Rules of
Department of Health and Senior Services
Division 30—Division of Regulation and Licensure
Chapter 81—Certification

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 81—Certification

19 CSR 30-81.010 General Certification Requirements

PURPOSE: This rule sets forth application procedures and general certification requirements for nursing facilities certified under the Title XIX (Medicaid) program and skilled nursing facilities under Title XVIII (Medicare), and procedures to be followed by nursing facilities when requesting a nurse staffing waiver.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Definitions.

(A) Certification shall mean the determination by the Missouri Department of Health and Senior Services, or the Centers for Medicare and Medicaid Services, that a licensed skilled nursing or intermediate care facility (SNF/ICF) licensed under Chapter 198, RSMo, or an ICF for person with mental retardation (ICF/MR), is in substantial compliance with all federal requirements and is approved to participate in the Medicaid or Medicare programs.

(B) CMS shall mean the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(C) Cost reporting year shall mean the facility's twelve (12)-month fiscal reporting period covering the same twelve (12)-month period that the facility uses for its federal income tax reporting.

(D) Distinct part shall mean a portion of an institution or institutional complex that is certified to provide SNF or NF services. A distinct part must be physically distinguishable from the larger institution and must consist of all beds within the designated area. The distinct part may be a separate building, floor, wing, ward, hallway or several rooms at one end of a hall or one side of a corridor.

(E) Department shall mean the Missouri Department of Health and Senior Services.

(F) ICF/MR shall mean intermediate care facility for persons with mental retardation.

(G) Medicaid shall mean Title XIX of the federal Social Security Act.

(H) Medicare shall mean Title XVIII of the federal Social Security Act.

(I) Nursing facility (NF) shall mean an SNF or ICF licensed under Chapter 198, RSMo which has signed an agreement with the Department of Social Services to participate in the Medicaid program and which is certified by the department. As used within the contents of this rule, licensed SNFs, SNF/ICF and ICFs participating in the Medicaid program are subject to state and federal laws and regulations for participation as an NF.

(J) Section for Long Term Care (SLTC) shall mean that section of the department responsible for licensing and regulating long-term care facilities licensed under Chapter 198, RSMo.

(K) Skilled nursing facility (SNF) shall mean an SNF licensed under Chapter 198, RSMo which has a signed agreement with the CMS to participate in the Medicare program and which has been recommended for certification by the department.

(L) Title XVIII shall mean the Medicare program as provided for in the federal Social Security Act.

(M) Title XIX shall mean the Medicaid program as provided for in the federal Social Security Act.

(2) An operator of an SNF or ICF licensed by the department electing to be certified as a provider of skilled nursing services under the Title XVIII (Medicare) or NF services under the Title XIX (Medicaid) program of the Social Security Act; or an operator of a facility electing to be certified as an ICF/MR facility under Title XIX shall submit application materials to the department as required by federal law and shall comply with standards set forth in the *Code of Federal Regulations* (CFR) of the United States Department of Health and Human Services in 42 CFR chapter IV, part 483, subpart B for nursing homes and 42 CFR chapter IV, part 483, subpart I for ICF/MR facilities, as appropriate.

(A) For Medicaid, the application shall include:

1. Long Term Care Facility Application for Medicare and Medicaid, