



Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MassHealth
Acute Inpatient Hospital Bulletin 122
January 2003

TO: Acute Inpatient Hospitals Participating in MassHealth
FROM: Wendy E. Warring, Commissioner *Wendy Warring, ds, h*
RE: **Changes in Clinical Assessment Forms**

Background

The Division determines clinical eligibility for MassHealth long-term-care services based upon documentation submitted by the provider. The Long Term Care Assessment form has been replaced by two new forms in order to facilitate communication between providers and the Division.

New Forms

Attached to this bulletin are copies of the two new forms required for approving referrals for long-term-care services, including, but not limited to, nursing-facility and adult-day-health services.

- Request for Services (RFS-1) (formerly called the MassHealth Long Term Care Assessment form)
- Minimum Data Set – Home Care (MDS-HC)

Acute inpatient hospitals must begin using these new forms by February 1, 2003. Please discard all previous versions of the Long Term Care Assessment form.

Who May Complete the MDS-HC

The MDS-HC must be completed by an assessment coordinator. The assessment coordinator must be a registered nurse who certifies the accuracy and completeness of the MDS-HC.

The following sections of the MDS-HC may be completed by a licensed social worker (LSW, LCSW, or LICSW).

- AA – Name and Identification Numbers
 - BB – Personal Items
 - CC – Referral Items
 - B – Cognitive Patterns
 - C – Communication/Hearing Patterns
 - E – Mood and Behavior Patterns
 - F – Social Functioning
 - G – Informal Support Services
 - O – Environmental Assessment
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**Who May Complete
the MDS-HC
(cont.)**

Each person who completes a portion of the MDS-HC must sign and certify the sections he or she completes in Section R – Assessment Information (Other Signatures, Title, Sections, Date).

**Qualifications for
Completing the Forms**

The registered nurse or social worker must be licensed by the Massachusetts Board of Registration.

ICD-9-CM Codes

The MDS-HC assessment requires the use of the ICD-9-CM codes for medical diagnoses.

Trainings

The Division holds periodic trainings for providers. You will receive notice of trainings when they are scheduled.

Supplies of the Forms

You may photocopy the forms as needed. To obtain supplies of the forms, use the information below to mail or fax your request. Include your provider number, address, telephone number, the exact title of the form, and the desired quantity.

MassHealth Forms Distribution
P.O. Box 9101
Somerville, MA 02145
Fax: 703-917-4087

Questions

If you have any questions about this bulletin, please contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	<i>(Code for observed indicators irrespective of the assumed cause)</i>	
	0. Indicator not exhibited in last 3 days 1. Exhibited 1-2 of last 3 days 2. Exhibited on each of last 3 days	
2. MOOD DECLINE	Mood indicators have become worse as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No 1. Yes	
	3. BEHAVIORAL SYMPTOMS Instances when client exhibited behavioral symptoms. If EXHIBITED, ease of altering the symptom when it occurred. 0. Did not occur in last 3 days 1. Occurred, easily altered 2. Occurred, not easily altered	
4. CHANGES IN BEHAVIOR SYMPTOMS	Behavioral symptoms have become worse or are less well tolerated by family as compared to 90 DAYS AGO (or since last assessment if less than 90 days) 0. No, or no change in behavioral symptoms 1. Yes	
	a. A FEELING OF SADNESS OR BEING DEPRESSED, that life is not worth living, that nothing matters, that he or she is of no use to anyone or would rather be dead	e. REPETITIVE ANXIOUS COMPLAINTS, CONCERNS—e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues
	b. PERSISTENT ANGER WITH SELF OR OTHERS—e.g., easily annoyed, anger at care received	f. SAD, PAINED, WORRIED FACIAL EXPRESSIONS—e.g., furrowed brows
	c. EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS—e.g., fear of being abandoned, left alone, being with others	g. RECURRENT CRYING, TEARFULNESS
	d. REPETITIVE HEALTH COMPLAINTS—e.g., persistently seeks medical attention, obsessive concern with body functions	h. WITHDRAWAL FROM ACTIVITIES OF INTEREST—e.g., no interest in long standing activities or being with family/friends
		i. REDUCED SOCIAL INTERACTION

