

Uniform Assessment Instrument (UAI) Training and Instruction Manual

Idaho Department of Health and Welfare
Bureau of Long Term Care

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Overview

Purpose

The purpose of the Uniform Assessment Instrument (UAI) is to gather information for determining participants' care needs, service eligibility, and for planning services. The UAI is a multidimensional questionnaire which assesses a participant's functioning level, social skills, and physical and cognitive abilities. It provides a comprehensive assessment of a participant's actual functioning level including those elements that are necessary for developing an individualized service agreement. The UAI was designed to provide a standardized way of conducting a participant interview to ensure that all participants have an objective assessment of their needs.

UAI General Form Instructions

The UAI is completed during a face-to-face interview with the participant. Any other information from medical records, family members, etc., should be used when available. The preferred source of information is the participant. In rare instances, a telephone interview may be completed as approved by the department with a timely follow-up visit.

In some situations (i.e., a cognitively-impaired participant) other sources of information may be necessary and obtained by contacting other parties, such as primary care giver. Be sure to note on the form when other sources are used to gather information. Also, if necessary, obtain a translator for participants who have communication problems and/or other limitations.

Crediting Primary and Secondary Sources of Information

The participant is the preferred source of information for the UAI. However, secondary sources such as medical records, the primary care physician, family, and others can be consulted to verify the reliability of the information if the Nurse Reviewer (NR) notes differences between the participant's reported situations and his/her observed needs. The NR should document carefully all primary and secondary sources of information in the following areas:

- UAI Page 1 in Questions #15 and #16. These questions include spaces to identify the names of the sources with their telephone numbers.
- Comment spaces provided throughout the instrument.

UAI Focus on Participant's Current Functioning Level

The purpose of the UAI is to assess the current functional abilities and behaviors of the participant, to determine his/her actual care needs, and identify anticipated changes that may occur within the next 30 days. "Current" is defined as within the previous two weeks. It is very important that the NR consider the actual needs of the individual, not potential needs which may or may not occur.

Psychological/Social/Cognitive Information

When assessing the participant's needs in Section 4 of the UAI, Psychological/Social/Cognitive Information, it is important to consider current and past behaviors. The participant may have needs for supervision and cueing to support their psychological, social, or cognitive functioning. For instance, a participant living in a congregate/community setting may currently be exhibiting fewer needs because of the supports offered by the setting.

Consider behavioral issues occurring over the previous six months when scoring this section. Assess if the behavior is an isolated issue or a potential recurring issue. The NR will document the sources of information in the UAI.

Please refer to the “Determining Medical Necessity or LOC for Applicants that have Deceased or Admitted to an Institution V1.0”. A link to this information is provided in the “Additional Resources” section located at the end of this manual.

Uniform Assessment Instrument Instructions

When the UAI tool opens you will see a blank screen with tabs at the top that will allow you to start new assessments, edit existing assessments, access a participant's Support Plan, and run reports.

Note: Please read and follow these instructions carefully. There may be functions within the UAI tool that are not mentioned in this document. Users should only use the functions outlined in this manual.

You can start a new assessment by:

- Clicking on the “File” tab at the top of the page and selecting “New Assessment” from the drop down menu that appears.
- Clicking on the “New Assessment” tab at the top of the page.

A new screen box will appear with tabs at the top of the box to access each section of the UAI assessment tool.

Section One

To begin, make sure the screen box is displaying the “Section 1” information (see screen shot below) and use the step-by-step instructions provided.

Note: required fields are indicated with a red asterisk (*), but please provide as much information as possible as you complete the assessment.

Important: *The UAI is in the process of being updated and some of the information on the screen shots in this manual may not match what you see on your computer screen. Please refer to the **written** information, descriptions, and instructions in this manual to make selections and update/add information to the UAI tool.*

The screenshot displays the 'Assessment' window with 'Section 1' selected. The form includes the following fields and sections:

- 1) The client has read and signed the confidentiality/release of information form?** (Yes/No dropdown)
- 2) SSN:** (Text input)
- 3) Name:** (Last Name, First Name, MI dropdown)
- 4) Medicaid No.:** (Text input)
- 5) Medicare No.:** (Text input)
- 6) Date of Birth:** (MM/DD input)
- 7) Sex:** (Dropdown)
- 8) Live Alone:** (Dropdown)
- 9) (AAA Only) Poverty Level Annual Income:** (Dropdown) and **Number in Household:** (Text input)
- 10) Client Address:** (Address 1, Address 2, City, State dropdown, Zip Code, County, Region dropdown, Home Telephone Number, and a text area for directions)
- 11) Marital Status:** (Dropdown)
- 12) Race / Ethnic Origin:** (Dropdown)
- 13) Emergency/Family Contact Name(s):** (Table with columns for Name, Relation, and Telephone, and a 'Delete Line' button)

- 1. Release of Confidentiality** - Use the drop down menu to select “Yes”.
Note: participants complete this action while applying for Medicaid so you will always select “Yes” for question #1.
- 2. SSN** - Enter the participant’s social security number (if known), but please note that this information is not required to complete the assessment.
- 3. Name** - Enter the participant’s last name, first name, and middle initial as shown on the screen.
Note: you must enter this EXACTLY as it appears in the System of Record.
- 4. Medicaid No.** - Enter the participant’s seven digit Medicaid number (if known), but please note that this information is not required to complete the assessment.
Note: Check the numbers to make sure the digits are recorded correctly.
- 5. Medicare No.** - Enter the participant’s Medicare number (if known), but please note that this information is not required to complete the assessment.
- 6. Date of Birth** - Enter the participant’s date of birth in the following format: mm/dd/yyyy.
- 7. Sex** - Select the participant’s gender from the drop down menu provided (if known), but please note that this information is not required to complete the assessment.
- 8. Live Alone** - Select “Yes” or “No” from the drop down menu to indicate if the participant lives alone (if known), but please note that this information is not required to complete the assessment.
- 9. Annual Income** – Do not enter information into this category.
Please note that this information is not required to complete the assessment.
- 10. Client Address** - This is a multiple-part question - please make sure every field is filled in accurately:
Note: you must enter the information requested EXACTLY as it appears in the System of Record.
 - Enter the participant’s street address, city, zip code, and county in the boxes provided for each.
 - Select the participant’s Medicaid region using the drop down menu provided.
 - Enter the participant’s telephone number beginning with the area code.
 - Use the text box field provided to enter directions (if necessary).
- 11. Marital Status** - Use the drop down menu to select the participant’s marital status (if known), but please note that this information is not required to complete the assessment.
- 12. Race/Ethnic Origin** - Use the drop down menu to select the participant’s race/ethnic origin (if known), but please note that this information is not required to complete the assessment.

13. Emergency/Family Contact Name(s) - Enter the names, relationships, and telephone numbers (starting with the area code) of the participant’s emergency or family contacts in the table provided.

- Each time information is added, a new line will appear.
- To delete a line, hover over the grey box to the left of the contact person’s name, wait for a black arrow to appear, left click your mouse to highlight the information on that line, and click the “Delete Line” button above the table.

The screenshot shows the 'Assessment' software window with the following sections:

- Section 14: Referred by:** Includes input fields for Individual, Agency, Telephone (with area code and hyphen), and Date (mm/dd).
- Section 15: Please indicate primary source of information:** Includes a dropdown menu, and input fields for Name, Agency, Relationship, and Telephone.
- Section 16: Please indicate secondary source(s) of information:** Includes a 'Delete Line' button and a table with columns for Name, Agency, and Contact Number. A grey box is visible in the table, and a black arrow points to it. Below the table is a 'Comments' field.
- Section 17: Assessment Date:** Includes a date input field (//), Assessment Type dropdown, Sections Completed dropdown, and Redetermination Due Date input field (//).

14. Referred by - This is a multiple-part question:

- Enter the name of the person who referred the participant (if known).
- Enter the name of the agency that referred the participant (if known).
- Enter the telephone number of the person or agency (if known).
- Enter the date the referral was made using the following format: mm/dd/yyyy (if known).

Please note that this information is not required to complete the assessment.

15. Primary Source of Information - This is a multiple-part question:

- Use the drop down menu to indicate the primary source of information for the assessment.

Note: Primary information is obtained from the participant or an informant when the participant clearly is not capable of responding to assessment items.

- If it is the participant, please choose “Client”.
- If it is not the participant, please choose “Other” and do the following:
 - Enter the name of the person or agency providing the information for the assessment.
 - Enter the relationship the person or agency has with the participant.

- Enter the telephone number of the person or agency (beginning with the area code).

16. Secondary Sources of Information - This is a multiple-part question:

- Enter the names, agency affiliations and telephone numbers (starting with the area code) of the people providing secondary sources of information for the assessment in the table provided.

Note: secondary sources can be verbal or written information that supplements information obtained from the participant. It can include the medical record, physicians, other providers, and any other person knowledgeable about the participant. **This information must be documented in the comment section provided.**

- Each time information is added to the table, a new line will appear.
 - To delete a line, hover over the grey box to the left of the contact person’s name, wait for a black arrow to appear, left click your mouse to highlight the information on that line, and click the “Delete Line” button above the table.
- Use the “Comments” text box provided to document the type of information received.

17. Assessment Date - This is a multiple-part question:

- Enter the date you are beginning the assessment in the text box provided using the following format: mm/dd/yyyy.
- Use the “Assessment Type” drop down menu to indicate if it is an “Initial”, “Update”, or “Annual” assessment.
 - Initial: first UAI completed for the participant and includes UAI Sections 1-4 (Full).
 - Update: completed if there has been a recent significant change in the participant’s functioning. The NR will use UAI section 1-4 (Full), but this does not necessarily mean that information must be changed in all sections.
 - A significant change is a major change in the participant’s status that affects more than one area of the participant’s functional or health status and requires a review or revision of the care plan or negotiated service agreement.
 - Annual: yearly administration of the UAI. The UAI must be completed within **364 days of the previous UAI assessment.**
- Use the “Sections Completed” drop down menu to indicate if this is an “Initial” or “Annual” assessment.
- Enter the date the next UAI assessment is due in the text box provided using the following format: mm/dd/yyyy.

18. Place of Assessment and Usual Housing Arrangement - This is a multiple-part question:

Note: DO NOT enter a date of admission until you have completed the “Place of Assessment” and “Usual Housing Arrangement” portions of this question.

- Use the “Place of Assessment” drop down menu to indicate where the assessment is being done.
 - If you choose “Other”, enter the place of assessment in the first text box titled “Other”.
- Use the “Usual Housing Arrangement” drop down menu to indicate the participant’s usual place of residence.
 - If you choose “Other”, enter the place of assessment in the second text box titled “Other”.
- Go back to the date of admission text box and enter a date of admission in the following format: mm/dd/yyyy.
 - If the participant resides in a custodial facility, enter the date of admission.
 - If the participant resides at home, enter the UAI date.

The screenshot shows a software window titled 'Assessment' with a menu bar containing 'Client' and 'Assessment Help'. Below the menu bar are tabs for 'Section 1', 'Section 2', 'Section 3', 'Section 4', and 'Disposition'. The main content area is divided into three sections:

- 19) Substitute Decision-Maker: (check any number)**
 - None
 - Guardian/Conservator (Non-DD)
 - Guardian/Conservator (DD)
 - Power of Attorney
 - Power of Attorney for Health Care
 - Other:
 - Informal Decision Maker
 - Living Will
 - Representative or Protective Payee
 - Limited Power of Attorney
 - Name:
 - Relationship: Telephone: () -
 - Comments:
- 20) Primary Language:** English (dropdown menu)
 - Requires Interpreter: (dropdown menu)
- 21) Legal Status:**
 - On Probation or Parole
 - Currently involved in criminal proceedings
 - Commitment to:
 - Other:
 - N/A
 - Comments:

At the bottom, there is a section for **22) Preparing for discharge from hospital, nursing facility, or institution.** with a dropdown menu, a 'Planned discharge date' field (//), and a 'Comments' field.

19. Substitute Decision Maker – This is a multiple-part question:

- Select as many check boxes as apply.
Note: If you choose “Other”, please give a description in the text box provided.
- Enter the name of the primary substitute decision maker in the text box titled “Name”.
- Enter the primary substitute decision maker’s relationship to the participant in the text box titled “Relationship”.
- Enter the primary substitute decision maker’s telephone number in the text box titled “Telephone” (beginning with the area code).
- Enter any additional or clarifying information to the text box titled “Comments”.

20. Primary Language – This is a two-part question:

- Enter the primary language of the participant.
- Use the drop down menu to indicate if the participant requires an interpreter.

21. Legal Status – This is a multiple-part question:

- Select as many check boxes as apply.
- If you select “Commitment to” or “Other”, please clarify in the text boxes provided next to each.
- Enter any additional comments or clarifying information in the text box titled “Comments”.

22. Preparing for Discharge from Hospital, Nursing Facility, or Institution

- Select “Yes” or “No” from the drop down menu provided to indicate if the participant is preparing for discharge.
- If you selected “Yes”, enter the planned discharge date in the following format: mm/dd/yyyy.
- Enter any additional comments or clarifying information in the text box titled “Comments”.

The screenshot shows a software window titled "Assessment" with a menu bar containing "Client" and "Assessment Help". Below the menu bar are tabs for "Section 1", "Section 2", "Section 3", "Section 4", and "Disposition". The main content area is divided into two sections:

23) Major Problem(s) at Time of Assessment and Anticipated Changes:

This section contains a large, empty text box for entering information.

24) Primary Caregiver Information:

This section contains several fields and dropdown menus:

- Is client in a CFH/RALF facility? [dropdown]
- If YES, Name Of Facility [text box]
- Is there a primary caregiver? [dropdown]
- Is the Caregiver present? [dropdown]
- Is primary caregiver paid? [dropdown]
- If YES, what is (are) the source(s) of payment? [text box]

Below these fields, there is a prompt: "If there is a primary caregiver, answer the following questions (Check the appropriate box):"

Fields for caregiver information include:

- Name of Primary Caregiver (current or potential): [text box] First [text box] MI [text box] Last [text box]
- Telephone: () - [text box]
- Address: [text box] City: [text box] State: [dropdown]

23. Major Problems and Anticipated Changes – Briefly describe the major problems the participant is experiencing, any anticipated changes, and the participant’s major concerns at the time of the UAI. Be sure to include what assistance the participant is seeking and who can provide that assistance.

