DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

Level of Care Re-Assessment Home & Community Services Tool 003

ASSESSMENT TO BE COMPLETED BY A REGISTERED NURSE

MEMBER Name (Last, First, Middle) _____ DOB _____/_____/_____

SSN _____-_____-_____ Medicaid ID _____

I. Medical Necessity of Care

☐ Member has an approved care plan which includes any of the following *ongoing* home and community services:

- Adult Day Services
- Assisted Living Care
- Behavioral Health
- Cognitive Services
- Consumer Directed Attendant Care
- Day Habilitation
- Home Delivered Meals
- Nutritional Supplements for the AIDS Population
- Personal Care Services
- Personal Emergency Response System
- Case Management
- Specialized Medical Equipment and Supplies

☐ These home and community services are required in order to allow the member to continue living safely in the home or community based setting and to prevent or delay placement in a nursing facility.

II. Need for Inpatient Nursing Home Care or Acute Hospital Care for HIV/AIDS members

☐ Member has a physical or mental condition, or impairment that requires ongoing supervision and/or assistance with activities of daily living in the home or community setting. Specify diagnoses/conditions below:

_____

_____

III. Functional Deficiencies

Member requires assistance in one or more of the following areas. Check below as applicable.

☐ **Eating**: Requires physical assistance to place food and drink in the mouth.

☐ **Transfer**: Requires physical assistance to transfer to and from bed, chair, or toilet.

☐ **Mobility**: Requires physical assistance for mobility AND is unable to propel a manual or electric wheelchair without assistance. (Members who are mobile using a wheelchair, walker, crutch, cane or other mobility aid independently do **not** meet this deficit.)

☐ **Toileting**: Requires physical assistance to use the toilet (which may include assistance with clothing and/or hygiene) or to perform incontinence, ostomy, or indwelling catheter care.

☐ **Bathing**: Requires physical assistance to bathe.

☐ **Hygiene**: Requires physical assistance with personal hygiene, including shaving, shampooing, nail and oral care.

☐ **Dressing**: Requires physical assistance with dressing.

- ☐ **Medication**: Is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance. (Limited assistance includes reminders, encouragement, opening bottles, handing to person and medication set-up.) For **Insulin Administration**, requires physical assistance:
  - To inject a **fixed dose** of insulin with a prefilled syringe
  - To draw up and inject insulin on a **sliding scale**.
- ☐ **Orientation**: Disoriented to person (e.g., fails to remember own name or recognize family members) or place (e.g., does not recognize home or familiar surroundings.)
- ☐ **Expressive Communication**: Cannot express basic wants/needs using verbal/written language or assistive devices.
- ☐ **Receptive Communication**: Cannot understand and follow simple instructions and commands without continual intervention.
- ☐ **Behavior**: Displays an established and persistent pattern of **dementia-related** behaviors (e.g., aggression, disrobing, or repetitive elopement) requiring continual intervention by other persons.

IV. Skilled Nursing Services

Member requires the following skilled nursing services. Check below as applicable.

- ☐ **Tube Feeding (PEG, NG, GT)**: Primary means of nourishment (greater than 50% of daily nutrition.)
- ☐ **Pressure Ulcer Care**: Pressure ulcer is stage 3 or 4 in severity.
- ☐ **IV or Hyperal Therapy**
- ☐ **Daily Intermittent Catheterizations:** Indwelling catheters do **not** qualify.
- ☐ **Complex Dressing Changes**: Excludes pressure ulcer care, peg site care, and skin tears.
- ☐ **Suctioning**: Nasopharyngeal, Trach (excludes trach care and oral suctioning.)
- ☐ **24 Hour Skilled Nursing**: Requires 24 hour skilled nursing observation, assessment, and/or intervention for unstable conditions, including ventilator care.

V. Does member continue to meet the level of care requirements: ☐ yes ☐ no

VI. Certification

I certify that the level of care information provided in this re-assessment is accurate. I understand that this information will be used to determine the member's continued eligibility and/or reimbursement for long term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the State's DSHP Plus program and Title XIX of the Social Security Act. I further understand that, under the Delaware Medicaid False Claims and Reporting Act, any person who presents or causes to be presented to the State a claim for payment under the DSHP Plus program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties.

Signature: _____ Credentials: _____ Date: _____

A new PAE Tool 001 is not required unless member does not continue to meet conditions established in Sections I, II, and III.

Maintain a copy of signed reassessment form in the member's file