

ADMISSION AND EVALUATION DATA

Date _____

Medicare Admission Date _____

Medicaid Discharge Date _____

Medicaid Admission Date _____

Date of Death _____

FROM _____ NPI Number _____

Name of Facility

Telephone Number _____

Address of Facility

Patient's First Name

M.I.

Patient's Last Name

Female _____ Male _____

Birth Date _____

Social Security Number _____

Medicaid Number _____

Diagnosis and Pertinent Medical Information (if needed, continue on page 3)

List all Medications to include: Route, Dosage, Time, Treatment, Diet, etc (if needed, continue on page 3)

1. Listed below, but not limited to, are specific services that a resident requires on a regular basis: *(Resident must meet at least two of the a-k criteria for initial admissions.)*

- _____ a. Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment. (Cannot be counted as a second criterion if used in conjunction with criterion **k-7**)
- _____ b. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders
- _____ c. Nasopharyngeal aspiration required for the maintenance of a clear airway
- _____ d. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created
- _____ e. Administration of tube feedings by nasogastric tube
- _____ f. Care of extensive decubitus ulcers or other widespread skin disorders
- _____ g. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse (provide supporting documentation). (Cannot be counted as a second criterion if used in conjunction with criterion **k-9**)
- _____ h. Use of oxygen on a regular or continuing basis
- _____ i. Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, postoperative, or chronic conditions per physician's orders
- _____ j. Comatose resident receiving routine medical treatment

Name: _____ Medicaid No. _____ Date: _____

k. Assistance with at least one of the activities of daily living below on an ongoing basis:

1. ____ Transfer - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or multiple times per week).
 2. ____ Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet his requirement.
 3. ____ Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.
 4. ____ Toileting - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).
 5. ____ Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g. how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.
 6. ____ Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g. does not know residence is a Nursing Facility).
 7. ____ Medication Administration - The individual is not mentally or physically capable of self administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose. (Cannot be counted as a second criterion if used in conjunction with criterion **a**)
 8. ____ Behavior - The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement attempts).
 9. ____ Skilled Nursing or Rehabilitative Services - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.(Cannot be counted as a second criterion if used in conjunction with criterion **g**)
2. Criterion **k** should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance. Multiple criteria checked under **k** will count as one criterion.
3. Medicaid residents who have had no break in institutional care since discharge from a nursing home and residents who are re-admitted less than 30 days after discharge into the community, will need to meet only one of the **a-k** criteria.

I certify this resident requires nursing facility care effective on the admission date appearing on this form.

Physician's Signature (Physician Must Sign)

Facility Registered Nurse Reviewer Signature

Physician's Printed Name

Date of Physician's Signature

Physician's Address

