



STATE OF ALASKA
DIV OF SENIOR & DISABILITIES SERVICES
3601 C STREET, SUITE 310
ANCHORAGE, AK 99503

TO ALL PERSONS REQUESTING ADMISSION TO NURSING HOMES:

Federal regulations require that every person applying for admission to a nursing home be screened to identify mental illness and mental retardation diagnoses and determine whether people with those diagnoses require nursing home services or active treatment in another setting.

MI/MR SUPPLEMENT ASSESSMENT
LEVEL 1

Client/Applicant Name _____ Date of Birth _____
Medicaid Number _____
Nursing Facility _____ Date of Admission _____

1. Does the individual have a current diagnosis of major MI or MR: _____ Yes _____ No
If yes, please indicate the diagnosis: _____

Describe symptoms observed or reported in the last two years:

2. Does the individual have a history of MI or MR? _____ Yes _____ No
If yes, describe briefly and list date(s) of onset:

3. Has the individual been referred by an agency serving persons with mental retardation or a developmental disability? _____ Yes _____ No

If yes, specify agency, location, type of service provided, contact person, and telephone number:

4. Does the individual have a prescribed major tranquilizer on a regular basis in the absence of a justifiable neurological disorder? _____ Yes _____ No

Specify all psychotropic medications on the following page. An attached list from medical records will be adequate as long as the following information is provided. Specify each medication by medication name, dosage, route of administration, purpose and degree of supervision. The degree of supervision should indicate if medication is self-administered or if the family provides assistance, provided by lay persons, or registered nurses. (Please specify)

CLIENT/APPLICANT NAME: _____ FACILITY: _____

MEDICATION NAME DOSAGE ROUTE OF ADMIN. PURPOSE SUPERVISION

5. CLINICAL AND PSYCHOSOCIAL DATA: Please indicate with a check any of the following behavior(s) which the individual has exhibited:

- | | |
|---|--|
| <input type="checkbox"/> is combative | <input type="checkbox"/> experiences difficulty learning new skills |
| <input type="checkbox"/> sets fires | <input type="checkbox"/> demonstrates severe maladaptive behavior |
| <input type="checkbox"/> bizarre behavior | <input type="checkbox"/> face or body twitches or jerks |
| <input type="checkbox"/> is destructive to self/property | <input type="checkbox"/> unable to understand simple commands |
| <input type="checkbox"/> suicidal thoughts, ideation's, or gestures | <input type="checkbox"/> self-stimulatory behavior (* e.g. rocks back & forth) |
| <input type="checkbox"/> appetite disturbance | <input type="checkbox"/> seriously impaired judgment |
| <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> displays inappropriate social behavior |
| <input type="checkbox"/> withdrawn | <input type="checkbox"/> hallucinates |
| <input type="checkbox"/> talks about his/her worthlessness | <input type="checkbox"/> has delusions |
| <input type="checkbox"/> has epilepsy | <input type="checkbox"/> disoriented |
| <input type="checkbox"/> bangs head | <input type="checkbox"/> thought disorders, please specify: |
| <input type="checkbox"/> cannot communicate basic needs | <input type="checkbox"/> other, please specify: |

Please describe the context in which any of the above-checked behaviors occurs:

6. Will a nursing facility or some additional resource beyond what is usually provided by a nursing facility be required to meet the mental, emotional, or training needs of this resident?
 Yes No

If yes, please explain.

7. Is there evidence of a dementia (including Alzheimer's disease or a related disorder)?
 Yes No

If there is a diagnosis of dementia, please provide supporting documentation including the relevant diagnostic criteria. Copies of existing medical records may be adequate.

CLIENT/APPLICANT NAME: _____ FACILITY: _____

8. Recommendation: _____ refer to DBH for Level II determination for MI or MR
_____ assessment does not indicate need for DBH referral
because individual:
_____ does not have known or suspected diagnosis of MI or MR
_____ has Alzheimer's disease or dementia as primary diagnosis
_____ terminal illness without need for active treatment
_____ severe illness without need for active treatment
_____ convalescent leave without need for active treatment

Evaluator's Signature

Title

Date

Telephone number

This section to be completed by DSS:

- _____ refer to DBH for Level II determination: Date sent: _____ To whom: _____
_____ process pre-authorization request; individual does not meet Level II screening criteria
_____ no indication of MI or MR
_____ has Alzheimer's disease or dementia as primary diagnosis
_____ terminal illness without need for active treatment
_____ severe illness without need for active treatment
_____ convalescent leave without need for active treatment

DSS Nurse Reviewer

Date