SECTION F. SOCIAL FUNCTIONING

1. INVOLVEMENT	a. At ease interacting with others (e.g., likes to spend time with others) 0. At ease 1. Not at ease b. Openly expresses conflict or anger with family/friends 0. No 1. Yes
2. CHANGE IN SOCIAL ACTIVITIES	As compared to 90 DAYS AGO (or since last assessment if less than 90 days ago), decline in the client's level of participation in social, religious, occupational or other preferred activities. IF THERE WAS A DECLINE, client distressed by this fact 0. No decline 1. Decline, not distressed 2. Decline, distressed
3. ISOLATION	a. Length of time client is alone during the day (morning and afternoon) 0. Never or hardly ever 1. About one hour 2. Long periods of time—e.g., all morning 3. All of the time b. Client says or indicates that he/she feels lonely 0. No 1. Yes

SECTION G. INFORMAL SUPPORT SERVICES

1. TWO KEY INFORMAL HELPERS	NAME OF PRIMARY AND SECONDARY HELPERS	
	a. (Last/Family Name)	b. (First)
Primary (A) and Secondary (B)	c. (Last/Family Name)	d. (First)
	e. Lives with client 0. Yes 1. No 2. No such helper [skip other items in the appropriate column]	(A) Prim (B) Secn
	f. Relationship to client 0. Child or child-in-law 1. Spouse 2. Other Relative 3. Friend/neighbor	
	Areas of help: 0. Yes 1. No	
	g.— Advice or emotional support	
	h.— IADL care	
	i.— ADL care	

1. TWO KEY INFORMAL HELPERS			(A) Prim (B) Secn
	If needed, willingness (with ability) to increase help: 0. More than 2 hours 1. 1-2 hours per day 2. No		
Primary (A) and Secondary (B) (cont)	j.— Advice or emotional support		
	k.— IADL care		
	l.— ADL care		
2. CAREGIVER STATUS	(Check all that apply) A caregiver is unable to continue in caring activities—e.g., decline in the health of the caregiver makes it difficult to continue Primary caregiver is not satisfied with support received from family and friends (e.g., other children of client) Primary caregiver expresses feelings of distress, anger or depression NONE OF ABOVE		a. b. c. d.
3. EXTENT OF INFORMAL HELP (HOURS OF CARE, ROUNDED)	For instrumental and personal activities of daily living received over the LAST 7 DAYS, indicate extent of help from family, friends, and neighbors		HOURS
	a. Sum of time across five weekdays		
	b. Sum of time across two weekend days		

SECTION H. PHYSICAL FUNCTIONING:

- IADL PERFORMANCE IN 7 DAYS
- ADL PERFORMANCE IN 3 DAYS

1. IADL SELF PERFORMANCE—Code for functioning in routine activities around the home or in the community during the LAST 7 DAYS, (A) IADL SELF PERFORMANCE CODE (Code for client's performance during LAST 7 DAYS) 0. INDEPENDENT—did on own 1. SOME HELP—help some of the time 2. FULL HELP—performed with help all of the time 3. BY OTHERS—performed by others 8. ACTIVITY DID NOT OCCUR (B) IADL DIFFICULTY CODE How difficult it is (or would it be) for client to do activity on own 0. NO DIFFICULTY 1. SOME DIFFICULTY—e.g., needs some help, is very slow, or fatigues 2. GREAT DIFFICULTY—e.g., little or no involvement in the activity is possible	(A) Performance (B) Difficulty
a. MEAL PREPARATION—How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils)	
b. ORDINARY HOUSEWORK—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)	
c. MANAGING FINANCE—How bills are paid, checkbook is balanced, household expenses are balanced	
d. MANAGING MEDICATIONS—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)	
e. PHONE USE—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)	
f. SHOPPING—How shopping is performed for food and household items (e.g., selecting items, managing money)	
g. TRANSPORTATION—How client travels by vehicle (e.g., gets to places beyond walking distance)	
2. ADL SELF-PERFORMANCE—The following address the client's physical functioning in routine personal activities of daily life, for example, dressing, eating, etc. during the LAST 3 DAYS, considering all episodes of these activities. For clients who performed an activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity [Note—For bathing, code for most dependent single episode in LAST 7 DAYS] 0. INDEPENDENT—No help, setup, or oversight —OR— Help, setup, oversight provided only 1 or 2 times (with any task or subtask) 1. SETUP HELP ONLY—Article or device provided within reach of client 3 or more times 2. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 3 days —OR— Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision) 3. LIMITED ASSISTANCE—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. EXTENSIVE ASSISTANCE—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: —Weight-bearing support —OR— — Full performance by another during part (but not all) of last 3 days 5. MAXIMAL ASSISTANCE—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. TOTAL DEPENDENCE—Full performance of activity by another 8. ACTIVITY DID NOT OCCUR (regardless of ability)	