Note: The NR will enter the date the narrative was entered.

24. Primary Caregiver Information – Skip this section. This information is not required to complete the assessment.

25. Relationship – Skip this section. This information is not required to complete the assessment.

26. Age – Skip this section. This information is not required to complete the assessment.

27. Hours Available to Provide Care – Skip this section. This information is not required to complete the assessment.

28. Length of Time as Client’s Caregiver – Skip this section. This information is not required to complete the assessment.

- 29. Special Training** – Skip this section. This information is not required to complete the assessment.
- 30.** Skip this section. This information is not required to complete the assessment.
- 31. Additional Caregivers/Supports** – Skip this section. This information is not required to complete the assessment.
- 32.** Skip this section. This information is not required to complete the assessment.
- 33.** Use the drop down menu provided to indicate if the participant is in danger of or is experiencing abuse, neglect, or exploitation (you can only choose one option from the list provided).
- Important Note:** Any indication of abuse, neglect, or exploitation **REQUIRES** a referral for assessment/investigation.

Section Two

Section 2 of the UAI is used to assess functional abilities, supports, and related information. Measurements of functional abilities and supports are commonly used across the country as a basis for differentiating among levels of long-term care giving. Functional abilities and supports are the degrees of independence with which a participant performs activities of daily living (ADL). Examples are bathing, dressing, toileting, transferring, eating, and mobility. Instrumental ADLs are meal preparation, money management, transportation, shopping, emergency telephone use, medication management, and housework.

There are three important points to remember when assessing functional abilities and supports:

1. Functional abilities and supports are measures of the participant's impairment level and need for personal assistance. In many cases, impairment level and need for personal assistance are described by the help received, but this could lead to an inaccurate assessment. For example, a disabled participant needs help to perform an activity in a safe manner, but he/she lives alone, has no formal supports, and receives no help. Coding the participant's performance as independent because no help is received is very misleading in terms of the actual impairment level. In order to avoid this type of distortion, interpret the ADLs in terms of what is usually needed to safely perform the entire activity.
2. An assessment of functional abilities and supports are based on what the participant is able to do, not what he/she prefers to do, regardless of the living situation. In other words, assess the participant's ability to do particular activities, even if he/she doesn't usually do the activity. Lack of capacity should be distinguished from lack of motivation, opportunity, or choice. This is particularly relevant for the instrumental ADLs mentioned above. In rating an able but unwilling participant, document discrepancies between stated and observed abilities.

For example, when asking someone if he/she can prepare light meals, the response may be "No", he/she does not prepare meals, even though the participant may be able to do so. The participant should be coded as not needing help. If a participant refuses to perform an activity, thus putting himself/herself at risk, it is important to probe for the reason why the participant refuses, in order to code the activity correctly.

The emphasis in this section is on assessing whether ability is impaired. Physical health, mental health, and cognitive or functional disability problems may manifest themselves as the inability to perform ADL and instrumental ADL activities. If a participant is mentally and physically free of impairment, there is not a safety risk to the participant, and the participant chooses not to complete an activity due to personal preference or choice, indicate that the participant does not need help.

3. The emphasis of measurement of each of the functional activities should be how the participant usually performed the activity over the past two weeks. For example, if a participant usually bathes with no help or reminding/cueing, but on the date of the interview requires some assistance with bathing, code the participant as not requiring help unless the participant's ability to function on the date of the assessment accurately reflects ongoing need.

There are several components to each functional activity, and the coded response is based on the participant's ability to perform all the components. For example, when assessing the participant's ability to bathe, it is necessary to ask about his/her ability to do all of the bathing activities such as getting in and out of the tub, preparing the bath, washing, and towel drying. Therefore, nurse reviewers will need to probe in detail in order to establish actual functional level. Information reported by a participant regarding functioning abilities should be verified with secondary sources if the accuracy of the information is in question. For example, a participant may state that they are able to complete a task but in reality may have problems doing so.

Some questions in the section are personal and the participant may feel somewhat embarrassed to answer (e.g., toileting, bladder and bowel control). Ask these questions in a straightforward manner and without hesitation. If you ask the questions without embarrassment or hesitation, the participant will be more likely to feel comfortable. If the participant is embarrassed, it is your responsibility to reassure the participant that it is alright and that you understand how he/she could feel that way. Let the participant know that answers to these questions are important because they will help you better understand his/her needs and provide a care plan that is right.

The Rating Scale

For each of the numbered activities listed (questions #1-#18), you will need to assess the participant in two categories: "Assistance Required" (first column) and "Available Supports" (second column). Once you have entered an assessment for each category, the UAI tool will automatically fill in the "Unmet Needs" (third column) category in this section. We've provided some brief guidelines for each category to help you with the assessment process.

Assistance Required: Base the selection of the appropriate code on the participant's ability to perform each activity on the day of the review and the performance over the last 14 days.

- If the participant is in a custodial facility, base the selection according to how the participant would perform each item if the participant lives on his/her own.
- If the participant has a temporary problem on the day of the review which interferes with how the activity is usually performed, base the selection on the participant's most typical performance.
- If the participant has a chronic condition with wide variations in performance of the activity, base the selection on the participant's most typical performance.

Available Supports: Indicate the degree of existing supports; paid or unpaid, or services that are paid for by the Department of Health and Welfare that will continue. This support can be from families, friends, neighbors, volunteers, church, caregivers, etc.

- "Available" refers to help that an agency or family/others has agreed to provide. If a family member was providing services to the participant he/she will be counted as an available support unless there is a medical reason or employment that prevents the family member from being able to continue to provide the care. Just because the family member does not want to continue providing the service is not a valid reason.
- A participant receiving meals on wheels, psychosocial rehabilitation, or attendant care shared by two participants paid by Medicaid, will be identified as available supports. If Department paid services are counted as an available support, the NR will document in the activities of daily living comment box the name of the agency and services provided.

Unmet Needs: Is the difference between the assistance required and the available supports. This will be automatically populated by the assessment tool.

The Comments Spaces

After you have made an assessment for each of the categories listed, you can add narrative notes and comments. Use this space to:

- Comment on functioning or observations in the areas of ADLs and IADLs. Comments should include the type of equipment used/needed to perform the activity and/or information about caregivers. The higher the level of need the more documentation the nurse reviewer should chart in the comment fields.
- Record any problems with the continued care giving related to that specific functional area. These may include, but are not limited to, poor health of the caregiver, employment of the caregiver, the caregiver's lack of knowledge about ways to appropriately care for the participant, or a poor relationship between the participant and the caregiver.
- Record whether the caregiver has a "backup" or someone who can provide for the participant when the caregiver is not available.
- Document any explanatory information related to the rating, as well as the names of any available informal care and paid, unpaid, or natural supports.
 - Informal care or natural supports refers to services that the participant's spouse, relative, or other individual(s) are both physically and mentally able to provide.

When entering information into the "Comments" text boxes, please remember:

- The text boxes have a limited amount of characters that can be entered.
- To delete the historical narrative notes in these comment fields when completing a redetermination or significant change UAI.

Functional Abilities Descriptions

For each of the numbered activities listed in the first column, you will need to use the drop down menu in column two, "Assistance Required" and column three, "Available Supports" to assess the participant's functional abilities and supports. **Use the following descriptions to choose the best option for each activity from the drop down menus provided with the exception of Night Needs and Medications. Please refer to those specific tasks for the description.**

N = None: No help or caregiver support needed.

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

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

E = 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.

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

Prompts, Examples, and General Information for Each Assessment Activity/Category (questions #1 - #18)

*Important: The UAI tool is in the process of being updated. The text on the screen shots below may not be accurate. Please use the **written** information, descriptions, and instructions in this manual to make selections and update/add information to the UAI tool.*

1. Preparing Meals

PROMPTS:

- What is a normal breakfast for the participant? Lunch? Supper?
- Does the participant need a specially equipped stove or specially arranged kitchen?
- Consider the participant's ability to carry food items from the refrigerator to the counter. If they have a walker, ask how they manage to prepare meals.
- Are there foul odors in the kitchen?
- Inquire what the participant fixed for breakfast, lunch, or dinner the day preceding the interview or what they will be preparing for their next meal. Have them give you details on how they prepare the meals.
- Request to observe the kitchen, meal prep area, and refrigerator. Check for dust on cans or expired food.
- How is the participant getting meals? Home delivered meals? How many? Does a facility provide the meals?
- Are they on a special diet?
- What is the most difficult for them to fix? Easiest?
- How do they get the foods they need to fix a meal?
- How do they open jars? Cans? Can they peel potatoes?
- Do they ever forget and leave a burner on? When was the last time? What happened?
- Observe for mental concentration during the interview.
- Does anyone ever help with meals? Who?
- What types of foods do they keep on hand?

Just because a participant is in a certified family home or residential assisted living facility does not mean that he/she cannot functionally prepare a portion of the meal. Assess the participant's ability as if they were residing in their own home.

EXAMPLES:

None: Should be able to use a can opener, open jars (with or without an adapter), remove protective cover from freezer packs, heat leftovers in microwave or conventional oven, peel carrots and potatoes, prepare their own meals, and feel they can do so and maintain nutritional needs and, furthermore, doesn't want anyone preparing their meals. If they are just having coffee and doughnuts, you need to find out why – *Home delivered meals are not to be authorized by NR.*

Minimal: Should be able to do most tasks. Requires cueing to complete tasks for meal preparation. May need reminders to start the meal. Caregiver may need to be present for oversight – no hands on assistance with actual food preparation – *Home delivered meals are not to be authorized by NR.*

Moderate: Needs assistance with main meal, can heat soup, prepare toast, make lunch meat or peanut butter sandwiches, and eats some raw fruits and vegetables. May need to have meals prepared ahead for easy retrieval and heated in microwave or on the stove (assuming it is safe) – *NR may authorize in-home delivered meals if meets IDAPA criteria listed below.*

Extensive: Needs assistance with completion of all meals including preparing formula for a gastrostomy tube feeding. May be able to assist with some meal preparation but is unable to sequence the complete task. Is able to complete small tasks such as peeling potatoes or cutting up lettuce while the caregiver prepares the rest of the meal – *NR may authorize in-home delivered meals if meets IDAPA criteria listed below.*

Total: this would be an individual who is unable to access and prepare any food. The person would be unable to intake nutrition without the physical assistance of another person.

Home Delivered Meals

Home delivered meals can be authorized for participants who need all meals at all times prepared by someone else due to a physical condition or inability (dementia, intellectual disability, or mental illness to the point of not being able to meet nutritional needs) or who's meals require special preparation (i.e., pureed or tube feedings). The NR may authorize in-home delivered meals if the participant meets the following IDAPA criteria:

- Rent or own their own home (home-delivered meals are not available for participants) residing in certified family homes or residential assisted living facilities.
- Are alone for significant parts of the day.
- Have no regular caretaker for extended periods of time.
- Are unable to prepare a balanced meal.

Note: The participant must meet IDAPA criteria before the services are authorized.

The NR will only count the home-delivered meal as an available support if you authorize two meals daily. If only one home delivered meal is authorized there is not adequate units authorized for the caregiver to prepare the other daily meals and the NR will note in the comment section “HDM not an available support due to inability to assist with all meal prep”.

2. Eating Meals

PROMPTS:

- Does the participant need special utensils such as built-up spoon, fork, non-spill cup, or plate guard?
- Does the participant need to be monitored while eating because of choking, chewing, or swallowing difficulties?
- Ask the participant if they have dentures. Do they cause any difficulties with eating?
- Are there some types of foods they can no longer eat?
- What are they? Why? (dentures, missing teeth, swallowing)
- How do they get meals from the stove or counter to the table?
- Can the participant serve up their own plate? (Observe for tremors, strength of grasp by holding out your index and middle finger and have them squeeze.)
- Have they ever gagged or choked while eating? When was the last time?
- Observe how the participant's clothes fit (i.e., to identify weight changes)
- Set-up: Participant requires the containers to be opened, food cut up, bread buttered, adding salt/pepper, and food brought to the table.
- If the participant lives in a certified family home setting or residential assisted living facility, it does not mean that he/she cannot functionally set up their own meal. Assess the participant's ability as if they were residing in their own home.

EXAMPLES:

None: Can feed self, chew, and swallow solid foods without difficulty or can feed self by gastrostomy tube or catheter. Is able to dish up own food, transfer to table, no choking or swallowing problems, independent with special utensils. Should be feeding self at least two meals a day with consistency.

Minimal: Can feed self, chew, and swallow foods without difficulty but needs reminding/cueing to maintain adequate intake. Requires encouragement to follow dietary needs (i.e., diabetic, low salt, low fat). May be in training program to learn ADLs. May need encouragement from caregiver to eat.

Moderate: Can feed self but requires hands on assistance to complete the meal. Participant is unable to get their food to the table without help. This includes someone who tires very easily while eating (i.e., lung problems, oxygen therapy). This would include a participant who is bed bound and able to feed self with set up or may need assistance with fluids.

Extensive: Can feed self but is unsafe without routine assistance to complete all meals. May have occasional gagging, choking, or swallowing difficulty, or require assistance with feeding appliances. Participant may have problems with swallowing due to stroke and is at risk for choking. May have Parkinson's and feeds self but requires constant cleanup or someone to steady their hand.

Total: May be fed by another person by mouth or gastrostomy tube.

3. Toileting

PROMPTS:

- Does the participant have the awareness of the need to toilet?
- Does the participant recognize the need to toilet but cannot do so without the assistance of another person?
- Inquire if the participant has any bowel or bladder accidents.
- Are there strong urinary or fecal odors present?
- Does the participant take a “water” pill?
- Does the participant wear protective garments? Pads or pull-ups? How do they dispose of these? Note for odors, cleanliness, and proper disposal of toileting items.
- Is the participant able to clean after toileting? Does anyone ever help him/her with this activity? Who?
- Catheter care: Who helps the participant with this activity? Last UTI?
- Ostomy Care: Who helps the participant with this activity? Who does set up? Clean up? Disposal?

EXAMPLES:

None: Can toilet self without physical assistance or supervision. May need grab bars or raised toilet seat or can manage own closed drainage system if has a catheter or sheath or protective aids. Has no bladder or bowel problems, is slow but able to get to the bathroom on time. Or, has occasional bladder incontinence but able to take care of own needs with cleaning self and proper disposal of incontinence supplies. If the participant can manage the catheter but requires assistance with a monthly catheter change, the nurse reviewer may authorize a skilled nursing visit.

Minimal: Needs cueing or stand by assistance for safety or task completion.

Moderate: Needs physical assistance with parts of the task completion. Needs caregiver assistance with toileting and clothing, pericare, protective garments, ostomy care, or drainage bags. Needs assistance with disposal of soiled items (i.e., needs caregiver to remove soiled items daily from living quarters).

Extensive: Cannot get to the toilet unassisted. May or may not be aware of need. Needs to be physically assisted to the bathroom and with toileting tasks. May need to have a toileting schedule; unaware of need. May need additional person and/or mechanical lift.

Total: Physically unable to be toileted. Requires continual observation and total cleansing. Needs someone else to manage care of closed drainage system if they have catheter or sheath. Requires protective garments to be checked, changed, and pericare done on a regular basis.

4. Mobility

PROMPTS:

- Did the participant answer the door?
- Ask the participant if they would mind standing up and walking about 10 steps, turn around and return to their chair (it's easier to observe transfers, balance, pace, gait, posture, and orientation in this manner).
- Ask what type of equipment the participant uses to get where they need to go inside and outside.
- How far can the participant walk without having to stop and rest?
- What does the participant do when he/she gets too tired or short of breath?
- When was the last time the participant fell? What happened?
- Does the participant ever have periods of extreme weakness or fatigue? How often? Can you describe the circumstances?

EXAMPLES:

None: Can get around independently inside and outside with or without assistive devices. May be in a wheelchair but can get around independently in or out of the home. May have assistive devices to help reach items, transferring out of a chair, etc. May use other devices for ambulating, walker, cane, prosthetics, but they can manage independently.

Minimal: Can get around inside without assistance. May need cueing or oversight to routinely use assistive devices.

Moderate: Due to variable status requires assist with mobility on some days inside. Always requires help when outside on outing and/or on uneven surfaces.

Extensive: Requires physical assist with mobility at all times. May be in a wheelchair and unable to self-propel.

Total: Immobile or bed bound.

5. Transferring

PROMPTS:

- Identify if the participant needs an overhead frame, slide board, etc.
- Does the participant need equipment to assist with transfers?
- Who helps the participant in and out of vehicles?
- How much help does the participant need to get from the chair to the bed, etc.?

EXAMPLES:

None: Can transfer independently and can manage own position changes. Consistently transfers safely and independently from sitting to standing position and back again.

Minimal: Transfers and changes position but needs standby assistance/cueing/encouragement. Includes participants with lift chairs, trapeze, or side rails. Needs reminders to use assistive devices.

Moderate: Can assist with own transfers and position changes but needs hands on assistance with part of the tasks to do so safely. Able to push self up from chair, but requires hands on assist to maintain balance during the position change. Needs assistance in/out of vehicles.

Extensive: Can assist with own transfers and position changes but needs hands on assistance all of the time. May be unsteady, tremulous or dizzy and requires physical assist with position changes or transfers. Participant able to bear weight or pivot when standing but has physical deficits (one sided weakness) and requires assistance all of the time. Additional person and or mechanical lift may be needed. Assessor may consider adding additional units.

Total: Must have another person transfer or change participant's bed or chair positions. Participant unable to assist at all. Participant may be bed bound or requires a mechanical lift. If the participant is able to assist using arms (i.e., using trapeze or side rails) then not a total.

6. Personal Hygiene

PROMPTS:

- Who does the participant's hair? (If they say they do it, you can ask them to raise their arms as high as they can to determine range of motion).
- How does the participant clean his/her glasses?
- How does the participant care for fingernails/toenails?
- How does the participant take care of dentures?
- How does the participant set up and prepare items for shaving?
- Is the participant diabetic? Does he/she daily inspect feet? Ever go barefoot?

EXAMPLES:

None: Maintains hygiene by themselves. Can manage personal hygiene without reminders, assistance, or supervision.

Minimal: Can manage personal hygiene but must be reminded or cued. Requires prompting or reminding to complete general hygiene tasks.

Moderate: Participant performs personal hygiene but caregiver may provide physical assistance. Requires hands on assistance with some tasks including set-up and clean-up. Caregiver may need to physically assist with completion of cares.

Extensive: Caregiver performs most personal hygiene but participant assists. Someone who tires easily or has limited range of motion or shortness of breath.

Total: Dependent on others to provide all personal hygiene; physically or cognitively unable to complete tasks.

7. Dressing

PROMPTS:

- Identify if the participant needs special consideration with manipulating closures (i.e., zippers, Velcro, etc.)
- How do they decide what to wear for the day (appropriate attire for situation and cleanliness)?
- What is the most difficult part about getting dressed?
- Where do they put soiled clothing?
- Do they wear special garments? TED hose or orthotics?
- How do they put the TED hose on?
- Can they snap, button, and zip clothing? Does anyone ever help with this? Who?
- Has anyone complained about their grooming or dress?
- Observe for clothing that is appropriate for the season.
- Are they able to get their closet or dresser?

EXAMPLES:

None: Can dress and undress and select clothing without help or supervision.

Minimal: Can dress and undress and select clothing but may need to be reminded or supervised. Requires cues to change clothes or put on appropriate clothing.

Moderate: Can dress and undress and select clothing with assistance. Some hands-on assistance is needed including assisting with TED hose, braces, splints, bra, shoes and stockings, zippers and fasteners, etc. Needs clothing brought from the dresser or closet.

Extensive: Caregiver must dress and undress the participant but the participant assists. Can only dress with hands on assistance. Only able to put arms in sleeves or legs in pants.

Total: Not able to assist with any dressing.

8. Bathing

PROMPTS:

- Does the participant shower or bathe? How often?
- Can they shampoo their hair? Reach their feet and backside? If no special equipment, who would they ask?

- What would they do to keep from falling in the tub or shower?
- Do they feel safe getting in and out of the tub or shower?
- Does anyone ever help with this activity? Who? How often?

EXAMPLES:

None: Can bathe safely as needed without reminders and without assistance or supervision.

Minimal: Can bathe without physical assistance but may need reminding or standby assistance due to history of falls, fear of falling, or episodes of dizziness. Will not bathe while home alone.

Moderate: Requires assistance with parts of bathing (hard to reach areas washing feet or rinsing hair, etc.). Needs assistance getting in or out of the tub or shower or needs help with any other bathing tasks. Could include caregiver support set up and clean up. Only requires assistance with washing ones back does not qualify as moderate.

Extensive: Caregiver must bathe the participant with the participant's assistance. Requires caregiver assistance with entire bath. Only able to wash face or limited areas if handed a washcloth. Additional person and/or mechanical lift may be needed (assessor may consider adding additional units).

Total: Dependent on others to provide complete bath, including shampoo.

9. Transportation

PROMPTS:

- Identify if the participant needs a specially equipped van or car.
- How do they get to where they need to go?
- Are there family members or support from the community who help with transportation? Are they able to continue to help?
- If family or friends are not available, how would the participant get there?
- Has the participant experienced problems trying to arrange for a ride?

EXAMPLES:

None: Can arrange their own transportation needs. Can drive safely or is capable of using alternate transportation without assistance.

Minimal: Can use available transportation but needs assistance arranging rides.

Moderate: Requires physical assistance getting in and out of vehicle.

Extensive: Needs assistance by the caregiver getting into the vehicle and during the ride.

Total: Cannot be transported unless by ambulance.

Important: Providers must have a Medicaid transportation provider number prior to authorization of transportation units. The NR may only authorize up to 1800 miles per year. The NR may add units for attendant care to cover non-medical transportation if the participant is not safe to be left unattended.

If a participant is physically not able to go to the store with the attendant (i.e., has a medical diagnosis which prohibits the participant from leaving the house) and there is not family, neighbors, friends, or community agencies which can provide this service without charge, the NR will authorize non-medical mileage.

A narrative note will be entered into Section 2, Question 9, “Access to Transportation”. Transportation services authorized under the A&D Waiver must be in the participant’s service plan.

If a participant is physically able to get into the automobile, does not have family, neighbors, friends, or community agencies which can provide this service without charge, but chooses not to go shopping or run errands with the caregiver, non-medical transportation services will not be authorized.

10. Finances – Insert “N” in all columns. No other information required for this section.

11. Shopping

PROMPTS:

- How do they get to the store to buy groceries or personal items?
- How do they get the items into the house/apartment and put them away?
- Do they enjoy shopping?
- Does anyone ever help with this activity? Who?

EXAMPLES:

None: Can shop without assistance. Is able to get to the store, take items off the shelf, purchase and carry items independently.

Minimal: Needs supervision and cueing to make appropriate shopping choices and expenditures. May spend money on junk food instead of nutritious food. Needs help with completing grocery list.

Moderate: Can shop with physical assistance.. Can make purchase decisions but unable to get the items off the shelf, needs help with paying or carrying bags into the house.

Extensive: Cannot complete without caregiver assistance. Caregiver must shop but participant assists. Only able to help with making the list or item selection. May or may not accompany the caregiver to the store.

Total: Totally dependent upon others for shopping. Unable to go to the store or make needs known.

12. Laundry

PROMPTS:

- Where are the washer and dryer?
- How many times a week/month does the participant do laundry?
- How often are bed linens and towels laundered?
- How does laundry get folded and put away?
- Does anyone help with this activity? Who?

EXAMPLES:

None: Able to sort, carry, load washer and dryer, fold and put away laundry independently.

Minimal: Does laundry without assistance but may need to be supervised or cued. Can follow verbal or written instructions to sort clothes, measure detergent, turn on washer/dryer, or reminders to fold and put away clothes.

Moderate: Can do laundry but needs physical assistance from caregiver to complete. Needs help taking clothes to the laundromat.

Extensive: Caregiver must do the laundry but participant assists. Able to fold or put away small items. May have steep stairs and unable to get to basement to do laundry. Limited access to laundry facilities.

Total: Unable to do any laundry tasks.

13. Housework

PROMPTS:

- Does the participant do the dishes after each meal?
- Do they have a vacuum cleaner? Can they use it?
- How do they get the tub, shower, toilet, or sinks cleaned?
- How do the floors get swept or mopped?
- Who changes the linen on your bed? Turns the mattresses?
- How do they clean out the refrigerator? Does it automatically defrost?
- How does the garbage get taken care of? Who takes it out?
- Does anyone ever help you with housecleaning? Who?

EXAMPLES:

None: Able to complete all housekeeping tasks independently.

Minimal: Physically capable of performing all housecleaning but needs supervision or cueing. Needs reminded to make bed, pickup dirty clothes, or take out the trash.

Moderate: Performs light housecleaning but caregiver must handle physically difficult housecleaning. Independently can wash dishes, make own bed, pick up dirty clothes, dust, etc. but can't vacuum, mop floors, change bed linen, or scrub the toilet or tub.

Extensive: Only able to complete cleaning tasks with hands on assistance including washing dishes, making own bed, picking up dirty clothes, dusting, vacuuming, mopping floors, changing bed linens, or scrubbing toilet/tub.

Total: Unable to complete any housekeeping tasks.

14. Wood/Coal Supply – Insert “N” in all columns and no other information required for this section unless primary heating source is fueled by wood or coal.

15. Night Needs

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.

PROMPTS:

- When was the last time the participant got up at night and felt confused about where they were? What did they do?
- How many times do they toilet at night? Do they need help?
- Do they have any regular or PRN medications at night?
- Do they wake up at night with pain?
- Have they recently had any falls during the night?
- Do they wake up short of breath?
- What is their normal bed time and wake up time?

EXAMPLES:

None: needs no assistance and is able to meet own needs if wakes up at night (i.e., able to toilet self).

Minimal: Wakes up 1-2 times a night requiring help (i.e., guidance to bathroom). May be fall risk, disoriented, unsteady, or need help with oxygen tubing. May have behavior issues that require redirection back to bed.

Moderate: Wakes up 3-4 times a night requiring help. May be a fall risk, disoriented, unsteady, or need help with oxygen tubing. May have behavior issues that require redirection

back to bed. Caregiver may need to physically take participant back to the room.

Extensive: Wakes up 5 or more times a night requiring help. May be a fall risk, disoriented, unsteady, or need help with oxygen tubing. May have behavior issues that require redirection back to bed. Caregiver may need to physically take participant back to the room.

Total: Requires ongoing intervention throughout the night; staff must be up and awake to assist. May be a fall risk, disoriented, unsteady, or need help with oxygen tubing. May have behavior issues that require redirection back to bed. Caregiver may need to physically take participant back to the room. Would need documentation to support staff safety interventions.

Important: Night time is the time period after bed time cares have been completed and before normal waking hours. PM cares are not authorized under night needs. The NR should not authorize in-home units if caregiver is unavailable.

16. Emergency Response

PROMPTS:

- Has the participant ever called 9-1-1 in an emergency? Anyone else?
- How would they leave the home/apartment in the event of an emergency? Who would they call?
- Have they had an emergency situation in the past? Recently?
- Ask them to tell you how they would handle an emergency such as falling in the bathtub or their bedroom.

EXAMPLES:

None: Able to get self out of the home and/or call 9-1-1 in an emergency.

Minimal: Needs supervision and/or verbal cueing to get outside of present dwelling or get emergency help. Easily confused, may have cognitive deficits, and requires verbal cues during an emergency.

Moderate: Participant can get out of present dwelling with limited physical assistance. Needs hands on assistance to get out of the home. A very sound sleeper and needs to be awakened during emergency drill or actual emergency – *NR may consider authorization of PERS if in-home only.*

Extensive: Needs help out of bed or into wheelchair. Cannot be left alone after an emergency evacuation – *NR may consider authorization of PERS if in-home only.*

Total: Requires total physical assistance to get outside of present dwelling. Unable to transfer self out of bed or into wheelchair. Must be propelled to safety – *NR may consider authorization of PERS if in-home only.*

17. 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.

PROMPTS:

- What medications is the participant taking OR what are they taking the medications for (many people know this but not the technical names)?
- How often are they taken?
- Do any medications need to be broken/crushed?
- When was the last PRN medication taken?
- Are the medications kept in a bottle or a medi-set? Who fills it?
- Does the participant have trouble opening medicine bottles?
- When was the last time they forgot to take medications? What happened?
- Does anyone ever help with medications? Who?
- Do they need assistance with ordering medication refills or picking up medications from the pharmacy?

EXAMPLES:

None: Can self-administer medication without assistance. Able to obtain and take medications and understand reasons and time for administration.

Minimal: Knows medications and routine, but needs occasional reminders to take medications.

Moderate: Participant may be forgetful and miss taking medicine once in a while and physical assistance is needed to open containers. Needs assistance filling the mediset.

Note: Paid caregivers may not fill medisets.

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

medicine without daily reminders. Participant may have a history of medication non-compliance. Diabetic participant who needs help with documenting blood sugar levels and handed prefilled insulin syringes and supplies.

Total: Requires licensed nurse to administer and/or assess the amount, frequency, or response to medication or treatment. A treatment is defined as a skilled nursing treatment. The medication or treatment must be required at least once a day.

Note: If the participant receives an injection once a month or once a week, they do not meet the definition for Total score.

Important: Whenever possible, family members, neighbors, community resources, or public transportation shall be utilized prior to the NR authorizing caregiver time or miles to pick up medications. The waiver states that participants in their own home will be able to administer their own medications. A score indicating an inability in this area could cause waiver services in the home to be denied as not being safe and effective.

If the participant meets the IDAPA medication critical indicator (12 points for Extensive or Total assistance with medications which require decision making prior to taking, or assessment of efficacy after taking), NR documents in comments box who is performing the medication decisions and assessment and any supports required.

Note: This function cannot be done by the caregiver.

- Skilled Nursing Services: the assistance required would be “Total”.
- Available Supports: the skilled nursing visits will be considered an available support.
 - Select the degree of support that makes the unmet needs score correspond to the score the participant should have received if no skilled nursing needs were identified.
 - Enter narrative comments to support participants assistance required with medications, skilled nursing visits and reason.

18. Supervision – This question cannot be answered until questions #1 - #13 in Section 4 of the UAI are completed. Please skip to the Section 4 questions and complete them now.

The UAI computer software will then take the Section 4 scores and determine the scoring for supervision. The NR will need to identify the participant’s unmet needs for supervision. The units for the in-home participant may be adjusted based on the participant’s condition and case-by-case basis using nursing judgment. This would be the exception not routine. The NR should consider participant safety and cost effectiveness.

Once Section 4 is completed, the participant’s total scores will determine the need for supervision. The scoring determinations are as follows:

- **None:** 0-15 points
- **Minimal:** 16-30 points
- **Moderate:** 31-45 points
- **Extensive:** 46-60 points
- **Total:** 61-100 points

Questions only for participants seeking services in home or from AAA (questions #19-#24)

Note: If the participant is not seeking services in home or from AAA, skip this section.

19. Environmental – Exterior

- For each “Area to Review”, use the drop down menus and check boxes provided in the “Observations” columns to provide as much information as possible about the participant’s exterior living environment.
- Check as many boxes as apply to each area.
- If an area does not apply to the participant’s exterior living environment (i.e., there are not handrails at the participant’s residence), check the box under the “N/A” column.

Note: When completing this question, try to verify as much of the reported information as possible.

Section 1
 Section 2
 Section 3
 Section 4
 Disposition

20) ENVIRONMENT - Interior			CHECK ALL THAT APPLY		
Areas to Review	Observations	N/A	Areas to Review	Observations	N/A
Wheechair Access	<input type="checkbox"/> Doorways <input type="checkbox"/> Kitchen <input type="checkbox"/> Bedroom <input type="checkbox"/> Bathroom	<input type="checkbox"/>	Stairs	<input type="checkbox"/> Adequate <input type="checkbox"/> Cluttered <input type="checkbox"/> Need Repair <input type="checkbox"/> Narrow <input type="checkbox"/> Need Handrail <input type="checkbox"/> Steep	<input type="checkbox"/>
Floors	<input type="checkbox"/> Adequate <input type="checkbox"/> Uneven <input type="checkbox"/> Broken <input type="checkbox"/> Loose Carpeting <input type="checkbox"/> Excessive Clutter	<input type="checkbox"/>	Electrical Safety	<input type="checkbox"/> Adequate <input type="checkbox"/> Bare Wires <input type="checkbox"/> Unsafe Extension Cords <input type="checkbox"/> Overloaded <input type="checkbox"/> Power Off <input type="checkbox"/> Unable to assess	<input type="checkbox"/>
Tub/Shower	<input type="checkbox"/> Adequate <input type="checkbox"/> Unsanitary <input type="checkbox"/> Clogged Drain <input type="checkbox"/> No Handrail <input type="checkbox"/> No Transfer Space	<input type="checkbox"/>	Appliances	<input type="checkbox"/> Adequate <input type="checkbox"/> Needs Repair Please identify appliance and reason for repair <input type="text"/>	<input type="checkbox"/>
Toilet	<input type="checkbox"/> Adequate <input type="checkbox"/> Leak <input type="checkbox"/> Won't Flush <input type="checkbox"/> Outdoors <input type="checkbox"/> Needs safety bar <input type="checkbox"/> No transfer space	<input type="checkbox"/>	Heating/Cooling	<input type="checkbox"/> Adequate <input type="checkbox"/> Poor ventilation <input type="checkbox"/> Space heaters <input type="checkbox"/> Gas fumes <input type="checkbox"/> Furnace not working <input type="checkbox"/> Unable to assess	<input type="checkbox"/>
Cleanliness	<input type="checkbox"/> Adequate <input type="checkbox"/> Odor <input type="checkbox"/> Rubbish / Trash <input type="checkbox"/> Unclean food prep area <input type="checkbox"/> Excessive Clutter	<input type="checkbox"/>	Safety Factors	<input type="checkbox"/> Adequate <input type="checkbox"/> Inaccessible exits <input type="checkbox"/> Limited phone access	<input type="checkbox"/>

20. Environment – Interior

- For each “Area to Review”, use the drop down menus and check boxes provided in the “Observations” columns to provide as much information as possible about the participant’s interior living environment.
- Check as many boxes as apply to each area.
- If an area does not apply to the participant’s exterior living environment (i.e., there are not stairs at the participant’s residence), check the box under the “N/A” column.
- If comments boxes are provided, please provide in detail as much of the requested information as possible.

21) Are there other things around the home that need care/repair?

22) ASSISTIVE DEVICES AND MEDICAL EQUIPMENT Please check all that apply

<p><u>Mobility</u></p> <p><input type="text"/> Cane</p> <p><input type="text"/> Crutches</p> <p><input type="text"/> Guide Dog</p> <p><input type="text"/> Hospital Bed</p> <p><input type="text"/> Hoyer Lift</p> <p><input type="text"/> Leg Braces</p> <p><input type="text"/> Prosthesis</p> <p><input type="text"/> Ramp Access</p> <p><input type="text"/> Transfer Board</p> <p><input type="text"/> Walker</p> <p><input type="text"/> Wheelchair (electric)</p> <p><input type="text"/> Wheelchair (manual)</p>	<p><u>Eating</u></p> <p><input type="text"/> Dentures</p> <p><input type="text"/> Hand Splint / Braces</p> <p><input type="text"/> Infusion Pump</p> <p><input type="text"/> Special Utensil / Plate</p> <p><input type="text"/> Other: (Please Specify)</p> <p><input type="text"/></p> <p><u>Skin Care</u></p> <p><input type="text"/> Special Mattress</p> <p><input type="text"/> Special Mattress Pad</p>	<p><u>Communication</u></p> <p><input type="text"/> Elec. Comm.</p> <p><input type="text"/> Glasses / Corrective Lenses</p> <p><input type="text"/> Hearing Aid</p> <p><input type="text"/> Interpreter (Language)</p> <p><input type="text"/> Interpreter (Sign)</p> <p><input type="text"/> Lifeline</p> <p><input type="text"/> Magnifying Glass</p> <p><input type="text"/> Picture Book</p> <p><input type="text"/> Symbol Book</p> <p><input type="text"/> TTY (Teletypewriter)</p> <p><input type="text"/> Other: (Please Specify)</p>
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21. Other things around the Home that Need Care or Repair

Use this comment box to address anything around the home, inside or out, which needs care or repair. Also comment on any need for specialized environmental controls for disabled participants. Include comments about neighborhood, transportation access, etc.

22. Assistive Devices and Medical Equipment

- Select “Has”, “Needs”, or “Both” from the drop down menus provided next to each assistive device or type of equipment listed to indicate the participant’s needs for each.
- If the participant doesn’t need or use something that is listed, leave the box blank.
- If you select “Other”, use the comments boxes provided to specify the participant’s needs.
- For the “Is an assistive device/technology assessment needed?” question.

- Select “Yes” or “No” to indicate if an assistive device/technology assessment is needed.

Note: You should select “Yes” if the NR has identified that a device may help the participant function at a higher level, but the participant does not have one at this time.

- If you select “Yes”, please type the person or agency the referral is made to and the reason for the referral in the text boxes provided.
- The “Referral Date” text box will auto populate with the current date.

23) ADDITIONAL NUTRITIONAL RISK INFORMATION:

- Do you eat less than two meals a day?
- Do you eat less than two servings each of fruits, vegetables, and milk and dairy
- Do you have two to three drinks of beer, liquor, or wine a day?
- Do you have tooth or mouth problems that make it hard to chew?
- Do you ever run out of money for food?
- Do you frequently eat alone?
- Do you take three or more different prescribed or over - the - counter drugs?
- Have you gained or lost ten pounds in the last six months without wanting to?
- Do you have an illness or condition that makes you change the kind of food and / or amount of food you eat?
- Do you require assistance to shop, cook, and feed yourself?
- Do you have difficulty swallowing?

23. Additional Nutritional Risk Information

- For each question listed, select either “Yes” or “No” from the drop down menus provided.
- Note:** Every question must have a response.

24) DIET INFORMATION:

Are you currently on a special diet? IF YES, please answer the following:

Are you following the diet?

Please specify which diet(s) from the choices below:

<input type="checkbox"/> ADA calorie - calculated	<input type="checkbox"/> Low Cholesterol
<input type="checkbox"/> Regular Diet with Added Nutrients	<input type="checkbox"/> Liquid
<input type="checkbox"/> Mechanically Altered	<input type="checkbox"/> Other (Please Specify)
<input type="checkbox"/> Restricted Sodium	
<input type="checkbox"/> Diabetic	

24. Diet Information

- Select “Yes” or “No” from the drop down menu provided to indicate if the participant is on a special diet.
- If you select “Yes”:
 - Select “Yes” or “No” from the second drop down menu provided to indicate if the participant is following the diet.
 - If the participant is on a diet ordered by a physician, check the appropriate box to indicate what diet(s) the participant is following (check as many as apply).
 - If none of the choices match the physicians order, please select “Other” and use the text box provided to specify the participant’s diet.

Section Three

Section 3 of the UAI is used to gather and assess the participant's health information. This section is not intended to be used to diagnose a problem. It is to record current conditions or diseases for which the participant is being treated or may need a health referral. A list of diagnosis categories with examples can be found at the end of the chapter. The medical record should be used to identify diagnoses and interventions.

- 1. Primary Physicians Name** – Enter the name of the participant's primary physician.
 - If you don't know the physician's name, write "unknown".
 - If the participant doesn't have a primary physician, write "none".
- 2. Telephone** – Enter the primary physician's telephone number (beginning with the area code).
 - If you don't know the physician's phone number, enter 000-000-0000.
- 3. Current Diagnosis (Physical and Mental Health)** –
 - For each condition listed, check all boxes that apply.
 - If you select "Other" for any of the conditions/categories listed, please identify and add any necessary clarifying notes or additional information in the text boxes provided.
 - Document confirmed diagnosis by health/mental health professionals or medical problems identified by the participant or family.
 - Note any sexually transmitted diseases under "Urinary/Reproductive Problems" and tuberculosis treatment under "Respiratory Problems".

The screenshot shows a software window titled 'Assessment' with a navigation bar at the top containing 'Section 1', 'Section 2', 'Section 3', 'Section 4', and 'Disposition'. The main content area is divided into sections 4 through 8:

- 4) Pertinent History (Physical and Mental Health):** A large text input field.
- 5) Last Hospitalization Date // and Reason:** Two text input fields.
- 6) Medications:** A section with a text input field for 'Total number of prescribed medications' (containing '0') and a 'Delete Line' button. Below is a table with columns: 'Name/Dosage (List)', 'Route', and 'Frequency'. The table contains one row with an asterisk in the first column.
- 7) Comments regarding medication use: (Be sure to note whether client requires liquids versus pill form, crushed pills, etc...)** A text input field.
- 8) Does the client use any Over-the-counter (OTC) medications or home remedies?** A dropdown menu and a text input field with the prompt 'If YES, Please list.'.

4. **Pertinent History** (Physical and Mental Health) – Enter the participant’s physical and mental health history that is relevant to his or her current functioning, including the dates of hospitalizations and mental health treatments, in the text box provided.
5. **Last Hospitalization** –
 - Enter the date of the participant’s last hospitalization using the format: mm/dd/yyyy.
 - Enter the reason for the hospitalization in the text box provided.
6. **Medications** – Leave blank. This information is not required to complete the assessment.
7. **Comments Regarding Medication Use** – Leave blank. This information is not required to complete the assessment.
8. **Over the Counter Medications/Home Remedies** – Leave blank. This information is not required to complete the assessment.

The screenshot shows a software window titled "Assessment" with a menu bar containing "Client" and "Assessment Help". Below the menu bar are tabs for "Section 1", "Section 2", "Section 3", "Section 4", and "Disposition". The main content area is divided into three columns for sections 9, 10, and 11. Section 9, "Bladder Control", has a dropdown menu and a "Type:" text box. Section 10, "Bowel Control", has a dropdown menu. Section 11, "Skin Problems", has a dropdown menu and a text box with the instruction "If YES, describe problems, including any special wound care, nail care, etc.:". Below these is section 12, "Treatments / Therapies", which features a table with a "Delete Line" button, a table with columns "Treatments/Therapies" and "Frequency", and a text box for "Other Treatments / Therapies".

