

CLIENT NAME _____

1. Eating and Meal Preparation

- a. 0 pt Independently feeds self.
- b. 1 pt Independently feeds self but needs someone to prepare meals or shop for food.
- c. 2 pts Person requires supervision or assistance to assure nutritional needs are met.
- d. 2 pts Requires specially prepared diet (i.e. calorie specific diabetic, renal dialysis diet etc); is on fluid restriction; administers own tube feedings.
- e. 3 pts. Swallowing or choking precautions needed.
- f. 4 pt Person requires constant attention and feeding by another person; receives tube feedings administered by an other person.

COMMENTS _____

2. Medication Management

- a. 0 pt No medications taken.
- b. 1 pt Takes minimal (1-4) oral or topical medications on a regular basis (including vitamins).
- c. 2 pts. Requires multiple (5 or more) maintenance medications as a daily regime; has weekly / monthly injections; has nebulizer treatments.
- d. 3 pts. Requires monitoring for cardiac rate depressors, hypertension, diabetic care, or anticoagulants, at least one time per month; any HG A1C monitoring. Client can monitor and administer insulin on a daily basis, includes sliding scale management.
- e. 4 pts Frequent monitoring **is required** for need or dosage regulation (insulin, narcotic, anti-coagulants). Requires medication box or insulin syringes filled. Sliding scale insulin managed by person other than client. Includes **regular and continuous** oxygen use, administration of IV medications and injection site care.

COMMENTS _____

3. Skin Care, Wound Dressing, Skin Treatments

- a. 0 pts Skin intact; can do own skin care.
- b. 1 pt Superficial skin conditions, fragility, rashes or chronic dermatitis or healed decubitus ulcers; diabetic care and monitoring.
- c. 2 pts Pressure areas; requires daily peri-care; small skin flap with dressing; multiple skin tears; surgical wounds or lesions that are not infected.
- d. 4 pts Open skin lesions present (i.e. post-operative wound with complications, decubiti, has sterile/special dressing) that can be cared for by non-licensed personnel for a portion of the day. Person requires trachea care.

COMMENTS _____

4. Speech, Vision, Hearing

- a. 0 pts Unimpaired or impaired but not dependent on assistance from another person.
- b. 1 pt Impaired communication due to literacy or language barrier.
- c. 2 pts Communication impairment that results in the need for regular assistance from another person.
- d. 3 pts Completely dependent in areas of communication.

COMMENTS _____

5. Dressing and Personal Grooming

- a. 0 pts Appropriate and independent dressing, undressing or grooming with no assistance.
- b. 1 pt Unable to dress or undress without regular assistance; inability to button or zip; cannot choose appropriate clothing; needs some assistance with grooming.
- c. 2 pts Significant assistance or cuing needed on a regular basis.
- d. 3 pts Requires total assistance with dressing or undressing or grooming.

COMMENTS _____

CLIENT NAME _____

6. Bathing

- a. 0 pts Independent bathing; uses assistance only for set up.
- b. 1 pt Mobile, but unable to safely bathe without regular assistance and supervision, includes stand-by assistance.
- c. 3 pts Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).

COMMENTS _____

7. Continence

- a. 0 pts Continent of bowel and bladder; occasional incontinence or stress incontinence where person is able to self-manage.
- b. 2 pts Occasional incontinence; requires toileting or reminder by another; needs help to clean self.
- c. 3 pts Frequent to total incontinence and needs help to clean self (including changing incontinence supplies); unable to participate in a training program; maintenance of colostomies and ileostomies; performs self-catheterization.
- d. 3 pts Requires a catheter and catheter care by another person, has a bowel program.

COMMENTS _____

8. Mobility

- a. 0 pts Independently and appropriately able to transfer and/or ambulate with or without an assistive device.
- b. 1 pt Endurance limits ability to ambulate or transfer. Ability varies over the day.
- c. 2 pts Able to transfer and/or ambulate with minimal or stand-by assistance; unstable, weak or frequent falls. Includes receiving restorative therapy services.
- d. 4 pts Completely dependent for frequent transfers or frequent repositioning.
- e. 4 pts Requires two person transfer; uses mechanical lift.
- f. 4 pts Participates in a prescribed specialized rehabilitative therapy in accordance with an individual plan of care.

COMMENTS _____

9. Behavior / Motivation

- a. 0 pts Appropriate behavior; well-motivated and cognitively capable of performing ADL's; person is comatose or unresponsive.
- b. 1 pt Intermittent forgetfulness, confusion or agitation that impacts care; requires occasional reminders as to person, place or time. Impaired motivation impacts self care.
- c. 2 pts History of substance abuse, including alcohol or prescription drugs **AND RECEIVES** intervention.
- d. 3 pts Frequently aggressive, abusive or disruptive; aggressive or abusive behavior impacts **self care and safety** of self or others.
- e. 4 pts Forgetful, may wander, safety concerns. In danger of self-inflicted harm or self-neglect. Behavior impacts care or safety.

COMMENTS _____

10. Socialization

- a. 0 pts Independent participation in social or therapeutic activities by choice. Isolated or reclusive by personal choice.
- b. 2 pts Requires special assistance or encouragement for participation in planned social activities due to depression, confusion or physical condition.
- c. 3 pts Requires one-on-one assistance to participate in activities.
- d. 4 pts Concern for abuse or neglect. Unable to report to others or defend self due to confusion, physical condition or fear.

COMMENTS _____

CLIENT NAME _____

SCORE _____

Placement Summary

1. Has 13 or more points. Client may be served either in a Nursing Facility or Swing Bed OR on either the HCBS LTC or ALF waiver.

2. DOES NOT have 13 points, but placement remains medically necessary to maintain optimal functioning and maintain the continued safety and welfare of the client.

3. DOES NOT have 13 points, and DOES NOT meet the medical necessity criteria for long term care.

FOR DENIAL OR FOR WAIVER ADMISSION has a Service Care Plan been prepared? YES NO

I give permission for sharing information directly related to my health, social, environmental and economic status with those agencies providing HCBS waiver or Project Out services, as necessary to determine if I am appropriate for a waiver service program.

Client Signature _____

Date _____

Witness Signature _____

Date _____

Case Manager / Care Coordinator _____
Or Project Out Transition Specialist

R.N. Signature _____

Date _____

Clock Time In _____ AM / PM

Travel Time: _____
(minutes)

Clock Time Out _____ AM / PM

Public Health Office _____

County Number _____

Provider NPI Number _____

Submit LT101 for Medicaid Payment YES NO