2. ADL SELF-PERFORMANCE (cont)	
a. MOBILITY IN BED —Including moving to and from lying position, turning side to side, and positioning body while in bed.	
b. TRANSFER —Including moving to and between surfaces—to/from bed, chair, wheelchair, standing position. [Note—Excludes to/from bath/toilet]	
c. LOCOMOTION IN HOME —[Note—If in wheelchair, self-sufficiency once in chair]	
d. LOCOMOTION OUTSIDE OF HOME —[Note—If in wheelchair, self-sufficiency once in chair]	
e. DRESSING UPPER BODY —How client dresses and undresses (street clothes, underwear) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.	
f. DRESSING LOWER BODY —How client dresses and undresses (street clothes, underwear) from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners	
g. EATING —Including taking in food by any method, including tube feedings.	
h. TOILET USE —Including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing any special devices required (ostomy or catheter), and adjusting clothes.	
i. PERSONAL HYGIENE —Including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (EXCLUDE baths and showers)	
j. BATHING —How client takes full-body bath/shower or sponge bath (EXCLUDE washing of back and hair). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. Code for most dependent episode in LAST 7 DAYS	
3. ADL DECLINE	ADL status has become worse (i.e., now more impaired in self performance) as compared to status 90 days ago (or since last assessment if less than 90 days) 0. No 1. Yes
4. PRIMARY MODES OF LOCOMOTION	0. No assistive device 3. Scooter (e.g., Amigo) 1. Cane 4. Wheelchair 2. Walker/crutch 8. ACTIVITY DID NOT OCCUR a. Indoors b. Outdoors
5. STAIR CLIMBING	In the last 3 days , how client went up and down stairs (e.g., single or multiple steps, using handrail as needed) 0. Up and down stairs without help 1. Up and down stairs with help 2. Not go up and down stairs
6. STAMINA	a. In a typical week, during the LAST 30 DAYS (or since last assessment), code the number of days client usually went out of the house or building in which client lives (no matter how short a time period) 0. Every day 2. 1 day a week 1. 2-6 days a week 3. No days b. Hours of physical activities in the last 3 days (e.g., walking, cleaning house, exercise) 0. Two or more hours 1. Less than two hours
7. FUNCTIONAL POTENTIAL	Client believes he/she capable of increased functional independence (ADL, IADL, mobility) Caregivers believe client is capable of increased functional independence (ADL, IADL, mobility) Good prospects of recovery from current disease or conditions, improved health status expected NONE OF ABOVE

SECTION I. CONTINENCE IN LAST 7 DAYS

1. BLADDER CONTINENCE	a. In LAST 7 DAYS control of urinary bladder function (with appliances such as catheters or incontinence program employed) [Note—if dribbles, volume insufficient to soak through underpants] 0. CONTINENT —Complete control; DOES NOT USE any type of catheter or other urinary collection device 1. CONTINENT WITH CATHETER —Complete control with use of any type of catheter or urinary collection device that does not leak urine 2. USUALLY CONTINENT —Incontinent episodes once a week or less 3. OCCASIONALLY INCONTINENT —Incontinent episodes 2 or more times a week but not daily 4. FREQUENTLY INCONTINENT —Tends to be incontinent daily, but some control present 5. INCONTINENT —Inadequate control, multiple daily episodes 8. DID NOT OCCUR —No urine output from bladder b. Worsening of bladder incontinence as compared to status 90 DAYS AGO (or since last assessment if less than 90 days) 0. No 1. Yes
2. BLADDER DEVICES	(Check all that apply in LAST 7 DAYS) Use of pads or briefs to protect against wetness Use of an indwelling urinary catheter NONE OF ABOVE

3. BOWEL CONTINENCE	In LAST 7 DAYS , control of bowel movement (with appliance or bowel continence program if employed) 0. CONTINENT —Complete control; DOES NOT USE ostomy device 1. CONTINENT WITH OSTOMY —Complete control with use of ostomy device that does not leak stool 2. USUALLY CONTINENT —Bowel incontinent episodes less than weekly 3. OCCASIONALLY INCONTINENT —Bowel incontinent episode once a week 4. FREQUENTLY INCONTINENT —Bowel incontinent episodes 2-3 times a week 5. INCONTINENT —Bowel incontinent all (or almost all) of the time 8. DID NOT OCCUR —No bowel movement during entire 7 day assessment period
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SECTION J. DISEASE DIAGNOSES

Disease/infection that doctor has indicated is present and affects client's status, requires treatment, or symptom management. Also include if disease is monitored by a home care professional or is the reason for a hospitalization in **LAST 90 DAYS** (or since last assessment if less than 90 days)

