. No history of alcohol or drug abuse.</p> <p>1. Current or history of alcohol or drug abuse which may cause some interpersonal and/or health problems, but does not significantly impair overall independent functioning. May have behavior management plan in place.</p> <p>2. Current or history of alcohol or drug abuse which cause moderate problems with peer, family members, law officials, etc., and may require some professional intervention. May have behavior management plan in place.</p> <p>3. Current or history of frequent alcohol or drug abuse which causes significant problems with others and severely impairs ability to function independently. May have behavior management plan in place.</p>
<p style="text-align: center;">Self Preservation/Victimization</p> <p>0. No history of self-preservation, victimization, or exploitation. Participant is clearly aware of surroundings and is able to discern and avoid situations in which he/she may be abused, neglected or exploited.</p> <p>1. Current or history of occasional inability to discern and avoid situations that he/she may be abused, neglected or exploited. May have behavior management plan in place.</p> <p>2. Current or history of frequent inability to discern and avoid situations that he/she may be abused, neglected, or exploited. May have behavior management plan in place.</p> <p>3. Requires constant supervision due to inability to discern and avoid situations in which he/she may be abused, neglected, or exploited. May have behavior management plan in place.</p>