

**STATE OF ALASKA-DIVISION SENIOR & DISABILITIES SERVICES
NURSING FACILITY LEVEL OF CARE
ASSESSMENT FORM FOR CHILDREN**

Initial Authorization _____
Reauthorization _____

CLIENT NAME _____

Name: (Last, First, MI)		Period of Care Requested From _____ To _____		Date of This Assessment: _____	<input type="checkbox"/> - Male <input type="checkbox"/> - Female
Client Current Address: (Street address, City, State, Zip Code)			Date of Birth	Age	Client Phone Number: (907) _____
Primary Caregiver				Relation	
Legal Guardian Address (Street Address, City, State, Zip Code)			Medicaid #	Tetra YES <input type="checkbox"/> NO <input type="checkbox"/>	
Aware of need to petition for Guardian before 18th birthday? YES <input type="checkbox"/> NO <input type="checkbox"/>	Name of Legal Guardian		Legal Guardian phone number	Comfort one YES <input type="checkbox"/> NO <input type="checkbox"/>	
Physician Name, Address & Phone Number					
LIVING ARRANGEMENTS					
Client lives with family YES <input type="checkbox"/> NO <input type="checkbox"/>	Foster Care YES <input type="checkbox"/> NO <input type="checkbox"/>	Family Habilitation/Shared Care YES <input type="checkbox"/> NO <input type="checkbox"/>	Name / Address of Family Habilitation/Shared Care residence		
DIAGNOSIS					
Primary Diagnosis & Date Diagnosed	ICD-9	Second Diagnosis & Date Diagnosed	ICD-9	Third Diagnosis & Date Diagnosed	ICD-9
Additional comments about diagnoses and health condition: (use page 5 if add'l space is needed)					
CURRENT MEDICATIONS / ROUTES / FREQUENCIES					
PERSONAL INFORMATION					
	APPROPRIATE TO AGE & DEVELOPMENT		IF NOT AGE APPROPRIATE, PROVIDE COMMENTS AND DESCRIBE SITUATION		
	YES	NO			
Weight	<input type="checkbox"/>	<input type="checkbox"/>			
Height	<input type="checkbox"/>	<input type="checkbox"/>			
Current Diet	<input type="checkbox"/>	<input type="checkbox"/>			
Nutritional Supplementation (explain)					

CLIENT NAME _____

**STATE OF ALASKA-DIVISION SENIOR & DISABILITIES SERVICES
NURSING FACILITY LEVEL OF CARE
ASSESSMENT FORM FOR CHILDREN**

Initial Authorization _____
Reauthorization _____

ACTIVITIES OF DAILY LIVING CODES				ASSISTIVE DEVICES										
LEVEL OF PERFORMANCE CODE: 0 = Performs ADLs independently 1 = Assistive device/mechanical assistance only 2 = Supervision with oversight or verbal cues. 3 = Supervision and minimal hands-on assistance 4 = Substantial human physical assistance 5 = Maximum physical assistance (total dependence)		FREQUENCY OF HELP CODE: 0 = Help not needed 1 = Once a week or less 2 = 2-3 times/week 3 = 4-6 times/week 4 = At least once/day 5 = Several times each day		Bath Bench Shower chair Commode Communication device Elevated Toilet Prone Stander Other <list below>		NEEDS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	USES <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Wheelchair Walker Grab Bars Braces/AFOs Lift/Mechanical Lift/ Aqua-tub Glasses Hearing Aide Special Bed		NEEDS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	USES <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
ACTIVITIES OF DAILY LIVING	LEVEL OF PERFORMANCE (select above code)	FREQUENCY OF HELP (select above code)	AGE APPROPRIATE		IF NOT AGE APPROPRIATE COMMENTS / DESCRIPTION									
			YES	NO										
Eating / Drinking			<input type="checkbox"/>	<input type="checkbox"/>										
Toileting			<input type="checkbox"/>	<input type="checkbox"/>										
Bathing			<input type="checkbox"/>	<input type="checkbox"/>										
Transfers			<input type="checkbox"/>	<input type="checkbox"/>										
Dressing			<input type="checkbox"/>	<input type="checkbox"/>										
Grooming			<input type="checkbox"/>	<input type="checkbox"/>										
Mobility			<input type="checkbox"/>	<input type="checkbox"/>										
Communication			<input type="checkbox"/>	<input type="checkbox"/>										
Medications			<input type="checkbox"/>	<input type="checkbox"/>										
FACTORS AFFECTING INSTITUTIONALIZATION														
1. Technology Dependent 2. 24 hr support /monitoring needed? 3. Assistance with transportation needed?	Yes	No	Hospital Admissions: 1. Currently Hospitalized 2. Within last 3 months: 3. Within last 6 months 4. Within last 9 months 5. Within last 12 months		Yes	No	REASON FOR ADMISSION: *Illness *Accident *Surgery *Diagnostic/Evaluation *Treatment/Therapy *Observation (*diagnosis & date required below for boxes marked yes)		Yes	No	Last Physician Visit. 1. Within last 3-6 months Dr. Name/Specialty 2. 7 months to 1 year. Dr. Name/Specialty 3. Over 1 year. Dr. Name/Specialty		Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADDITIONAL INFORMATION AFFECTING INSTITUTIONALIZATION:														