[blank]. Not present 1. Present—not subject to focused treatment or monitoring by home care professional 2. Present—monitored or treated by home care professional [If no disease in list, check J1ac , <i>None of Above</i>]																																					
1. DISEASES	<table border="0"> <tr> <td>HEART/CIRCULATION</td> <td>p. Osteoporosis</td> </tr> <tr> <td>a. Cerebrovascular accident (stroke)</td> <td>SENSES</td> </tr> <tr> <td>b. Congestive heart failure</td> <td>q. Cataract</td> </tr> <tr> <td>c. Coronary artery disease</td> <td>r. Glaucoma</td> </tr> <tr> <td>d. Hypertension</td> <td>PSYCHIATRIC/MOOD</td> </tr> <tr> <td>e. Irregularly irregular pulse</td> <td>s. Any psychiatric diagnosis</td> </tr> <tr> <td>f. Peripheral vascular disease</td> <td>INFECTIONS</td> </tr> <tr> <td>NEUROLOGICAL</td> <td>t. HIV infection</td> </tr> <tr> <td>g. Alzheimer's</td> <td>u. Pneumonia</td> </tr> <tr> <td>h. Dementia other than Alzheimer's disease</td> <td>v. Tuberculosis</td> </tr> <tr> <td>i. Head trauma</td> <td>w. Urinary tract infection (in LAST 30 DAYS)</td> </tr> <tr> <td>j. Hemiplegia/hemiparesis</td> <td>OTHER DISEASES</td> </tr> <tr> <td>k. Multiple sclerosis</td> <td>x. Cancer—(in past 5 years) not including skin cancer</td> </tr> <tr> <td>l. Parkinsonism</td> <td>y. Diabetes</td> </tr> <tr> <td>MUSCULO-SKELETAL</td> <td>z. Emphysema/COPD/asthma</td> </tr> <tr> <td>m. Arthritis</td> <td>aa. Renal Failure</td> </tr> <tr> <td>n. Hip fracture</td> <td>ab. Thyroid disease (hyper or hypo)</td> </tr> <tr> <td>o. Other fractures (e.g., wrist, vertebral)</td> <td>ac. NONE OF ABOVE</td> </tr> </table>	HEART/CIRCULATION	p. Osteoporosis	a. Cerebrovascular accident (stroke)	SENSES	b. Congestive heart failure	q. Cataract	c. Coronary artery disease	r. Glaucoma	d. Hypertension	PSYCHIATRIC/MOOD	e. Irregularly irregular pulse	s. Any psychiatric diagnosis	f. Peripheral vascular disease	INFECTIONS	NEUROLOGICAL	t. HIV infection	g. Alzheimer's	u. Pneumonia	h. Dementia other than Alzheimer's disease	v. Tuberculosis	i. Head trauma	w. Urinary tract infection (in LAST 30 DAYS)	j. Hemiplegia/hemiparesis	OTHER DISEASES	k. Multiple sclerosis	x. Cancer—(in past 5 years) not including skin cancer	l. Parkinsonism	y. Diabetes	MUSCULO-SKELETAL	z. Emphysema/COPD/asthma	m. Arthritis	aa. Renal Failure	n. Hip fracture	ab. Thyroid disease (hyper or hypo)	o. Other fractures (e.g., wrist, vertebral)	ac. NONE OF ABOVE
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2. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	<table border="0"> <tr> <td>a. _____</td> <td> ● </td> </tr> <tr> <td>b. _____</td> <td> ● </td> </tr> <tr> <td>c. _____</td> <td> ● </td> </tr> <tr> <td>d. _____</td> <td> ● </td> </tr> </table>	a. _____	●	b. _____	●	c. _____	●	d. _____	●																												
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SECTION K. HEALTH CONDITIONS AND PREVENTIVE HEALTH MEASURES

1. PREVENTIVE HEALTH (PAST TWO YEARS)	(Check all that apply—in PAST 2 YEARS) Blood pressure measured Received influenza vaccination Test for blood in stool or screening endoscopy IF FEMALE: Received breast examination or mammography NONE OF ABOVE
2. PROBLEM CONDITIONS PRESENT ON 2 OR MORE DAYS	(Check all that were present on at least 2 of the last 3 days) Diarrhea Difficulty urinating or urinating 3 or more times at night Fever Loss of appetite Vomiting NONE OF ABOVE
3. PROBLEM CONDITIONS	(Check all present at any point during last 3 days) PHYSICAL HEALTH Shortness of breath MENTAL HEALTH Chest pain/pressure at rest or on exertion No bowel movement in 3 days Dizziness or lightheadedness Edema Delusions Hallucinations NONE OF ABOVE

