471-000-220 Instructions for Completing Form DSS-14AD. "Functional Criteria"

Use: Form DSS-14AD is used by HHS staff and contractors to determine nursing facility level of care eligibility for adults to receive Medicaid-funded services in a nursing facility or through the Aged and Disabled Medicaid Waiver. It is also used to begin to identify client needs for the purpose of developing a waiver plan of services and supports. Part A need only be completed at the time of initial referral. Part B must be completed at least annually.

Completion:

Part A: The services coordinator uses this cover sheet to gather demographic and referral information. The shaded sections of the form are used only for the purposes of Senior Care Options; however, we must have the referral date and Medicaid number for those on the Aged and Disabled Medicaid Waiver.

Identifying information: Enter the Social Security Number, Medicaid number, name, address, phone number, and birthdate for the waiver applicant. Check the appropriate living arrangement box to indicate the person's usual living arrangement. (This arrangement must match the address shown.)

- Check "Independent" if the person lives in a house or apartment.
- Check "Assisted Living" is the person is currently residing in a licensed assisted living facility.
- Check "NF" if the person is currently in a nursing facility and, for Senior Care Options, enter in the shaded conversion area the date of admission to that facility and indicate whether the person was admitted private pay or on Medicare.
- Check "Other" if the person lives in a relative's home, group setting other than NF or assisted living, Veteran's Hospital, long-term swing bed, etc.

If the person is in a hospital for acute care, indicate the living arrangement from which s/he was admitted.

For SCO only: If an SCO referral is received for a person who is Medicaid eligible and has already moved to a nursing facility without the necessary SCO authorization (i.e., the referral was not made prior to admission), mark "Independent" or "Other" and do not complete the gray Admission Date box. Use the "Other Information" section for explanation, including date of admission.

Enter the name of the person who will be gathering the functional criteria information; this will usually be the services coordinator. Enter identifying information about the referral source (e.g., name, phone and/or FAX numbers, office address) and check the type of referral source.

Request Date (SCO only): Enter a date here in special situations such as when Medicaid status is pending and immediate evaluation is not required or when information is provided for a person who is not currently a candidate for evaluation (e.g., Medicare is still involved.)

Referral Date: Enter the date a referral is received for an immediate NF evaluation or for waiver evaluation.

Referral Time (SCO only): Enter the time of day the referral was received. (This date and time starts the 48-hour time frame for evaluation.)

Enter information to identify the person's Medicaid worker and indicate the Medicaid status.

Shaded conversion box (for SCO only): If the client's status is pending and "NF" is the living arrangement, enter the date the person entered this facility and indicate the payment type. If this is a relatively new admission of a person who was Medicaid-eligible at the time of admission you may record that date in the "Other Information" areas, but not in this box.

Check the appropriate box(es) to indicate the source(s) of the information used to determine functional eligibility.

Enter the names and identifying information for the person(s) who provided information used in determining functional eligibility and place an "I" in the last column. This area may also be used to store information on other interested persons. If so, place an "O" in the last column. Additional persons may be listed in the "Other Information" section or on the back of the form.

Enter the name (phone number, etc.) of the person's primary physician.

Other Information: Use this space, as appropriate, to take notes, to document additional information, or to provide further clarification of the items above.

Result: The shaded result box is used only for Senior Care Options.

Check "Home with A/D Waiver Services if the SCO-evaluated person will remain or return home and will be receiving one or more waiver services. This includes a person receiving Assisted Living Service through this waiver program.

Check "Home with supportive services (non-waiver) if the SCO-evaluated person will remain or return home, but will not receive waiver services. For example, the person's needs might be instead met by Medicaid personal care aide, Social Services Block Grant chore and meals, and/or Case Management services.

Check "Home with no services needed/accepted" if the SCO-evaluated person will remain or return home, but will not be receiving any formal long-term care support services.

Check "Assisted Living" and indicate the facility name and location if the SCO-evaluated person will be residing in an assisted living facility. If Assisted Living is a waiver service, also check the earlier box to indicate "Home with A/D Waiver Services."

Check "Nursing Facility" and indicate the facility name and location if the SCO-evaluated person will be residing in a nursing facility. Also check "Short Term" and enter a date if this admission is approved for a limited time period.

Part B: The services coordinator enters the client's name and Social Security number and indicates the location and date evaluation information was obtained.

ACTIVITIES OF DAILY LIVING: The services coordinator checks the box corresponding to each of the seven ADL areas, as appropriate, when the client requires assistance to complete the task.

RISK FACTORS: The services coordinator checks the box corresponding to each of the three risk factors, as appropriate. If no risk factors are present, this section is not marked.

MEDICAL TREATMENT OR OBSERVATION: The services coordinator checks the box corresponding with each of the statements that indicates the client's status in this area. If the third option is checked, enter the number(s) (found in regulations) which correspond to the client's specific medical/nursing service(s). If the client does not need medical treatment or observation, this section is not marked.

COGNITION: The services coordinator checks the box corresponding to any of the four identified cognition limitations. If no cognitive limitation is present, this section is not marked.

Comments: This section is available for supportive information the services coordinator wishes to document, including details of the person's functioning to support this level of care decision.