9. Bladder Control –

- Select the participant’s level of continence from the drop down menu options provided.
- If you choose “Catheter Type”, please enter the type of catheter in the text box provided.

10. Bowel Control – Select the participant’s level of continence from the drop down menu options provided.

11. Skin Problems –

- Select “Yes” or “No” from the drop down menu provided to indicate if the participant has skin problems.
- If you select “Yes”, describe the problems in the text box provided (include dry areas, rashes, stasis, ulcers, red areas, pressure sores/decubitus ulcers, open sores, incisions, open wounds, and/or any open sore that has not healed in the last 30 days).

12. Treatment/Therapies - Must be marked “Yes” or “No”. No comment is required.

13. Identify Assistance Required – Leave blank.

14. Does a Recommendation Need to be Made

- Select “Yes” or “No” from the drop down menu provided to indicate if the participant needs to be referred to a physician for a medical condition not currently being addressed.
- If you select “Yes”, enter the name of the physician and the reason for the referral in the text boxes provided.
- The “Referral Date” text box will auto populate with the current date.
- Enter any possible interventions or care not already listed in the last, blank text box provided.

15. Vision – Check the option from the list provided that best describes the participant’s ability to see.

16. Hearing – Check the option from the list provided that best describes the participant’s ability to hear.

<p>17) Receptive Speech: (Check One)</p> <p><input type="radio"/> Understands information without difficulty.</p> <p><input type="radio"/> Understands information with difficulty.</p> <p><input type="radio"/> Recognizes environmental cues only.</p> <p><input type="radio"/> Does not understand information conveyed.</p> <p><input type="radio"/> Cannot determine.</p>	<p>18) Expressive Speech: (Check One)</p> <p><input type="radio"/> Communicates information and is understood.</p> <p><input type="radio"/> Communicates information but is difficult to understand.</p> <p><input type="radio"/> Does not communicate or convey needs.</p> <p><input type="radio"/> Cannot determine.</p>
<p>19) Nutrition:</p> <p>Height: <input type="text"/> Weight: <input type="text"/></p> <p>Weight / Appetite / Nutrition / Eating Disorder Comments:</p> <div style="border: 1px solid gray; height: 60px; width: 100%;"></div>	<p>20) Allergies:</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Food <input type="text"/></p> <p><input type="checkbox"/> Medication <input type="text"/></p> <p><input type="checkbox"/> Environmental <input type="text"/></p> <p>Comments</p> <div style="border: 1px solid gray; height: 30px; width: 100%;"></div>

17. Receptive Speech – Check the option from the list provided that best describes the participant’s ability to comprehend verbal or spoken language.

18. Expressive Speech – Check the option from the list provided that best describes the participant’s ability to communicate.

19. Nutrition

- Enter the height of the participant in the text box provided, if known (an estimate is acceptable).
- Enter the weight of the participant in the text box provided, if known (an estimate is acceptable).
- Use the “Weight/Appetite/Nutrition/Eating Disorder” comments box to add additional information.

Note: The NR may use the BMI scale to determine obesity or failure to thrive.

20. Allergies – Leave blank. This information is not required to complete the assessment.

Section Four

Section 4 of the UAI is used to assess psychological, social, and cognitive information about the participant. This section is not meant to diagnose the participant but to record specific abilities and limitations which will assist in identifying appropriate resources. Some issues may be triggered in multiple areas in this section. The NR will document these triggers in all identified areas. Example: anxiety and depression or memory and delusions.

When assessing a participant with a mental illness diagnosis, it is important to assess and access other supporting and verifying information, specifically the participant's psychosocial assessment. To validate the participant's information, the NR may obtain clarification from collateral contacts.

For the purposes of this section:

- “Current” is defined as the last 6 months.
- “History of” is defined as when the participant has experienced at least one of the following:
 - Psychiatric treatment more intensive than outpatient care more than once in the past two years.
 - An episode of significant disruption to their normal living situation within the last two years due to mental illness or a related condition. Supportive services were required to maintain function at home or in a residential treatment environment, or resulted in intervention by housing or law enforcement officials.

The Comment Spaces

After you have made an assessment for each of the categories listed, you can add narrative notes and comments. Use this space to note information such as:

- A situation where the nurse reviewer has concerns about his/her rating.
- Family problems, a recent death, stresses, etc.
- Any description of legal issues related to:
 - Disruptive/socially inappropriate behavior (Question #9).
 - Assaultive/destructive behavior (Question #10).
 - Alcohol /drug abuse (Question #12).
- Quality of life issues.
- Provider/physician input.
- Positive/negative triggers which initiate certain behaviors (families may accept unusual behavior as normal for the participant).
- Any other emotional problems or needs.

Assessment Activities/Categories

Prompts, Examples, and General Information for Each Assessment Activity/Category (Questions #1 - #13)

- 1. Orientation** – Check the option from the list provided that best describes the participant’s ability to relate to people, places, time, and situations.

In assessing orientation, it is important to determine if the participant has an understanding of his/her surroundings and relationships to people around (orientation to person), knows where he/she is (orientation to place), the month and year (orientation to time), and knows why he/she is being interviewed (orientation to situation). Adequate assessment of these areas is an important indicator of a participant’s ability to function and care for himself/herself with minimal supervision.

DESCRIPTIONS:

<p>1) Orientation: <i>Ability to relate to person, place, time and / or situation.</i></p> <ul style="list-style-type: none"><input type="radio"/> Oriented to person, place, time, and / or situation.<input type="radio"/> 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.<input type="radio"/> 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.<input type="radio"/> Always disoriented and requires constant supervision and oversight for safety. Extensive intervention needed to manage behavior.

PROMPTS:

- May I ask you some standard questions we ask everybody?
- How old are you?
- What is the date?
- What is this place called?
- What year were you born?
- Who is the President? Governor?

- 2. Memory** – Check the option from the list provided that best describes the participant’s ability to recall and use information.

There are several different types of memory that can be assessed. Short-term verbal memory is probably the most important type of memory to assess because it influences a participant’s ability to communicate with others and to remember and subsequently follow instructions in a work, home, or care setting. Long-term memory is not as important for daily functioning but does affect the participant’s quality of life. Written or visual memory, also, is not as important as short-term verbal memory, in terms of daily functioning, but is important for the participant in terms of being able to function well in a work situation. Also, visual memory, such as of written instructions, can be used to offset impairments in verbal memory.

DESCRIPTIONS:

<p>2) Memory: <i>Ability to recall and use information.</i></p> <ul style="list-style-type: none"><input type="radio"/> Does not have difficulty remembering and using information. Does not require directions or reminding from others.<input type="radio"/> 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.<input type="radio"/> 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.<input type="radio"/> Cannot remember or use information. Requires continual verbal PROMPTS. May have behavior management plan in place.
--

PROMPTS:

- During the interview, determine if the participant can remember your name and why you are talking with him/her.
- You can also ask if the participant remembers details of a recent situation, such as, “What did you have for breakfast this morning?”
- To formally assess memory, explain to the participant that you will identify three common items which you will ask him/her to recall later in the interview.

3. **Judgment** – Check the option from the list provided that best describes the participant’s ability to make appropriate decisions, solve problems, or respond to major life changes.

Judgment refers to the participant’s ability to make choices or decisions that are in his/her best interest. Examples include: the types of people the participant chooses to be around, the way the participant spends resources, and risky situations the participant chooses for fun or thrill, but which endanger his/her safety. Often a participant’s judgment is impaired because he/she cannot see the consequences of certain actions.

DESCRIPTIONS:

<p>3) Judgment: <i>Ability to make appropriate decisions, solve problems, or respond to major life changes.</i></p> <ul style="list-style-type: none"><input type="radio"/> Judgment is good. Makes appropriate decisions.<input type="radio"/> 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.<input type="radio"/> 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.<input type="radio"/> 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.

PROMPTS:

- Where do you plan on living (where the participant has few options and cannot live alone)?
- What are you going to do when your savings account is empty?
- On a rainy day/bad weather, what would you wear for clothing if going outdoors?
- Tell me about some of the good decisions you have made?
- Who would you turn to for help?

4. **Hallucinations** – Check the option from the list provided that best describes the participant’s current visual, auditory, tactile, olfactory, or gustatory perceptions that have no basis in reality.

Hallucinations are perceptual distortions that people sometimes experience. Loss of sleep, too much caffeine, abuse of drugs, and even alcohol, head injury, and other causes can lead to hallucinations. People with mental retardation or schizophrenia sometimes report hallucinations. This item assesses if the participant has hallucinations which impair his/her ability to function. Auditory and visual hallucinations are most distracting to people compared to other types of distorted perceptions. If the participant experiences hallucinations, does this cause him/her significant problems in communicating with others, trusting others, making rational day-to-day decisions, concentrating, etc.?

DESCRIPTIONS:

<p>4) Hallucinations: <i>Visual, auditory, tactile, olfactory, or gustatory perceptions that have no basis in reality.</i></p> <ul style="list-style-type: none"><input type="radio"/> No history of hallucinations.<input type="radio"/> 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.<input type="radio"/> Current or history of frequent hallucinations which interfere with functioning and may require medication and routine monitoring by behavioral health professional. May have behavior management plan in place.<input type="radio"/> Presently has hallucination(s) which significantly impair ability for self-care, may or may not be taking medication. May have behavior management plan in place.
--

PROMPTS:

- Most often the best approach during an assessment is to be direct and ask, "Do you hear voices that others do not hear, or experience things others do not experience?"
- Have you heard any sounds or people talking to you or about you when there is nobody around?
- Have you seen any visions or smelled any smells that others don't seem to notice?
- Have these experiences interfered with your ability to perform your usual activities or work?

5. **Delusions** – Check the option from the list provided that best describes the participant’s current beliefs that are not based on fact, such as having special powers, being persecuted, or being spied upon.

Delusions are false beliefs not based on reality. Sometimes people experience delusions of jealousy, persecution, or grandiosity, where they think they have special abilities others do not have. Sometimes there is a fine line between what is a delusion and an exaggerated opinion. Therefore, delusional thinking is not an all-or-nothing phenomenon, but can be viewed as a continuum. This item assesses if delusional thinking is obvious and if these delusional beliefs impair functioning so that more care and/or supervision is needed. Often by just talking with a participant, the nurse reviewer can recognize delusional beliefs without direct questioning. It is often difficult to assess delusional thinking in people with impaired language skills, and caution should be used.

DESCRIPTIONS:

<p>5) Delusions: <i>Beliefs not based on fact, such as having special powers, being persecuted, being spied upon.</i></p> <ul style="list-style-type: none"><input type="radio"/> No history of delusions.<input type="radio"/> 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.<input type="radio"/> 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.<input type="radio"/> 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.

PROMPTS:

- Have things or events had special meanings for you?
- Did you see any references to yourself on TV or in the newspapers?
- Do you feel someone is inserting thoughts into your head that are not your own?
- Have you felt that you were under the control of another person or force?
- Do you get along with other people pretty well?
- Do you have special abilities or powers that others do not have?
- Is anyone out to get you or harm you?
- Do you ever hear things that other people don’t hear or see things that other people don’t see?
- Do you feel that someone is watching you or trying to hurt you?

6. **Anxiety** – Check the option from the list that best describes the participant’s level of excessive worry, apprehension, fear, nervousness, or agitation.

Anxiety can be very discomforting and debilitating. We all have different levels of anxiety at different times, but here the focus is on anxiety that impairs a participant’s functioning. Intense anxiety is experienced as worry, apprehension, fear, nervousness, or agitation. If a

participant experiences panic attacks, he/she may have shortness of breath, palpitations, chest pain, choking or smothering sensations, fear of going crazy, impending doom, etc. Sometimes people experience agoraphobia, where they have intense anxiety and avoid places and situations. They may have a specific anxiety about a specific object or situation, like spiders, or riding in a bus, or anxiety about social situations and, consequently, avoid these situations to their own detriment.

DESCRIPTIONS:

<p>6) Anxiety: <i>Indicated by excessive worry, apprehension, fear, nervousness, or agitation.</i></p> <ul style="list-style-type: none"><input type="radio"/> No history of anxiety.<input type="radio"/> 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.<input type="radio"/> Current or history of frequent anxiety which interferes with functioning and may require medication and routine monitoring by behavioral health professional. May have behavior management plan in place.<input type="radio"/> 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.
--

PROMPTS:

- Have you felt worried or anxious?
- Is there anything that bothers you so much that you try to avoid it?
- Do you have chest pains? Are there times when your heart races? (may be the physical manifestation of anxiety)
- Do you worry enough that you find it difficult to make a meal or eat?
- Do you have trouble sleeping due to excessive worry?
- Do unpleasant thoughts constantly go round and round in your mind?

7. **Depression** – Check the option from the list provided that best describes the participant’s feelings of hopelessness/despair, sleep disturbance, appetite impairment, change in energy level, lack of motivation, or thoughts of death.

Depression can significantly impair a participant’s quality of life and ability to function. Most people feel blue or depressed at times. The focus here is the severity and persistence of the depression and how it impairs a participant’s ability to function. The American Psychiatric Association has published criteria that are helpful in assessing the presence of depression (from the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition):

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% body weight in a month) or decrease or increase in appetite nearly every day.

- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

The NR should not arrive at a formal diagnosis of the participant, but assess if some of these symptoms are present and if they impair the participant's ability to function.

DESCRIPTIONS:

<p>7) Depression: <i>Indicated by feelings of hopelessness / despair, sleep disturbance, appetite impairment, change in energy level, lack of motivation, thoughts of death.</i></p> <ul style="list-style-type: none"> <input type="radio"/> No history of depression. <input type="radio"/> 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. <input type="radio"/> 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. <input type="radio"/> 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.
--

PROMPTS:

- Have you felt unhappy, sad, down or depressed? How often? How much of the time?
- Are you able to switch your attention to more pleasant topics when you want to?
- Have your interests in work, hobbies, social or recreational activities changed?
- Has it interfered with your ability to perform your usual activities or work?
- Are there some days you don't get out of bed? If so, what are the circumstances?
- Do you enjoy being alone?
- Did any special events happen this week for you?
- Do you have friends or loved ones who visit you often? How often? Who?
- What do you do for fun? Entertainment? Crafts?
- Do you belong to or attend any special gatherings (e.g., church, bridge club, bingo, or meal sites)?

8. Wandering – Check the option from the list provided that best describes the participant's propensity to move about aimlessly and wander without purpose or regard to safety.

Wandering refers to a participant's not using good judgment and moving about without purpose or concern for his/her safety. In extreme cases, the participant may be disoriented, experiencing delirium and mental confusion. The participant may forget where he/she was going, or have an unreasonable idea of where he/she wants to go. The participant may get in harm's way by exposing himself/herself to severe weather, to people who would take advantage, or to dangerous situations. A participant who wanders, and potentially places himself/herself in danger, most likely would need a more intense level of supervision.

DESCRIPTIONS:

<p>8) WANDERING <i>Moving about aimlessly; wandering without purpose or regard to safety.</i></p> <ul style="list-style-type: none"><input type="radio"/> No history of wandering.<input type="radio"/> 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.<input type="radio"/> 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.<input type="radio"/> 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.
--

PROMPTS:

- Do you go outside alone?
- Have you ever gotten lost? If so, what did you do?
- Has there been a past history of elopement or exit seeking?
- Does the participant ever wander into other's rooms?

9. **Disruptive/Socially Inappropriate** – Check the option from the list provided that best describes the participant's level of inappropriate behavior such as making excessive demands for attention, taking another person's property, being verbally abusive, disrobing in front of others, and displaying inappropriate sexual behavior.

Again, because of poor judgment, mental illness, or a character disorder, a participant may interact socially with others in an inappropriate fashion and stimulate fear, apprehension, hostility, and even retaliation. Examples include stealing, fighting, threatening gestures, and sexual misbehavior, such as masturbating or exhibiting oneself in public. A participant with these behaviors would need a fairly high level of supervision to caution, redirect, or manage his/her behavior. These maladaptive behaviors are displayed by participants in community settings as well as in nursing home and other residential care facilities and, in either case, would need supervision. Records and observations from others are usually quite important in assessing the degree to which socially disruptive behavior is present.

DESCRIPTIONS:

9) DISRUPTIVE/SOCIALLY INAPPROPRIATE BEHAVIOR: *Inappropriate behavior such as making excessive demands for attention, taking another's possessions, being verbally abusive, disrobing in front of others, and displaying inappropriate sexual behavior.*

- No history of disruptive, aggressive, or socially inappropriate behavior.
- 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.
- 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.
- 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.

PROMPTS:

- Have you done anything that has attracted the attention of others?
- Have you done anything that could have gotten you into trouble with the police?
- Have you done anything that seemed unusual or disturbing to others?
- Do you ever raise your voice to others in anger?
- Does the participant use inappropriate language in a group setting?

10. Assaultive/Destructive – Check the option from the list provided that best describes the participant's level of assaultive or combative behavior toward others.

Participants sometimes display assaultive/destructive behaviors toward others for various reasons. Sometimes they may become assaultive toward others or destructive of property because of organic disorders related to head trauma, epilepsy, mental illness, etc., and, therefore, may require intense supervision. Obviously, these participants would pose a threat in the community or in a residential care facility and would require a high level of supervision. Sometimes, these participants require a behavior management program that is designed and supervised by a mental health professional. If residential treatment is required, it can be very difficult finding appropriate settings with the required structure to serve the needs of these participants and maintain safety. Again, records and observations of others are quite important in assessing the degree to which assaultive/destructive behaviors are present.

DESCRIPTIONS:

10) ASSAULTIVE/DESTRUCTIVE BEHAVIOR: Assaultive or combative to others (throws objects, strikes or punches, bites, scratches, kicks, makes dangerous maneuvers with wheelchair, destroys property, sets fires, etc.).

- No history of combative or destructive behaviors.
- 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.
- Current or history of frequent combative or destructive behaviors, and may require professional consultation or staff training. May have behavior management plan in place.
- 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.

PROMPTS:

- Have you ever hit or struck another person?
- Do you ever throw or break items on purpose?
- Do you destroy property or set fires intentionally?
- Have you ever been arrested for assault?

11. Danger to Self – Check the option from the list provided that best describes the participant’s level of neglect, or propensity toward behaviors such as head banging, suicidal thoughts, self-mutilation, etc.

Sometimes participants have specific disorders that contribute to self-destructive behaviors. These behaviors can include self-neglect, suicidal thoughts and actions, and mutilation. For example, a participant may be depressed or have a borderline personality disorder that contributes to impulsive and self-destructive behaviors, or be mentally confused. It is important that the participant be assessed by a mental health professional and that a professionally supervised intervention is implemented. Again, records, observations of others, and information about successful interventions are all important in assessing the degree to which these behaviors are present and the degree to which the participant’s level of functioning is impaired. The purpose of the UAI assessment is to determine the level of help and supervision necessary for this participant and to determine if the participant has been referred to the proper mental health professionals. The level of supervision for these individuals can be quite intense depending upon the severity and persistence of self-destructive behaviors.

Note: Identifying that the participant displays self-injurious behavior and requires constant supervision requires a referral for a specialized assessment and/or assistance.

DESCRIPTIONS:

11) DANGER TO SELF: *Indicated by self-neglect, head banging, suicidal thoughts, self-mutilation, suicide attempts, etc.*

- No history of self-injurious behavior.
- 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.
- 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.
- 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.

PROMPTS:

- Does the participant refuse to eat (may include Alzheimer's, dementia, or psychotic participants)?
- Does the participant refuse to take medications?
- Does the participant currently have suicidal thoughts and do they have a plan?
- Have they ever attempted suicide? If so, how, when, and how many times? Most recent?
- Have they ever felt like hurting or cutting their body?

Remember: The participant still has the right to make choices (i.e., participant makes the decision to snack all day rather than eating balanced meals or chooses to live in a filthy environment). These issues should be addressed under the Question #3, "Judgment" section.

12. Alcohol/Drug Abuse – Check the option from the list provided that best describes the participant's level of psychoactive substance use and the extent it interferes with functioning.

It is apparent that alcohol and or drug abuse can significantly interfere with a participant's ability to function in families, at work, and in the community. The purpose of this item is not so that the UAI administrator can arrive at a specific diagnosis of alcohol or drug abuse, but to again assess the degree to which alcohol and/or drug abuse impairs the participant's ability to function. This item also requires the UAI interviewer to inquire not only about alcohol-related problems, but also other drugs, such as marijuana, cocaine, amphetamines, and over-the-counter products that may be contributing to the participant's inability to function well. Besides asking questions about usage of drugs, review of records can be helpful to understand the degree of abuse/dependence and subsequent problems in living.

DESCRIPTIONS:

12) ALCOHOL/DRUG ABUSE: *Psychoactive substance use to the extent that it interferes with functioning.*

- No history of alcohol or drug abuse.
- 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.
- 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.
- 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.

PROMPTS:

- How much do you currently drink or use drugs? When was the last time?
- Do you ever use alcohol or drugs while in the facility?
- Are you currently attending any kind of treatment program?
- Has alcohol or drug use ever caused you legal problems?

13. Self Preservation/Victimization – Check the option from the list provided that best describes the participant’s ability to avoid situations where he or she might be taken advantage of and his or her ability to protect personal property.

The purpose of this section is not to identify any neglect, abuse, or victimization that may be occurring, although the UAI nurse reviewer needs to report any identified abuse/victimization to authorities, but to identify if a participant has the capacity and judgment to make decisions on his/her own behalf to protect himself/herself from abuse, neglect, and exploitation.

For example, perhaps the participant does not have the proper judgment and displays inappropriate gullibility toward others so that people may take advantage of him/her financially or sexually. This vulnerability to victimization/exploitation may lead to the participant’s safety being jeopardized. A participant with this vulnerability would need supervision, whether in the community or in a residential setting.

Records or observations of friends or family members are very helpful in evaluating this potential. Direct questions such as, “Have you been abused by anyone in your life?”, may be helpful. However, frequently people will not share this information because of embarrassment, and collateral information is always helpful.

The definitions for the terms are:

- **Abuse** - The non-accidental infliction of physical pain, injury, or mental injury.
- **Neglect** - Failure of a caretaker to provide food, clothing, shelter, or medical care reasonably necessary to sustain the life and health of a vulnerable adult, or the failure of a vulnerable adult to provide these services for him/herself.

- **Exploitation** - An action which may include, but is not limited to, the misuse of a vulnerable adult’s funds, property, or resources by another person for profit or advantage.
- **Vulnerable Adult** - A person, 18 years of age or older, who is unable to protect him/herself from abuse, neglect, or exploitation due to physical or mental impairment which affects the person’s judgment or behavior to the extent that he/she lacks sufficient understanding or capacity to make or communicate or implement decisions regarding his/her person.

IMPORTANT: IF ABUSE IS SUSPECTED, REPORT IT!

DESCRIPTIONS:

<p>13) SELF PRESERVATION/VICTIMIZATION: <i>Ability to avoid situations in which person may be easily taken advantage of, and to protect him/herself and his/her property from others.</i></p> <ul style="list-style-type: none"> <input type="radio"/> 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. <input type="radio"/> 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. <input type="radio"/> 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. <input type="radio"/> 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.
--

PROMPTS:

- Have you ever bought things over the phone from telemarketers?
- Do you open your door to strangers?
- Do your family members or caregivers ask to borrow money from you?
- Has anyone ever taken advantage of you?
- Do you know your neighbors?
- Have you ever been abused or touched inappropriately? Do you know who to contact if this should happen?
- Have you had others steal things from you?

Other assessments needed –

Choose “Yes” or “No” from the drop down menu provided to indicate if other assessments are needed for the participant.

- If you select “Yes”, enter the type of assessments needed in the large text box provided.

Referral for an assessment –

Choose “Yes” or “No” from the drop down menu provided to indicate if any other assessment has been made.

- If you select “Yes”, enter the name of the person or agency the participant was referred to and the reason for the referral in the text boxes provided.
- The “Date Referred” text box will auto populate with the current date.

Important: After you have completed the Section 4 questions, go back to Section 2 and answer question #18 (and any other remaining, relevant questions in Section 2).

Disposition

Enter the assessor's last name, first name, and middle initial EXACTLY as it appears in the system of record in the text boxes provided.

Note: no other information is required to complete this screen.

Support Plan

The Support Plan is the result of the assessment that is located within the UAI. To view the Support Plan you must access the record through "Edit Assessment" on the first page of the UAI. When the record shows on the toolbar you may click "Support Plan" and the first page of the support plan will appear.

Note: There may be functions within the UAI Support Plan that are not mentioned in this document. Users should only use the functions outlined in this manual.

Part One

Support Plan as of 4/15/2014
Wilson, Nicole
Transmit to RMS Unlock RMS Record Region 2 GetRegion

Part 1 Part 2 Part 3 Part 4 Loc Authorization Log

Living Arrangement: Home Congregate Certified Family Home
 Attendant Type: PCS Both A&D
 Responsible For Rent or Mortgage: Yes No

UAI Item	Unmet Needs	Min Units	Mitplr	Units/ Month	Adjusted Units/Month	Hours/ Month	Rate/ Hr	Code	Total
1-Meal Preparation	0	48.64	0	0.00	5	1.15	14.16	S5130-U2	16.28
2-Eating	0	24.32	0	0.00	0	0.0	15.72	S5125-U2	0.00
3-Toileting	0	24.32	0	0.00	0	0.0	15.72	S5125-U2	0.00
4-Mobility	0	12.16	0	0.00	0	0.0	15.72	S5125-U2	0.00
5-Transferring	0	12.16	0	0.00	0	0.0	15.72	S5125-U2	0.00
6-Hygiene	0	14.56	0	0.00	0	0.0	15.72	S5125-U2	0.00
7-Dressing	0	12.16	0	0.00	0	0.0	15.72	S5125-U2	0.00
8-Bathing	0	9.76	0	0.00	0	0.0	15.72	S5125-U2	0.00
11-Shopping	0	4.8	0	0.00	0	0.0	14.16	S5130-U2	0.00
12-Laundry	0	4.8	0	0.00	0	0.0	14.16	S5130-U2	0.00
13-Housework	0	12.16	0	0.00	0	0.0	14.16	S5130-U2	0.00
15-Night Needs	0	120	0	0.00	0	0.0	15.72	S5125-U2	0.00
17-Medication	0	4.8	0	0.00	0	0.0	15.72	S5125-U2	0.00
18-Supervision	0	120	0	0.00	0	0.0	15.72	S5125-U2	0.00
UAI Item Subtotal									16.28

Authorize: Weekly Monthly
 Services: Monthly

Weekly Hours: 0.27 Hours Per Month: 1.15
 Weekly Units: 1.08 Units Per Month: 4.60

Additional Comments for: 1- Meal Preparation

Living Arrangement -

Choose "Home", "Congregate", or "Certified Family Home" from the check boxes provided to indicate the participant's living arrangement.

Note: The living arrangement for residential assisted living facility participants is congregated.

Attendant Type -

- Choose either "PCS" or "A&D" from the check boxes provided to indicate the participant's attendant type.

Note: Make sure the living arrangement and attendant type matches the services being authorized.

Responsible for Rent or Mortgage -

- Select “Yes” from the drop down menu provided.
Note: the NR will always select “Yes” for all living arrangements (Home, Congregate, and CFH).
 - Shaded fields are populated based on the unmet needs entered into Part 2, based on the attendant type and living arrangement. The “Adjusted Units/Month” column (white fields), can be adjusted based on the participant’s assessed need.

Adjusted Units/Month Fields -

The units per month may be adjusted to reflect increased care needs required by the participant. This should be supported in the documentation kept by the provider. If documentation is absent or lacking, the provider should be encouraged to submit a Significant Change request once those needs have been appropriately established. Increased units are the **exception** and should only be used for participants with extraordinary needs; however, adjusted units **may** occur in any care setting (i.e., in-home, CFH, or RALF). Any adjusted units of 100 or greater must be reviewed and approved by the Nurse Manager and a “UAI Unit Adjustment Review Form V1.1” must be completed.

EXAMPLE: The NR determines that a participant requires more time to complete bathing than the UAI allots due to weakness and shortness of breath. Determine how many additional units are to be added to appropriately meet the participant’s needs – taking into consideration the units in the tool.