4.	PAIN	<p>a. Frequency with which client complains or shows evidence of pain 0. No pain (score b-e as 0) 2. Daily - one period 1. Less than daily 3. Daily - multiple periods (e.g., morning and evening)</p> <p>b. Intensity of pain 0. No pain 2. Moderate 4. Times when pain is horrible 1. Mild 3. Severe or excruciating</p> <p>c. From client's point of view, pain intensity disrupts usual activities 0. No 1. Yes</p> <p>d. Character of pain 0. No pain 1. Localized - single site 2. Multiple sites</p> <p>e. From client's point of view, medications adequately control pain 0. Yes or no pain 1. Medications do not 2. Pain present, adequately control pain medication not taken</p>	
5.	FALLS FREQUENCY	Number of times fell in LAST 90 DAYS (or since last assessment if less than 90 days) If none, code "0"; if more than 9, code "9"	
6.	DANGER OF FALL	<p>(Code for danger of falling) 0. No 1. Yes</p> <p>a. Unsteady gait</p> <p>b. Client limits going outdoors due to fear of falling (e.g., stopped using bus, goes out only with others)</p>	
7.	LIFE STYLE (Drinking/ Smoking)	<p>(Code for drinking or smoking) 0. No 1. Yes</p> <p>a. In the LAST 90 DAYS (or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking, or others were concerned with client's drinking</p> <p>b. In the LAST 90 DAYS (or since last assessment if less than 90 days), client had to have a drink first thing in the morning to steady nerves (i.e., an "eye opener") or has been in trouble because of drinking</p> <p>c. Smoked or chewed tobacco daily</p>	
8.	HEALTH STATUS INDICATORS	<p>(Check all that apply) Client feels he/she has poor health (when asked)</p> <p>Has conditions or diseases that make cognition, ADL, mood, or behavior patterns unstable (fluctuations, precarious, or deteriorating)</p> <p>Experiencing a flare-up of a recurrent or chronic problem</p> <p>Treatments changed in LAST 30 DAYS (or since last assessment if less than 30 days) because of a new acute episode or condition</p> <p>Prognosis of less than six months to live—e.g., physician has told client or client's family that client has end-stage disease</p> <p>NONE OF ABOVE</p>	a. b. c. d. e. f.
9.	OTHER STATUS INDICATORS	<p>(Check all that apply) Fearful of a family member or caregiver</p> <p>Unusually poor hygiene</p> <p>Unexplained injuries, broken bones, or burns</p> <p>Neglected, abused, or mistreated</p> <p>Physically restrained (e.g., limbs restrained, used bed rails, constrained to chair when sitting)</p> <p>NONE OF ABOVE</p>	a. b. c. d. e. f.

SECTION L. NUTRITION/HYDRATION STATUS

1.	WEIGHT	<p>(Code for weight items) 0. No 1. Yes</p> <p>a. Unintended weight loss of 5% or more in the LAST 30 DAYS [or 10% or more in the LAST 180 DAYS]</p> <p>b. Severe malnutrition (cachexia)</p> <p>c. Morbid obesity</p>	
2.	CONSUMPTION	<p>(Code for consumption) 0. No 1. Yes</p> <p>a. In at least 2 of the last 3 days, ate one or fewer meals a day</p> <p>b. In last 3 days, noticeable decrease in the amount of food client usually eats or fluids usually consumes</p> <p>c. Insufficient fluid—did not consume all/almost all fluids during last 3 days</p> <p>d. Enteral tube feeding</p>	
3.	SWALLOWING	<p>0. NORMAL—Safe and efficient swallowing of all diet consistencies</p> <p>1. REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS (mechanical diet or able to ingest specific foods only)</p> <p>2. REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS (puree, thickened liquids)</p> <p>3. COMBINED ORAL AND TUBE FEEDING</p> <p>4. NO ORAL INTAKE (NPO)</p>	

SECTION M. DENTAL STATUS (ORAL HEALTH)

1.	ORAL STATUS	<p>(Check all that apply) Problem chewing (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control, pain while eating)</p> <p>Mouth is "dry" when eating a meal</p> <p>Problem brushing teeth or dentures</p> <p>NONE OF ABOVE</p>	a. b. c. d.
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SECTION N. SKIN CONDITION

