

For OLTC Use Only

Date Keyed:

Keyed By:

Service Control No.:

ARKANSAS DEPARTMENT OF HUMAN SERVICES
EVALUATION OF MEDICAL NEED CRITERIA

DAAS WAIVER PROGRAMS - EC [] AAPD [] AL [] Tier [] 1 [] 2 [] 3 [] 4
FACILITIES - NH [] ICF/MR []

PART I [] ASSESSMENT (New Application) [] REASSESSMENT (UR) [] CHANGED CONDITION [] TRANSFER

Name of Nursing Facility (if applicable)
Entered NF From: [] Hospital [] Nursing Facility [] ALF [] Other
Date of Admission:

Client's Name (Last, First, Middle Initial) Social Security Number Medicaid ID Number

[] Male [] Female [] Single [] Divorced [] Widowed Date of Birth

Lives [] Alone [] With Spouse [] With Adult Child [] With Sibling [] Other

Client's Current Residence [] House/Apt. [] NF [] RCF [] Other County (Code)

Has client been in a NF before? [] Yes [] No If Yes, Date of Discharge if within last 12 months

Name of NF:

Has client applied for ElderChoices, Alternatives or Assisted Living before? [] Yes [] No If Yes, when?

For the purpose of determining my need for licensed nursing home care, I hereby authorize the release of any medical information by a licensed physician to the Arkansas Department of Human Services. (If signed by MARK, must have witness.)

Signature of Client or Legal Guardian Signature of Witness (if required)

Part II Hospitalized within last 6 months? [] Yes [] No If Yes, what dates?

Reason for hospitalization

Hospice patient? [] Yes [] No Hospice start date: Hospice discharge date:

- TRANSFERRING
[] Bed to chair without help
[] Bed to chair with help of another person or persons
[] Must be lifted into chair by another person or persons
[] Requires turning in bed by another person or persons
[] Bedfast
[] Transfers with assistive devices

- AMBULATION
[] Walks alone
[] Walks holding to HH objects
[] Walks with cane, crutches, walker
[] Walks with help of another person or persons
[] Wheelchair push by another person
[] Wheelchair using self-propulsion

If assistance is required, please indicate the frequency and type of assistance:

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Needs assistance: [] Daily Times per week Needs assistance: [] Daily Times per week

(Next Page)

Applicant/Resident Name:

CONTINENCE STATUS **Incontinent Bladder** Yes No Occasionally
 Incontinent Bowel Yes No Occasionally
 Artificial Aids Yes No Occasionally Bladder/Bowel Training
 Assistance Required Yes No Occasionally
If assistance is required, please indicate the frequency and type of assistance: Daily _____ Times per week

NUTRITIONAL STATUS Height: _____ Weight: _____ Therapeutic Diet: Yes No
Appetite: Good Fair Poor
EATING Feeds self Fed by another person Some assistance from another person is needed
 Fed by other than mouth.
If assistance is needed from another person, please explain the type of assistance, the frequency, and by whom provided. If fed by other than mouth, please explain.

HEARING No difficulty Adequate Limited Profound loss
 Hearing Aid Unable to determine Other: _____
VISION No difficulty Adequate Limited Blind
 Corrected w/lenses Unable to determine Other: _____
SPEECH/LANGUAGE No difficulty Can understand Can't understand
 Can express self Can't express self Difficulty expressing self
 Other: _____
SKIN No problem Clear Dry Rash Bruises Stasis Ulcers
 Tears Fragile Jaundiced Decubitus - Stage: 1 2 3 4
If receiving treatment for decubitus, please describe treatment:

BEHAVIOR/ATTITUDE Happy Depressed Cooperative Abusive Forgetful Sad
 Lonely Withdrawn Restless Agitated Lethargic
 Argumentative Aphasic Anxious/Apprehensive Normal
 Other: _____
MENTAL STATUS Clear Somewhat confused Moderately confused Markedly confused
 Alert Forgetful Needs supervision for personal safety
 Hyperactive Withdrawn Needs restraint
If confused or needs supervision for personal safety, please explain:

ORIENTATION LEVEL Alert Oriented x 3 Disoriented x 3 Oriented person/place
 Non-responsive Oriented person only Unable to determine
OTHER MED. COND. Nausea/Vertigo Pain Edema Arrhythmia Contractures-UE,LE
 Dyspnea Tremors Paresis/Paralysis Frail
 Seizures/Convulsions Date of last seizure: _____ Controlled by meds Yes No
 Other: _____

(Next Page)

Applicant/Resident Name:

PART III MEDICATION: Independent Dependent/Assisted Help Available
 Help Available 50% No Help Available

If assisted, please explain the type of assistance, the frequency of the assistance, and by whom the assistance is provided:

MEDICATIONS/TREATMENTS:

If therapies are listed, please include the frequency of the therapies, the provider of the therapies, and the expected duration:

List all durable medical equipment and any specialized equipment currently being used by the applicant:

RN/COUNSELOR COMMENTS (including reported medical history):

Estimated duration of need for nursing home care: Convalescent Permanent Indefinite _____ months

Signature of licensed DHS RN/NF RN/COUNSELOR and Date

Recommendation Code (if applicable)

STATUS OF MAJOR IMPAIRMENT Improving Stable Deteriorating

PROGNOSIS _____

DIAGNOSIS (Please list in the order of significance as related to the need for nursing home care)

Diagnosis A _____

Diagnosis B _____

Waiver Programs only: To individual completing DHS-703 - If Alzheimer's or dementia is entered above as diagnosis, please explain related behavior:

Is this person's need for nursing home care the result of an accident caused by a third party? Yes No
(If yes, please attach any identifying information you may have about the accident, plus the name of any insurance company involved.)

I have examined this patient within the past thirty (30) days and have reviewed this form and certify the accuracy of the information. I am aware of the Utilization Review requirements for the necessity of admission and for continued stay and that this form will be reviewed by the Utilization Review Committee of the Arkansas Department of Human Services.

Signature of Examining Physician

Date