Determination of Level of Care Eligibility: Using the information marked in the above four domains, the services coordinator marks the boxes corresponding to identified needs/limitations.

Certification Summary: A client is eligible if all the boxes on at least one of the horizontal lines (I-IV) in the Determination section are checked. If so, the services coordinator checks the "Met" box and indicates any combination of I, II, III, and IV on the status line. If the client does not have needs/limitations in any of the four possible level of care status areas, the client is not eligible and the "Not Met" box is marked.

De-institutionalization Status: For "De-institutionalization Status", check the "Met" box and on the status line enter "De-institutionalization on _date_," showing the last date of Medicaid payment to a nursing facility for this person. This status will continue as long as the person is a waiver client.

The services coordinator signs the form and enters the date that the level of care decision was made. For Senior Care Options only, the time the decision was made is also required.

Distribution: Form DSS-14AD, Part A, is a one-page form with two copies which is filed in the client's case. For Senior Care Option)s, this information is also submitted to the HHS, Division of Aging Services.

Part B is a one-page NCR form with two copies distributed as follows:

1. White copy maintained in the client case record; and
2. Yellow copy available for information-sharing with other staff who need this information (e.g., to HHS from a contractor, to the Medicaid eligibility worker) or to Division of Aging Services for SCO billing purposes).

Retention: Form DSS-14AD, Part A, is retained in the client's case record for four years from the date of referral. Part B is retained in the client's case record for four years from the date of certification.

Aged and Disabled Medicaid Waiver
Nebraska Department of Health and Human Services
FUNCTIONAL CRITERIA

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

Social Security Number	Medicaid Number (if known)	Reviewer		
Client Name (First, Last)		Request Date (if applicable)	Referral Date	Referral Time
Address (Street, City)		Referral Source		
❑ Independent ❑ Asst. Living ❑ NF ❑ Other		❑ Self ❑ Relative/Friend ❑ NF ❑ Hospital ❑ HHS/AAA ❑ Other		
Phone	Date of Birth			

HHS Medicaid Worker (Name, Location, Phone Fax)

Medicaid Status: ❑ Open ❑ Pending

If conversion: Admission Date:_____ ❑ From Private Pay ❑ From Medicare

Information gathered through: ❑ Observation ❑ Medical record review and/or in person or phone interview with:
Check all that apply: ❑ Client ❑ Family/Friends ❑ NF ❑ Hospital ❑ Home Health ❑ Physician ❑ Other

Please list persons who provided information (I). You may also list other persons (O) who were not contacted. Do not list referral.

Name	Agency/Relationship	Address	Phone Number	I/O

Physician	Health Status/Diagnosis

Other Information

Result

❑ Home with A/D Waiver Services ❑ Home with supportive services (non-waiver) ❑ Home with no services needed/accepted
❑ Assisted Living. Facility Name:_____ Location:_____
❑ Nursing Facility. Facility Name: _____ Location:_____
❑ Short-term approval through_____

Distribution: Client Case Record

MILTC-14AD (Part A) Rev. 2/00 (27075)
(Previous version DSS-14AD (Part A) should be used first)

To view printable form click here: Functional Criteria

DHHS
Nebraska Department of Health and Human Services

Functional Criteria
Home and Community Based Waiver for Aged Persons and Adults and Children with Disabilities
Nebraska Department of Health and Human Services

Section 1	
Client Name	Social Security Number
Evaluation Location	Evaluation Date
Functional Status: Information to be gathered through observation, documentation review, and/or interview.	

Section 2 - Activities of Daily Living

Check each ADL for which the person requires any degree of assistance from another person or with the use of available equipment.

❑ Bathing ❑ Continence ❑ Dressing/Grooming
❑ Eating ❑ Mobility ❑ Toileting ❑ Transferring

Section 3 - Risk Factors

Check each area in which the person is not able to function independently with minimal or acceptable risk in the living situation.

❑ Behavior ❑ Frailty ❑ Safety

Section 4 - Medical Treatment or Observation

Check each area in which the person has a need for medical treatment or observation

❑ Requires observation and assessment ❑ Complexity of conditions causes potential instability
❑ Requires ongoing medical/nursing service. Indicate specific area(s):_____

Section 5 - Cognition

Check each area in which information, observation, or testing indicates cognitive limitations.

❑ Memory ❑ Orientation ❑ Communication ❑ Judgment

Section 6 - Comments

Section 7 - Determination of Functional Eligibility

Check boxes according to information gathered. All boxes in at least one horizontal set must be checked to meet criteria.

I. ❑ 3 + ADLs ❑ 1 + Risk factor(s)
II. ❑ 3 + ADLs ❑ Medical treatment or observation
III. ❑ 3 + ADLs ❑ 1 + Cognition limitation(s)
IV. ❑ 1 + ADLs ❑ 1 + Risk factor(s) ❑ 1 + Cognition limitation(s)

Section 8 - Certification Summary

I certify that NF criteria is:

❑ Met, with the following functional level of care status(es):_____
❑ Not met.
Time:_____

Signature of Evaluator_____Date_____

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MILTC-14AD (Part B) Rev. 3/08 (27075)
(Previous version should be used first)