1.	SKIN PROBLEMS	Any troubling skin conditions or changes in skin condition (e.g., burns, bruises, rashes, itchiness, body lice, scabies) 0. No 1. Yes	
2.	ULCERS (Pressure/Stasis)	<p>Presence of an ulcer anywhere on the body. Ulcers include any area of persistent skin redness (Stage 1); partial loss of skin layers (Stage 2); deep craters in the skin (Stage 3); breaks in skin exposing muscle or bone (Stage 4). [Code 0 if no ulcer, otherwise record the highest ulcer stage (Stage 1-4).]</p> <p>a. Pressure ulcer—any lesion caused by pressure, shear forces, resulting in damage of underlying tissues</p> <p>b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities</p>	
3.	OTHER SKIN PROBLEMS REQUIRING TREATMENT	<p>(Check all that apply)</p> <p>Burns (second or third degree)</p> <p>Open lesions other than ulcers, rashes, cuts (e.g., cancer)</p> <p>Skin tears or cuts</p> <p>Surgical wound</p> <p>Corns, calluses, structural problems, infections, fungi</p> <p>NONE OF ABOVE</p>	d. e. f.
4.	HISTORY OF RESOLVED PRESSURE ULCERS	<p>Client previously had (at any time) or has an ulcer anywhere on the body</p> <p>0. No 1. Yes</p>	
5.	WOUND/ ULCER CARE	<p>(Check for formal care in LAST 7 DAYS)</p> <p>Antibiotics, systemic or topical</p> <p>Dressings</p> <p>Surgical wound care</p> <p>Other wound/ulcer care (e.g., pressure relieving device, nutrition, turning, debridement)</p> <p>NONE OF ABOVE</p>	a. b. c. d. e.

SECTION O. ENVIRONMENTAL ASSESSMENT

1.	HOME ENVIRONMENT	<p>Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)</p> <p>Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)</p> <p>Bathroom and toiletroom (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)</p> <p>Kitchen (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs)</p> <p>Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic)</p> <p>Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)</p> <p>Access to home (e.g., difficulty entering/leaving home)</p> <p>Access to rooms in house (e.g., unable to climb stairs)</p> <p>NONE OF ABOVE</p>	a. b. c. d. e. f. g. h. i.
2.	LIVING ARRANGEMENT	<p>a. As compared to 90 DAYS AGO (or since last assessment), client now lives with other persons—e.g., moved in with another person, other moved in with client 0. No 1. Yes</p> <p>b. Client or primary caregiver feels that client would be better off in another living environment 0. No 1. Client only 2. Caregiver only 3. Client and caregiver</p>	

SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

1.	FORMAL CARE	<p>Extent of care or care management in LAST 7 DAYS (or since last assessment if less than 7 days) involving</p> <p>(Minutes rounded to even 10 minutes)</p> <p>a. Home health aides</p> <p>b. Visiting nurses</p> <p>c. Homemaking services</p> <p>d. Meals</p> <p>e. Volunteer services</p> <p>f. Physical therapy</p> <p>g. Occupational therapy</p> <p>h. Speech therapy</p> <p>i. Day care or day hospital</p> <p>j. Social worker in home</p>	<table border="1"> <thead> <tr> <th rowspan="2"></th> <th colspan="3">(A)</th> <th colspan="3">(B)</th> <th colspan="3">(C)</th> </tr> <tr> <th>Days</th> <th>Hours</th> <th>Mins</th> <th>Days</th> <th>Hours</th> <th>Mins</th> <th>Days</th> <th>Hours</th> <th>Mins</th> </tr> </thead> <tbody> <tr><td>a.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>b.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>c.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>d.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>e.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>f.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>g.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>h.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>i.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>j.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>		(A)			(B)			(C)			Days	Hours	Mins	Days	Hours	Mins	Days	Hours	Mins	a.										b.										c.										d.										e.										f.										g.										h.										i.										j.									
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2.	SPECIAL TREATMENTS, THERAPIES, PROGRAMS	Special treatments, therapies, and programs received or scheduled during the LAST 7 DAYS (or since last assessment if less than 7 days) and adherence to the required schedule. Includes services received in the home or on an outpatient basis.	[Blank]. Not applicable	2. Scheduled, partial adherence
		1. Scheduled, full adherence as prescribed	3. Scheduled, not received	(If no treatments provided, check NONE OF ABOVE P2aa)
	RESPIRATORY TREATMENTS			o. Occupational therapy
	a. Oxygen			p. Physical therapy
	b. Respirator for assistive breathing			PROGRAMS
	c. All other respiratory treatments			q. Day center
	OTHER TREATMENTS			r. Day hospital
	d. Alcohol/drug treatment program			s. Hospice care
	e. Blood transfusion(s)			t. Physician or clinic visit
	f. Chemotherapy			u. Respite care
	g. Dialysis			SPECIAL PROCEDURES DONE IN HOME
	h. IV infusion - central			v. Daily nurse monitoring (e.g., EKG, urinary output)
	i. IV infusion - peripheral			w. Nurse monitoring less than daily
	j. Medication by injection			x. Medical alert bracelet or electronic security alert
	k. Ostomy care			y. Skin treatment
	l. Radiation			z. Special diet
	m. Tracheostomy care			aa. NONE OF ABOVE
	THERAPIES			aa.
	n. Exercise therapy			
3.	MANAGEMENT OF EQUIPMENT (In Last 3 Days)	Management codes:	0. Not used	
		1. Managed on own	2. Managed on own if laid out or with verbal reminders	
			3. Partially performed by others	
			4. Fully performed by others	
	a. Oxygen			c. Catheter
	b. IV			d. Ostomy
4.	VISITS IN LAST 90 DAYS OR SINCE LAST ASSESSMENT	Enter 0 if none, if more than 9, code "9"		
		a. Number of times ADMITTED TO HOSPITAL with an overnight stay	b. Number of times VISITED EMERGENCY ROOM without an overnight stay	c. EMERGENT CARE—including unscheduled nursing, physician, or therapeutic visits to office or home
5.	TREATMENT GOALS	Any treatment goals that have been met in the LAST 90 DAYS (or since last assessment if less than 90 days)		
		0. No	1. Yes	
6.	OVERALL CHANGE IN CARE NEEDS	Overall self sufficiency has changed significantly as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days)		
		0. No change	1. Improved—receives fewer supports	2. Deteriorated—receives more support
7.	TRADE OFFS	Because of limited funds, during the last month, client made trade-offs among purchasing any of the following: prescribed medications, sufficient home heat, necessary physician care, adequate food, home care		
		0. No	1. Yes	

SECTION Q. MEDICATIONS

1.	NUMBER OF MEDICATIONS	Record the number of different medicines (prescriptions and over the counter), including eye drops, taken regularly or on an occasional basis in the LAST 7 DAYS (or since last assessment)[If none, code "0", if more than 9, code "9"]		
2.	RECEIPT OF PSYCHOTROPIC MEDICATION	Psychotropic medications taken in the LAST 7 DAYS (or since last assessment) [Note—Review client's medications with the list that applies to the following categories]		
		0. No	1. Yes	
	a. Antipsychotic/neuroleptic			c. Antidepressant
	b. Anxiolytic			d. Hypnotic
3.	MEDICAL OVERSIGHT	Physician reviewed client's medications as a whole in LAST 180 DAYS (or since last assessment)		
		0. Discussed with at least one physician (or no medication taken)	1. No single physician reviewed all medications	
4.	COMPLIANCE/ADHERENCE WITH MEDICATIONS	Compliant all or most of time with medications prescribed by physician (both during and between therapy visits) in LAST 7 DAYS		
		0. Always compliant	1. Compliant 80% of time or more	2. Compliant less than 80% of time, including failure to purchase prescribed medications
		3. NO MEDICATIONS PRESCRIBED		

= When box blank, must enter number or letter a. = When letter in box, check if condition applies

5.	LIST OF ALL MEDICATIONS	List prescribed and nonprescribed medications taken in LAST 7 DAYS (or since last assessment)		
		a. Name and Dose —Record the name of the medication and dose ordered. b. Form : Code the route of Administration using the following list:		
		1. By mouth (PO) 5. Subcutaneous (SQ) 9. Enteral tube 2. Sub lingual (SL) 6. Rectal (R) 10. Other 3. Intramuscular (IM) 7. Topical 4. Intravenous (IV) 8. Inhalation		
		c. Number taken —Record the amount of medication administered each time the medication is given		
		d. Freq : Code the number of times per day, week, or month the medication is administered using the following list:		
		PRN. As necessary 5D. Five times daily QH. Every hour QOD. Every other day Q2H. Every two hours QW. Once each wk Q3H. Every three hours 2W. Two times every week Q4H. Every four hours 3W. Three times every week Q6H. Every six hours 4W. Four times each week Q8H. Every eight hours 5W. Five times each week QD. Once daily 6W. Six times each week BID. Two times daily 1M. Once every month (includes every 12 hrs) 2M. Twice every month TID. Three times daily C. Continuous QID. Four times daily O. Other		
	a. Name and Dose	b. Form	c. Number Taken	d. Freq.
	a.			
	b.			
	c.			
	d.			
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	g.			
	h.			
	i.			
	j.			
	k.			

SECTION R. ASSESSMENT INFORMATION

1. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:			
a.	Signature of Assessment Coordinator		
b.	Title of Assessment Coordinator		
c.	Date Assessment Coordinator signed as complete	<input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/>	Month Day Year
d.	Other Signatures	Title	Sections Date
e.			Date
f.			Date
g.			Date
h.			Date
i.			Date



Request for Services

Date _____

Type of clinical eligibility determination all requested services.

Service(s) requested <input type="checkbox"/> Pre-admission nursing facility (NF) <input type="checkbox"/> Adult day health (ADH) <input type="checkbox"/> Adult foster care (AFC) <input type="checkbox"/> Group adult foster care (GAFC)	<input type="checkbox"/> Home and community based services (HCBS) waiver <input type="checkbox"/> Program for All-inclusive Care for the Elderly (PACE) <input type="checkbox"/> Other _____	Nursing facility use only <input type="checkbox"/> Conversion <input type="checkbox"/> Continued stay <input type="checkbox"/> Short term review <input type="checkbox"/> Transfer NF to NF <input type="checkbox"/> Retrospective
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Member information

Member/applicant

Last name	First name	Telephone
Address		City Zip
Check one <input type="checkbox"/> MassHealth member <input type="checkbox"/> MassHealth application pending <input type="checkbox"/> GAFC/ Assisted living residence		
_____	_____	_____
MassHealth ID number	Date application filed	Date SSI-G application filed

Next of kin/Responsible party

Last name	First name	Telephone
Address		City Zip

Physician

Last name	First name	Telephone
Address		City Zip

Screening for mental illness, mental retardation, and developmental disability

Does the member/applicant have any of the following diagnoses/conditions? Check all that apply.

Mental illness Specify: _____

Mental retardation without related condition

Developmental disability with related condition that occurred prior to age 22. **Check all that apply.**

<input type="radio"/> Autism	<input type="radio"/> Deafness/severe hearing impairment	<input type="radio"/> Multiple sclerosis	<input type="radio"/> Severe learning disability
<input type="radio"/> Blindness/severe visual impairment	<input type="radio"/> Epilepsy/seizure disorder	<input type="radio"/> Muscular dystrophy	<input type="radio"/> Spina bifida
<input type="radio"/> Cerebral palsy	<input type="radio"/> Head/brain injury	<input type="radio"/> Orthopedic impairment	<input type="radio"/> Spinal cord injury
<input type="radio"/> Cystic fibrosis	<input type="radio"/> Major mental illness	<input type="radio"/> Speech/language impairment	

Community services recommended

Check all that apply.

- | | | | |
|--|--|---|---|
| <input type="radio"/> Skilled nursing | <input type="radio"/> HCBS waiver | <input type="radio"/> Rest home | <input type="radio"/> Homemaker |
| <input type="radio"/> Physical therapy | <input type="radio"/> Personal emergency response system | <input type="radio"/> Elderly housing | <input type="radio"/> Meals |
| <input type="radio"/> Occupational therapy | <input type="radio"/> Adult foster care | <input type="radio"/> Adult day health | <input type="radio"/> Transportation |
| <input type="radio"/> Speech therapy | <input type="radio"/> Group adult foster care | <input type="radio"/> PACE | <input type="radio"/> Chore service |
| <input type="radio"/> Mental health services | <input type="radio"/> Assisted living | <input type="radio"/> Home health aide | <input type="radio"/> Grocery shopping/delivery |
| <input type="radio"/> Social worker services | <input type="radio"/> Congregate housing | <input type="radio"/> Personal care/homemaker | <input type="radio"/> Other: _____ |

Additional information

1. Is the home or apartment available for the member or applicant? yes no
2. Is there a caregiver to assist the member in the community? yes no
3. Has the member or applicant experienced unexplained weight gain in the last 30 days? yes no
4. Does the member or applicant receive personal care/homemaker services? yes no
 If yes:

days per week	hours per week
---------------	----------------
5. Has the member or applicant experienced a significant change in condition in the last 30 days? yes no
 If yes: improvement deterioration
 Indicate the changes below. _____

For nursing facility requests only

1. Does the nursing facility member/applicant express an interest to remain in or return to the community? yes no
2. Is the nursing facility stay expected to be short-term (up to 90 days)? yes no
3. Is the nursing facility stay expected to be long-term (more than 90 days)? yes no

Referral source Name of registered nurse completing this form

Signature	Print name	Title
Name of organization		Telephone
Address		City Zip

For community providers: Attach the MDS-HC and Physician’s Summary form according to provider’s regulations/guidelines.

For nursing facility providers: Attach the most recent comprehensive MDS, current quarterly MDS, and current physician orders.