CLIENT NAME _____

**STATE OF ALASKA-DIVISION SENIOR & DISABILITIES SERVICES
NURSING FACILITY LEVEL OF CARE
ASSESSMENT FORM FOR CHILDREN**

Initial Authorization _____
Reauthorization _____

VOLUNTARY AND INFORMAL SUPPORTS			
Name, relationship and phone number of who provides the help	Describe what help is provided	Describe where the help is provided	How often is the help provided?

SKILLED SERVICES		
	<u>LEVEL OF PERFORMANCE CODE/Comments</u>	<u>FREQUENCY OF HELP CODE/Comments</u>
	0 = Performs independently 1 = Assistive device/mechanical assistance only 2 = Supervision with oversight or verbal cues 3 = Supervision and minimal hands-on assistance 4 = Substantial human physical assistance 5 = Maximum physical assistance (total dependence)	0 = Help not needed 1 = Once a week or less 2 = 2-3 times/week 3 = 4-6 times/week 4 = At least once/day 5 = Several times each day
Ventilator dependent		
Respiratory Therapy		
Chemotherapy		
Feeding: Tubes		
Intravenous Access		
Feeding: Syringe		
Injections		
Medications Administration		
Medications Monitoring		
Oxygen		
Ostomy Care		
Physical Therapy		
Occupational Therapy		
Speech Therapy		
Skin Care		
Urinary catheter		
Wound Care / sterile dressings		
Other Skilled Service Needs		

CLIENT NAME _____

**STATE OF ALASKA-DIVISION SENIOR & DISABILITIES SERVICES
NURSING FACILITY LEVEL OF CARE
ASSESSMENT FORM FOR CHILDREN**

Initial Authorization _____
Reauthorization _____

COGNITIVE STATUS

Daily decision making skills:
Requires cues and / or supervision Unable to make decisions Functions independently Problems in new situations only

Rate the following cognitive/behavior patterns according to the following codes by placing a "X" in the appropriate column:

PATTERN	Unable to address	Not a problem	Occasional 1-2 per month	Frequent Several per week	Daily	COMMENTS
ORIENTATION: Recognizes family members/care givers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ORIENTATION IN HOME: able to find bedroom/bathroom without assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SHORT-TERM MEMORY: unable to recall after 5 minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LONG-TERM MEMORY: unable to recall past events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BEHAVIOR: Wandering moves with no rational purpose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
VERBALLY ABUSIVE: threatens, screams, curses at others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PHYSICALLY ABUSIVE: hits, shoves, scratches, sexually abusive to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SOCIALLY INAPPROPRIATE / DISRUPTIVE self abuse, sexual behavior, disruptive sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OBSERVABLE SIGNS OF MENTAL DISTRESS: Tearful, emotional, sighing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Motor agitation such as pacing, hand-wringing or picking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Failure to eat or take medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PICA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Persistent concern with health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Recurrent thoughts of death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oblivious to safety and consequences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Withdrawal from self-care or leisure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Suicidal/homicidal thoughts/actions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other/describe:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

CLIENT NAME _____

STATE OF ALASKA-DIVISION SENIOR & DISABILITIES SERVICES
NURSING FACILITY LEVEL OF CARE
ASSESSMENT FORM FOR CHILDREN

Initial Authorization _____
Reauthorization _____

Narrative Summary:

(Current conditions, skilled nursing needs, therapy goals. If a re-assessment, please describe, in detail, any improvements or deterioration in condition that have occurred in the previous 12 months)

CLIENT NAME _____

STATE OF ALASKA-DIVISION SENIOR & DISABILITIES SERVICES
NURSING FACILITY LEVEL OF CARE
ASSESSMENT FORM FOR CHILDREN

Initial Authorization _____
Reauthorization _____

NURSE CERTIFICATION
(to be completed by nurse completing assessment)

To the best of my knowledge, the information in this assessment report is true, accurate, complete and the requested services are necessary.

Nurse Signature Date

Printed Name of Nurse

Contact Information: Email: _____

Phone: _____

DIVISION OF SENIOR AND DISABILITIES SERVICES DETERMINATION

Approved Nursing Facility Level of Care

Denied Nursing Facility Level of Care

Comments: _____

DSS Signature: _____ Date: _____