**CARE LEVEL II RESIDENT REVIEW**

***INTELLECTUAL/DEVELOPMENTAL DISABILITY/RELATED CONDITIONS***

*All questions must be answered completely*

\*Date Referral to KHS       Date Referred to Assessor

Date of Assessment       Date of Last Assessment

Date Faxed to KHS       \*Tracking #

Person requesting Level I screening:

# *\*This information will be provided to you by KHS. If there was not a previous assessment, leave it blank.*

# SECTION I – IDENTIFICATION

**Name:**  Phone: (     )      -      DOB:

Residential Address:

     ,      

County:

SSN:      -     -      Gender:

Medicaid Number:       County of Responsibility:

**Current Location:**       Ward/Unit:

Current Address:

     ,

County:

Contact Person:       Admission Date:

Phone: (     )      -      Fax: (     )      -

**Attending Physician Name:**

Address:

     ,

Work Phone: (     )      -

**Proposed Facility (if applicable):**

Contact Person:

Address:

     ,

County:

Phone: (     )      -      Fax: (     )      -      Proposed Date of Admission:

Please give the following information about any individuals serving as (**attach signature page of the court order**):

Guardian   DPOA  Other Legal or Medical Representative

**Name:**

Address:

     ,

County:

Home Phone: (     )      -      Work Phone: (     )      -

Does the individual have another person involved in a significant way from whom we may be able to obtain additional information about the individual’s social, medical, emotional or environmental history and status?

If “yes,” please provide the following information:

**Name**:

Address:

     ,

County:

Home Phone: (     )      -      Work Phone: (     )      -

Relationship to Individual:

## SECTION II – DIAGNOSIS & EXCLUSIONS

1. a) Has the diagnostic picture changed since the last assessment?

Please list:

b) Does the individual have a diagnosis of intellectual/developmental disability/related condition listed as defined by the AAMR on pages 5-7 of the RR manual?

Please list:

2. Does the individual have a primary diagnosis of dementia or dementia related disorder?

You must provide documentation from the clinical record to support your answer in #2 if you checked yes. If the answer to #1b is **No** or #2 is **Yes**, the Resident Review assessment is finished. Please proceed to the Clinical Summary in Section VI **AND** Section VII.

3. a) Does this individual have a medical condition which is:

Permanent?

Progressive?

For the purpose of this assessment the following definitions apply:

\***Permanent**: Permanent infirmities of aging are identified as the current primary factor causing the individual to need twenty-four hour nursing care **AND** the individual will no longer benefit from specialized services for persons with intellectual/developmental disability or developmental disability.

\***Progressive**: A medical condition of a progressive degenerative nature which, due to the current increasing deterioration directly related to the condition, is a primary factor determining the need of the individual **AND** the individual can no longer benefit from specialized services for persons with intellectual disability, developmental disability, or for mental illness.

\*Permanent and Progressive related exemptions require a Level II Assessor to initiate an assessment and make the determination regarding the status of the individual’s condition. Documentation is required.

b) If the responses to #3a are **BOTH** “Yes,” please describe the medical condition and the treatment required.

If the responses to #3a are **BOTH** “Yes,” please provide supporting documentation and proceed to the Clinical Summary in Section VI **AND** Section VII.

## SECTION III – SUMMARY OF TREATMENT SINCE LAST REVIEW

Please attach the most recent MEDICAL HISTORY AND PHYSICAL. The review cannot be accepted without this document and will be counted as an incomplete assessment. If you cannot obtain the history

and physical, please contact KHS.

4. Please describe any changes in living arrangements, including hospitalizations that have occurred since the last review. State dates and the reasons for these changes.

5. a) Please describe the current physical condition and medical needs of this individual. Include any special

treatments and equipment this individual requires (i.e., needs wheelchair, walker, cane, needs to be fed, falls

easily, short of breath, oxygen, frail, etc.)

b) Have there been any changes in physical condition since last review?

If Yes, please describe:

6. List all medications the individual currently takes including over the counter medication, and indicate whether the medication is: S = Stable *OR* A = Being Adjusted.

| **MEDICATION** | **DOSAGE** | FREQ | **ROUTE** | **S/A** |
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7. Has there been a change in medication since last review?

If yes, please describe:

| **MEDICATION** | **DOSAGE** | FREQ | **ROUTE** | **S/A** |
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8. Have the recommendations listed in the PASRR Level II approval letter been addressed?

Please explain:

## SECTION IV – CURRENT LEVEL OF FUNCTIONING

9. *Check your response under the code* for EACH activity of IADL and ADL that indicates the average level of functioning for this individual during the course of the day in their present setting.