Methodology for Calculating Additional Units

The following methodology should be used when the functional or physical needs (e.g., mobility, incontinence, ostomy) requires more time to complete the task or is needed more frequently than the UAI assessment allocation.

Note: This methodology is not used for non-medical reasons such as the participant liking to take long showers or preferring the caregiver make the meals.

- When conducting the assessment, the NR will ask the participant the actual amount of time needed to complete the task and how many times a week the task is done.
- Take the amount of time in units per week X 4 = weekly units.
- Take the weekly units X 4.33 = monthly units.
- Using the “Units/Month” column from the table (column 4), find the corresponding units the UAI has allocated for each need. Subtract those from the total monthly units you have determined the participant actually needs. The resulting amount is the units that need to be entered into the “Adjusted Units/Month” column.
- If you add or change information in the “Adjust Units/Month” column, the name of the item will be highlighted in column one. When the item highlights, enter a note in the “Additional Comments” box at the bottom of the screen explaining how you determined the amount needed and how they should be used.

Note: The additional units being added need to be identified in Part 2 of the Support Plan. If the participant requires a caregiver to accompany them into the community due to physical or cognitive deficits and the support is unable to do so, the NR may authorize additional units under the area of need (e.g., mobility).

Part Two

Supplies	Number/ Month	Rate/ Month	Total/ Month
Catheter	0	0	0
Attends	0	0	0
Oxygen Supplies	0	0	0
Chux	0	0	0
Medical Supplies	0	0	0
Other (specify)	0	0	0
Supplies Subtotal			0

Equipment	Number/ Month	Rate/ Month	Total/ Month
Wheelchair	0	0	0
Walker	0	0	0
Hospital Bed	0	0	0
Oxygen Equipment	0	0	0
Hoyer Lift	0	0	0
Commode	0	0	0
Other (specify)	0	0	0
Equipment Subtotal			0

Services	Number/ Month	Rate/ Month	Total/ Month
Registered Nurse	0	0	0
QMRP	0	0	0
Speech Therapy	0	0	0
Physical Therapy	0	0	0
Occupation Therapy	0	0	0
DDC Service	0	0	0
Mental Health Serv.	0	0	0
Medical Transportation	0	0	0
Home Health	0	0	0
Case Management	0	0	0
Hospice	0	0	0
Other (specify)	0	0	0
Services Subtotal			0

Supplies	Equipment	Services	Total
0	+	0	+
0	+	0	=
0			0

Additional Comments for: Attends

Part 2 information is obtained from costs that have been paid by Medicaid for the participant. For initial UAIs, no information will be available and this will remain blank. For redetermination, the NR will obtain a Cognos report which contains costing information for a specific Medicaid participant. “Over cost” reports are obtained quarterly by QA specialist in Central Office and then communicated to the Program Managers in each hub. Please do one of the following:

- If you checked “PCS” for the “Attendant Type” in Part 1, skip this section and proceed to Part 3.
- If you checked “A&D” for the “Attendant Type” in Part 1:

Do Not enter amounts from the Department costing report in the “Number/Month” and “Rate/Month” columns of the table provided. The Cognos report is the record of cost effectiveness.

Part Three

Support Plan Part 3 enters values for services. Services must be entered correctly in order to transfer the services to the Authorization Log accurately. Information entered into Part 3 populates into Support Plan Part 4.

Enhancement	Reported Amount	Service Months	Code	Total
Assistive Technology	0	0	E1399-U2	0
Home Modification	0	0	S5165-U2	0

Transportation	Miles	Rate/ Mile	Code	Total	<input type="checkbox"/> Add to Daily Rate
Asst Transportation	0		A0080-U2	0.00	<input type="checkbox"/>

PERS	Rate	Code	Total	<input type="checkbox"/> Add to Daily Rate	<input type="checkbox"/> Zero out PERS
PERS Installation	4440.00	0.00	4,440.00	<input type="checkbox"/>	<input type="checkbox"/>
PERS (rent/mo)	33.83	S5161-U2	33.83	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Other Service	Hours/ Day	Allowed Hour/Day	Days/ Month	Hours/ Month	Rate/ Hour	Code	Service Months	Total
Adult Day Care	0	14	0	0.0	6	S5100-U2		0.00
In-Home Respite	2	5	0	0.0	10.56	T1005-U2		0.00
Home Companion	0	24	31	0.0	11.24	S5135-U2		0.00
Home Delivered Meals	0	3	0	0.0	5.23	S5170-U2		0.00
Chore Service	0	0	0	0.0	10.56	S5120-U2	0	0.00
Consultation	0	0	0	0.0	20.52	S5115-U2	0	0.00
Behavior Consultation	0	0	0	0.0	40.08	90899-U2	0	0.00
Other Service Type Subtotal								0.00

Licensed Nurse Visit			
Nurse Type	None		
Billing	None		
Code	0		
Hrs / Visit per Month	0		
Rate per Hour	0		
Total	0		
<input type="checkbox"/> Add to Daily Rate			

Enhancements –

- Enter the total cost for the equipment or modification in the “Reported Amount” column of the table provided.
- Enter the number of months the nurse reviewer wants the item to be amortized – usually 12 months to maximum of 5 years – in the “Service Months” column of the table provided.

Note: Environmental accessibility adaptation is entered as “Home Modification”. Please refer to “Environmental Accessibility Adaptation Chapter”, “Environmental Accessibility Adaptation Bid Forms”, “A&D Waiver Service List Help Aid V1.0”, and “Assistive Technology Medical Equipment and Supplies Help Aid V1.0”.

Transportation –

Note: This is ONLY available for A&D Waiver participants.

- Enter the amount of miles per month (up to 150 miles, with a total of 1,800 miles per year limit) in the “Miles” column of the table provided.

Note: A participant may also be authorized a monthly bus pass under code A0110 (use “BLTC Adult Communication Form” to manually PA this service). The manual price is the amount the transit authority charges for the bus pass. All non-medical transportation services are prior authorized specifically to the non-medical transportation provider.

Non-Medical Transportation UAI Documentation

- If the UAI indicates the participant requires assistance or supervision during essential errands (e.g., grocery store, bank, library) and no unpaid support person is available, shopping units are utilized to meet this need.
- The NR documents these errands and what problem/need exists for the participant to make it necessary that they be accompanied in the community in the UAI Section 2, Question #11, “Comment” box.
- Authorize non-medical transportation mileage and document the number of miles in the UAI Section 2, Question #9, “Comment” box.

PERS (Personal Emergency Response System)

Note: This is NOT available for PCS, RALF, or CFH participants.

- The PERS provider is authorized the Medicaid allowable rate for the first month’s rental fee and installation. Ongoing authorization for rent begins the day after the last date of installation.

EXAMPLE:

Participant is approved for PERS September 15th. PA authorization for installation (\$5160) will span September 15 thru October 14. The first month and ongoing monthly rent (\$5161) will begin October 15th and continue through September 13th of the next year.

- For those providers that do not provide installation (i.e., they mail the unit to the participant with instructions to install), begin authorization for rental on month one, regardless of the date within the month.
- For in-home participants not receiving PERS, the NR will check the “Zero out PERS” box.

Other Services

Note: You will only be able to enter information into this table if you selected “A&D” as the “Attendant Type” in Part 1 of the Support Plan.

- In the “Hours/Day” column of the table provided, enter the number of actual hours/amounts for each of the services listed.

Note: Services are entered per limitations and eligibility guidelines. Pre-set limits and coding in the gray areas cannot be altered.

The following are descriptions/clarifications for each category listed in the table provided:

- Adult Day Health (called Adult Day Care in the UAI)
 - 12 hours for in-home participants.
 - Participants residing in a CFH may only receive Adult Day Health care services if there is an assessment of unmet socialization needs that cannot be provided by the CFH provider.
- In-Home Respite
 - Short-term breaks only for non-paid caregivers.

- Home Companion
 - Companion care is not available in a RALF or CFH.
- Home Delivered Meals
 - 1-2 meals per day.
- Chore Services
 - Enter the expected number of service hours per visit and the days per month.

Note: When you enter an amount, the name of the item will be highlighted in column one of the table. When the item highlights, enter a note in the “Additional Comments” box at the bottom of the screen explaining hours/day and hours/month. The software automatically provides the subtotal for each section and the total of all sections at the end.

Licensed Nurse Visit

- Choose “RN”, “A&D Nurse”, “PCS – RN”, “RN”, or “LPN” from the drop down menu provided.

The following are descriptions/clarifications for each option provided in the drop down menu:

- A&D In-Home (Procedure Code T1001 for Plan Development) - all A&D and PCS in-home participants are required to have a care plan developed initially and at annual redetermination. Authorization guidelines are as follows:
 - Select “A&D Nurse” from the “Nurse Type” drop down menu provided.
 - T1001 Plan Development is authorized as 2 units for initials and 1 unit for redeterminations (1 unit = 1 visit).
 - For initials the authorization start date is the day the Choice form is received and the stop date is 1 month minus 1 day.
 - For redeterminations where units **do not** change, the authorization start date is the day after the previous year’s units expire and the stop date is 1 month minus 1 day.
 - For redeterminations where units **decrease**, the authorization start date is 10 days from the redeterminations UAI date and stop date is 1 month minus 1 day.
 - For redeterminations where units **increase**, the authorization start date is the date of the UAI and stop date is 1 month minus 1 day.
- PCS In-Home (Procedure Code G9002 for Plan Development)
 - G9002 Plan Development is authorized as 10 units for initials and 5 units for redeterminations (1 unit = 15 min).
 - Start and stop dates are the same as those for the A&D Waiver listed above.
- A&D CFH
 - Do not fill out the Licensed Nurse Visit section unless “Additional Nursing Visit” criteria are met.
- Additional Supervisory RN Visits (T1001) In-Home, RALF, CFH
 - The nurse reviewer must complete the “BLTC Adult Communication Form” authorizing

a manual PA for 4 visits (T1001) a year or 1 visit per month (T1001).

- Additional supervisory visits are authorized separately to the provider. Complete the “BLTC Adult Communication Form” authorizing a manual PA for the number of visits (T1001). The frequency of the visits should be based on the participant’s needs on a case-by-case basis.
- A supervisory RN visit may be authorized for individuals if a need is identified. The frequency of the visits should be based on the participant’s needs on a case-by-case basis. (The exemption to this is in residential assisted living where a supervisory RN visit of one monthly is routinely authorized.) Supervisory RN visits are not a quality assurance tool. This job aid provides additional clarification and parameters to ensure statewide consistency when supervisory RN visits are authorized.
- Assess and authorize supervisory RN visits based on the following criteria:
 - A participant has an unstable medical condition that is likely to require routine changes in the service plan. Examples of unstable medical conditions include frequent emergency room visits; frequent unscheduled medical appointments; and frequent changes of antipsychotic, anti-anxiety, hypnotic, diuretic, or diabetic medications.
- The delegated task that the caregiver is providing has been identified on the Idaho Training Matrix, Standards for Direct Care Staff & Allowable Tasks, Participant Specific Endorsements are new or the participant is at high risk for complications.
- No PCS RN Supervisory Visit (T1001) will be authorized if the provider uses an LPN to fill medication boxes for participants. The provider is required to have a licensed professional nurse (RN) on staff whose administrative function is to provide oversight to the LPN.

Part Four

Note: This section is NOT required for PCS participants.

Client Contribution Calculation	
PNA-Personal Needs Allowance	1082.00
Allowable Deductions	0
Subtotal	1082.00
Available Client SSI Income	0
Available Client non-SSI Income	0
Client Contribution Amount	0
Contribute?	No

Cost-Effectiveness Calculations	
Monthly Waiver Service Costs	51.53
Supplies, Equipment, Therapies	0.00
Client Contribution	0.00
Monthly Medicaid Program Cost Total	51.53
Average Cost of Medicaid Institutional Care	6163.63
Available Client non-SSI Income <small>40.00 Subtracted For NF, PNA</small>	0
Monthly Medicaid Institutional Costs	6163.63
Cost Effectiveness Comparison	6112.10
Cost Effectiveness for A&D Waiver	Yes
Adult Residential & Assisted Living Daily Rate	0.00
Rate Cost Effective?	N/A

Expected Plan Outcomes	

0	Days/Week out of the Facility Adjustment	0.00
	RALF/CFH Adjusted Daily Rate	0.00
	Rate Cost Effective?	N/A

Client Contribution Calculation

Do not enter information into this area.

Cost Effectiveness Calculations

To determine if the participant is cost effective please refer to the Cognos report. For initial UAI's there is no information available.

- If the participant requires a special rate (e.g., ventilator or tracheostomy care), the NR must:
 - Complete the “Increased Nursing Facility Cost Limit Form”.
 - Submit to BLTC Central Office to request a new cap amount.
- If the participant is over cost and is not receiving hospice or does not meet criteria for special rates, review all services.
- If duplicative services or areas that are questionable need are identified the NR will work with the participant and the family to adjust the amount of services.

Nursing Facility Level of Care & RALF/CFH Level (LOC)

Part 1
Part 2
Part 3
Part 4
Loc
Authorization Log

Nursing Facility Level Of Care & RALF/CFH Level

UAI Item	Asst Reqd Score	NF Loc Score	UAI Item	Asst Reqd Score	NF Loc Score
1- Meal Preparation	N	0	11- Shopping	N	N/A
2- Eating	N	0	12- Laundry	N	N/A
3- Toileting	N	0	13- Housework	N	N/A
4- Mobility	N	0	14- Wood /Coal	N	N/A
5- Transferring	N	0	15- Night Needs	N	N/A
6- Hygiene	N	0	16- Emergency Resp.	N	N/A
7- Dressing	N	0	17 (a) Medications (Routine)	N	0
8- Bathing	N	0	17 (b) Medication (Decision Required)	0	0
9- Access to Transport	N	N/A	18- Supervision	N	0
10- Finances	N	N/A			

NF Final LOC

Score	Loc Met:	Cost Effective:
0	No	Yes

RALF/CFH

Level	Hours	Daily Rate	Cost Effective:
No Level	0	0.00	Yes
<input checked="" type="checkbox"/> Override Level		Level 4	12.50

Assistance Required Score -

For each of the numbered items in the first column of the table provided, the level of care (LOC) is determined by the assistance required scores entered into Section 2 of the UAI. The “Asst Reqd Score” columns are transferred automatically to the Part 1 and the LOC sections of the Support Plan.

Adjusted Medication (#17 in the table provided) – Decision Required -

- If the participant meets the IDAPA medication critical indicator, 12 points for Extensive or Total, the NR highlights the “0” Asst Reqd Score and enters either 3 (Extensive) or 4 (Total).
- If the NR overrides the 17 (a) 17(b) with a 3 or 4, the UAI score will subtract 17(a) LOC points from “NF Final LOC Score” and adds 17(b) score for a new “NF Final LOC Score.”
- The Support Plan Part 1, Question 17 – Medications, the units/hours calculated do not change when 17 (b) Medication score override is entered.

UAI Item	Asst Reqd Score	NF Loc Score
1- Meal Preparation	T	12
2- Eating	T	12
3- Toileting	T	12
4- Mobility	T	6
5- Transferring	T	6
6- Hygiene	T	6
7- Dressing	T	3
8- Bathing	T	3
9- Access to Transport	E	N/A
10- Finances	T	N/A

UAI Item	Asst Reqd Score	NF Loc Score
11- Shopping	T	N/A
12- Laundry	T	N/A
13- Housework	T	N/A
14- Wood /Coal	T	N/A
15- Night Needs	T	N/A
16- Emergency Resp.	T	N/A
17 (a) Medications (Routine)	T	6
17 (b) Medication (Decision Required)	3	12
18- Supervision	E	3

NF Final LOC Score -

- If the score is 12 or greater, the participant meets A&D Waiver nursing facility level of care and services may be authorized.
- If the A&D Waiver participant score is less than 12, the participant may be eligible for PCS services. Note: Refer to Adult PCS chapter for next steps.

PCS Levels I-IV (RALF/CFH) -

- If the RALF or CFH participant’s UAI score is less than 12 points, and participant is open Medicaid, the participant may still be eligible for state plan PCS payment Level I, II, III, IV. The participant’s income can be found in IBES in the EDBC information area.

Note: Ignore the “Daily Rate” amount listed; this rate does not relate to reimbursement for PCS participants.

Reimbursement Level I

NF Final LOC

Score	Loc Met:	Cost Effective:
0	No	Yes

RALF/CFH

Level	Hours	Daily Rate	Cost Effective:
Level 1	8.75	29.01	Yes
<input type="checkbox"/> Override Level			
		Level 4	12.50

Reimbursement Level II

NF Final LOC

Score	Loc Met:	Cost Effective:
6	No	Yes

RALF/CFH

Level	Hours	Daily Rate	Cost Effective:
Level 2	10.50	29.30	Yes
<input type="checkbox"/> Override Level			
		Level 4	12.50

Reimbursement Level III

NF Final LOC

Score	Loc Met:	Cost Effective:
9	No	Yes

RALF/CFH

Level	Hours	Daily Rate	Cost Effective:
Level 3	15.75	44.38	Yes
<input type="checkbox"/> Override Level			
		Level 4	12.50

- If the RALF/CFH Level field shows as Level III AND the participant meets the Level IV criteria in the PCS Level I-IV Job Aid, (diagnosis of Mental Illness, Intellectual disability or Alzheimer's disease) leave the field as III. The reimbursement for a Level III is higher than a Level IV.

Reimbursement Level IV

- If the RALF/CFH Level field shows as Level I or II AND the participant meets the Level IV criteria in the PCS Level I-IV Job Aid; (diagnosis of mental Illness, Intellectual disability or Alzheimer's disease) check the override level box for Level IV.

Note: The NR must check the "Override Level" box to ensure the correct units are transferred to the Authorization Log and correctly print on the Summary Page.

Note: Ignore the "Cost Effective" box for PCS participants.

Authorization Log

Authorization Log												
Services	Proc Code	Freq	Hours	Qty Units	Dollar Amount	Provider	Date		PA Number	Item Detail	Clerk Date	Transfer PA
							Start	Stop				
Total PCS Units	T1019	MO	.	106.96								<input type="checkbox"/>
Total ATT Care Units												<input type="checkbox"/>
Homemaker Services	S5130	MO	1.25	5.00								<input type="checkbox"/>
Consultation	S5115-U2		0.0	.00								<input type="checkbox"/>
Home Delivered Meals	S5170-U2	MO		0.0								<input type="checkbox"/>
A & D Licensed Nurse Visit												<input type="checkbox"/>
Hourly RN / LPN												<input type="checkbox"/>
PCS Sup RN Visit												<input type="checkbox"/>
PCS Assmt - Agency	G9002											<input type="checkbox"/>
PERS (Install)	0.00				4440.00							<input type="checkbox"/>
PERS (Rent / MO)	S5161-U2	MO		1	33.83							<input type="checkbox"/>
CFH / Residential Care	S5140				0.00							<input type="checkbox"/>
CO-Pay		MO			0							<input type="checkbox"/>
Case Mgmt Assmt												<input type="checkbox"/>
Case Mgmt Units												<input type="checkbox"/>
Chore	S5120-U2	MO	.									<input type="checkbox"/>
Adult Day Care	S5100-U2	MO	.									<input type="checkbox"/>
Behavioral / Psych Cons	90899-U2	MO	.									<input type="checkbox"/>
In - Home Respite	T1005-U2	MO	.									<input type="checkbox"/>
Home Companion	S5135-U2	MO	.									<input type="checkbox"/>
Assistive Technology	E1399-U2				0							<input type="checkbox"/>
Home Modification	S5165-U2				0							<input type="checkbox"/>
Assisted Trans (35/mi)	A0080-U2			0								<input type="checkbox"/>

Authorize services using a service date range. The prior authorizations generated in QNXT from this information will be monthly.

- If a participant has an identified medical condition that is expected to improve (i.e., recent surgery) services may be authorized for a short term (i.e., 3-6 months instead of yearly).
Note: A&D Waiver participants will be authorized up to 16 hours of State Plan PCS.
- Services are auto-populated and cannot be altered. The “Proc Code”, “Freq”, “Hours”, “Qty/Units”, and “Dollar Amt.” columns are auto populated from the information entered into section 3 of the Support Plan.
- Supported Employment, Residential Habilitation, and Day Habilitation are not entered in the Authorization Log. The NR must enter these services on the “BLTC Adult Communication Form” for manual authorization

A&D in-home participants

- Verify the “Nursing Services” entered in Support Plan Part 3 are correct within the Authorization Log.
- If quarterly nursing visits are required, add the detail by manually entering the frequency and units on the “BLTC Adult Communications Form”.
- For Care Plan Development (T1001) enter the visit number (2 for initials and 1 for redeterminations) provider number, and start and stop dates (1 month minus 1 day).

PCS in-home participants

- If PCS is chosen as Attendant Type in Support Plan Part 1, G9002 will auto populate on the authorization log.
- For Care Plan Development the NR enters units (8 for initials, 4 for redeterminations), provider number, start and stop date (1 month minus 1 day).

Transportation -

- No mileage cost is entered into the Dollar Amount column.

Provider Region & Get Region -

- The region box defaults to Region 2. If your participant is not located in Region 2, select the region where the participant resides
- On the Authorization Log screen, select the 'Get Region' search icon. For the region selected, all providers will populate in the Authorization Log provider drop-down box. The correct region will need to be selected each time the support plan is opened.
- Note: The region can be updated from any tab of the support plan, not just the Authorization Log. If the region is not updated, the NR will not find the correct providers in the provider drop-down box.
- If the correct provider is not in the drop-down list, select 'All' in the region list, click Get Region to search for the provider
- Click on drop down arrow to open provider list. Enter the provider number or the Provider Name and select from the drop down table. Click on the provider name/number and tab out of the box or the NR may type in the provider number and the information will be pulled up. The provider number can be copied and pasted to other Provider Fields. Be sure to TAB once you have entered the number

Note: If you do not have the provider number the providers are listed in alphabetical order and you can scroll through to find the provider.

Start and Stop Dates -

- Enter start and stop dates for all authorized services. For yearly approval periods the start date will be date service is approved to start. End date will be 1 year minus 2 days from the approval start date (3 days on leap years). I.e. 09-05-2013 – 09-03-2014.

Important: Make sure you save ALL information using the disc icon at the top of the screen.

Specialized Authorizations

Habilitation, Day Rehabilitation, Supported Employment, and Behavior Consultation

Reviewers will authorize these services to be delivered by providers with an “Additional Terms Provider Agreement for Residential Habilitation and Supported Employment”.

Process

To facilitate consistency of like services across Medicaid programs, habilitation services for A&D waiver participants will be assessed and authorized using the same methodology as the DD waiver for habilitation services. This requires that an individual on the A&D waiver who requests habilitation services have an annual SIB-R completed to determine the level of support and payment rate for a supported living daily rate (24 hour rate); supported living hourly rate (individual or group), or day habilitation. Habilitation services can be authorized in place of attendant care/homemaker services when it is identified in the UAI that the participant would benefit from habilitation (training) rather than have someone complete the services for them. Residential habilitation/day habilitation services are not available to PCS participants.

Habilitation Definition

Residential habilitation (Supported Living) is defined as an array of individually – tailored services and supports designed to assist the participant to reside as independently and successfully as possible in their own homes, with their families, or in alternate family homes. Residential habilitation can be approved as a daily rate or as an hourly rate. The hourly rate can never exceed the daily rate amount. Habilitation services include training in one or more of the following areas (IDAPA 16.03.10.326.16.a):

- Self Direction
- Money Management
- Daily Living Skills
- Socialization
- Mobility
- Behavior Management

Day rehabilitation is defined as services that consist of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that occur in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in the participant’s plan of care (i.e., mental health services).

Determination of Services

- Upon application or redetermination (annually) for habilitation services the participant must be assessed for a level of needed support through the administration of a SIB-R assessment.
- Participants who are Medicaid eligible may receive a SIB-R under the psychological evaluation benefit. The NR does not need to prior authorize the SIB-R.

The support level identified in the SIB-R is used to determine the daily rate or hourly rate as follows:

Residential Habilitation (Supported Living) - High Support

- Participant requires 24-hour supports and supervision and has a SIB-R Support Level of Pervasive, Extensive, or Frequent. High support allows for a blend of one-on-one and group staffing.
- Participant authorized for a high support daily rate will not be authorized day habilitation, adult day care, attendant care, homemaker services, chore services, respite services, PERS, home delivered meals, crisis management/behavior consultation, or non-medical transportation services. These services are included in the high support daily rate.
- Participant received a SIB-R score of:
 - 1-24 = Pervasive
 - 25-39 = Extensive
 - 40-54 = Frequent
- Prior authorize and manually enter H2022 Daily Supported Living Services High Support (1 Unit = 1 Day) into MMIS.

Residential Habilitation (Supported Living) - Intense Support

- Participant requires 24-hour supports and supervision. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed and cost effectiveness determined on a case by case basis.
- Participants authorized for an intense support daily rate will not be authorized day habilitation, adult day care, attendant care, homemaker services, chore services, respite services, PERS, home delivered meals, crisis management/behavior consultation, or non-medical transportation services. These services are included in the intense support daily rate.
- To qualify for this level of support, participants must be evaluated to meet one or more of the following criteria:
 - Recent felony convictions or charges for offenses related to serious injury or harm of another person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration.
 - History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional.
 - Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of behavior must require continuous monitoring to prevent injury to themselves or others.
- Prior authorize and manually enter H2016 Daily Supported Living Services Intense Support (1 Unit = 1 Day) into MMIS.

Residential Habilitation/Supported Living - Hourly Support

- A&D waiver participants who do not meet the above criteria may be eligible for hourly residential habilitation services. The number of hours authorized for hourly supported living must be supported by the UAI.
- The attendant care/homemaker services should be substituted with the hourly supported living codes. These codes must be prior-authorized and manually entered into MMIS.
 - H2015 Individual Supported Living (1 Unit = 15 Minutes)
 - H2015 HQ Group Supported Living (1 Unit = 15 Minutes)

Day Habilitation – Hourly

- A&D waiver participants who are identified in the UAI as needing day skill acquisition, retention, or improvement in self-help, socialization, and adaptive skills that occur in a non-residential setting, separate from the home or facility in which the participant resides are eligible for day habilitation.
- Day habilitation services must be prior-authorized and manually entered into MMIS.
 - T2021 Day Habilitation Waiver (1 unit = 15 minutes) Refer to “Personal Care Services Fee Schedule V1.2”.

Authorization of Residential Habilitation Services

Note: Habilitation services cannot be authorized via the interface.

Daily Supported Living

- Use SIB-R Support Level to determine the daily rate.
- Complete the “BLTC Communication Form” with daily rate supported by the SIB-R for manual authorization by SS.

Hourly Supported Living

- If the participant does not meet the criteria on the SIR-R for a daily rate, and the participant chooses hourly supported living instead of attendant care/homemaker services, the NR will use the “Hourly Supported Living Worksheet V1.0” to determine the number of individual and group units to authorize.
 - Enter the number of units for each UAI Item from the UAI Support Plan Part 1 in Column A.
 - For UAI items that are ADL (Activities of Daily Living) needs or IADLs (Instrumental Activities of Daily Living) requiring 1:1 staff training/intervention, enter the units from Column A in Column B.
 - For UAI Items that are needs /interventions that are shared with other participants enter the Units from Column A in Column C.
- Complete the “BLTC Communication Form” with the number of Individual Supported Living units from Column B (H2015) as one line and Group Supported Living Units from Column C (H2015HQ) as one line item.
- In “Comments/Instructions” section of “Communication Form” – note that this is a TBI Hourly/Daily Rate.
 - Copy “Hourly Supported Living Worksheet” and submit with the Communication Form.

Additional Resources

Help Aids

- AD Waiver Service List Help Aid V1.0
- Assistive Technology Medical Equipment and Supplies Help Aid V1.0
- Cost Effectiveness Help Aid V1.2
- Interpretive Services Help Aid V1.0

Job Aids

- Determining Medical Necessity or LOC for Applicants That have Deceased or Admitted to an Institution V1.0

Forms

- BLTC Adult Communication Form V1.1
- Environmental Accessibility Adaptation Bid Form
- Hourly Supported Living Worksheet V1.0
- UAI Unit Adjustment Review Form V1.1

Additional Documents

- IDAPA 16.03.10.326.12