New Choices Waiver

Nursing Facility Level of Care Determination

Name: _____ DOB: _____ Medicaid ID: _____

☐ Initial Assessment ☐ Annual Reassessment ☐ Substantial change in health status ☐ Other_____

(a) Due to diagnosed medical conditions, the individual requires substantial physical assistance with daily living activities above the level of verbal prompting, supervising, or setting up. (Please rate the amount of assistance required for each activity):

	Does not meet factor (a)			Meets factor (a)		
	Performs Independently	Independent with assistive device or set up	Prompting or Supervision	Minimal Physical Assist	Moderate Physical Assist	Complete Dependence on others
a. Bathing/Showering:	☐	☐	☐	☐	☐	☐
b. Grooming/Hygiene:	☐	☐	☐	☐	☐	☐
c. Dressing/Undressing:	☐	☐	☐	☐	☐	☐
d. Eating/Self feeding:	☐	☐	☐	☐	☐	☐
e. Transferring:	☐	☐	☐	☐	☐	☐
f. Toileting:	☐	☐	☐	☐	☐	☐
g. Mobility/Ambulation:	☐	☐	☐	☐	☐	☐
h. Bed Mobility:	☐	☐	☐	☐	☐	☐

(b) The attending physician has determined that the individual's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through a Medicaid Home and Community-Based Waiver program. Please rate your assessment of the individual's care requirement:

a. Level of dysfunction in orientation to person: ☐ N/A ☐ Requires NF care ☐ Does not require NF care

b. Level of dysfunction in orientation to place: ☐ N/A ☐ Requires NF care ☐ Does not require NF care

c. Level of dysfunction in orientation to time: ☐ N/A ☐ Requires NF care ☐ Does not require NF care

If your assessment indicates that the individual may meet this factor, please verify this with the physician or through applicable medical records.

Name of verifying physician:_____

Verification obtained by:_____ Date:_____

Physician verification is not required to confirm your assessment of the following:

d. Impaired decision making ability: ☐ None ☐ Mild ☐ Moderate ☐ Severe

e. Impaired communication ability: ☐ None ☐ Mild ☐ Moderate ☐ Severe

f. Impaired memory recall: ☐ None ☐ Short-term ☐ Long-term ☐ Procedural

g. Does the client experience periods of confusion that have potential to endanger the client or others? ☐ Yes ☐ No

(c) The medical condition and intensity of services indicate that the care needs of the individual cannot be safely met in a less structured setting, or without the services and supports of a Medicaid Home and Community-Based Waiver program. List the medical diagnoses, treatments, therapies and programs necessary for the health and safety of this client. This area should not include a reiteration of any ADL assistance identified in section (a).

A minimum of 2 out of the 3 factors listed above are required to determine that an individual meets nursing facility level of care.

☐ Based upon the assessment dated_____, this individual has been determined to meet nursing facility level of care.

☐ Based upon the assessment dated_____, this individual has been determined to NOT meet nursing facility level of care.

Notes: _____

RN Name: _____ Signature: _____ Date: _____