1. Independent

2. Supervision needed

3. Physical assistance needed

4. Unable or unwilling to perform

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **ADL’S** | | | | | | |
|  | **1** | **2** | **3** | **4** | **IMPROVED** | **DECLINED** | **UNCHANGED** |
| Bathing |  |  |  |  |  |  |  |
| Dresses Appropriately |  |  |  |  |  |  |  |
| Toileting |  |  |  |  |  |  |  |
| Transfers |  |  |  |  |  |  |  |
| Walking/Mobility |  |  |  |  |  |  |  |
| Eating |  |  |  |  |  |  |  |

Comments:

10. Please answer the following questions related to communication:

a) Can the individual effectively communicate needs to the staff?

b) Is he/she easily understood?

c) Is the individual able to maintain a conversation?

11. Is the individual able to self-administer and schedule medical treatments, self-monitor health and

nutritional status?

Please explain:

**SECTION V – LIVING ARRANGEMENT AND SUPPORT NETWORK**

12. Indicate the individual’s preferred living arrangement (individual’s choice, not service provider’s recommendation):

13. If there is a legal guardian, do they agree with the individual’s choice of living arrangement?

If no, please explain:

14. Indicate current and past resources used:

a) Currently has a home or apartment available.

b) Has lived independently or semi-independently in the past.

How recently?       For how long?

d) Has individual received ID/DD services?

Name of CDDO or service provider:

15. Individual’s Support Network includes: Check available supports and provide specific information (names, phone numbers, availability, etc. ) in space provided.

Family Members – Identify:

Case Manager -- Identify:

Guardian or Payee – Identify:

Others – Identify:

Please explain:

16. Is transfer to a community-based setting reflected in the current plan of care? Give date of proposed discharge from the facility:

Proposed Date:

Comments:

17. Please list the reasons why this individual continues to need 24-hour nursing care. Take into consideration medical, physical, and or functional needs which require the level of care provided in a nursing facility:

18. Support Services and Resources that may be used to assist the individual to live successfully in the community living arrangement of their choice: Check  all that apply. Indicate whether they would be available, not available or unknown.

| **NEEDED** | **AVAILABLE** |  | NOTAVAILABLE |  | **UNKNOWN** |
| --- | --- | --- | --- | --- | --- |
| Affordable housing or housing subsidy |  |  |  |  |  |
| Supportive home care (estimated hrs per day or week      ) |  |  |  |  |  |
| Residential services |  |  |  |  |  |
| Case management service |  |  |  |  |  |
| Day services/valued activities |  |  |  |  |  |
| Consumer-Run Drop-In Center or other social support activities |  |  |  |  |  |
| Crisis stabilization/Respite Program available as needed |  |  |  |  |  |
| Medication management |  |  |  |  |  |
| Nutritional program |  |  |  |  |  |
| Conservator or Payee |  |  |  |  |  |
| Natural supports: such as family, roommates, friends, church, etc. |  |  |  |  |  |
| Transportation Assistance |  |  |  |  |  |
| Medical assistance |  |  |  |  |  |
| Supported Employment |  |  |  |  |  |
| **Medical Assistance** |  |  |  |  |  |
| Assistive technology |  |  |  |  |  |
| Home health care |  |  |  |  |  |
| Visiting nurses |  |  |  |  |  |
| Hospice |  |  |  |  |  |
| **Other services (*please list* below)** |  |  |  |  |  |
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## *Please list CDDO responsible for providing these services*

## SECTION VI – CLINICAL SUMMARY

*Include your impressions and final analysis*

19. Clinical Summary

## SECTION VII – FINAL RECOMMENDATIONS

20. Mark the appropriate placement/service recommendation:

Nursing facility level of care **is** needed/Specialized intellectual/developmental disability services **are not** needed

Nursing facility level of care **is not** needed/Specialized intellectual/developmental disability services **are** needed

Nursing facility level of care **is not** needed/Specialized intellectual/developmental disability services **are not** needed

21. Your recommendations are critical to ensuring that this individual receives care and treatments appropriate for their condition. As a QDDP, please give additional recommendations for support services to meet the individual’s needs (such as: review of medications; reevaluation of diagnosis) and why these services are recommended:

22. What resources were utilized to gather information for this assessment?  **Include names of individuals and title**. Every effort must be made to contact and involve the guardian in the assessment. If the guardian declines involvement or is unavailable, please explain why in the remarks section of this question.

Date of interview with individual (face to face):

Exact location where assessment took place:

***Guardian should be included in the assessment!***

Guardian:       Date Interviewed:

(indicate if interview was in person or by phone)

Family Members:

Health Care Professionals (must be interviewed and listed):

Clinical Records:

Minimum Data Set (MDS) Version 2.0:

Remarks:      

**SECTION VIII – QDDP SIGNATURE**

23. Assessor’s Name:        
*Print your full name (first, middle initial, last) and title*

Assessor’s phone number(s):

Date:

Assessor’s license type and number:

Assessor’s Email address:

Assessor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24. Is this a courtesy screen?

Date faxed to responsible CDDO:

Contact person @ responsible CDDO:

25. Time Documentation Summary:

Screen Time:       Hours       Minutes

Travel Time:       Hours       Minutes

Total Time:       Hours       Minutes

***PLEASE NOTE:***

***It is the Assessor’s responsibility to make sure all necessary referrals are made.***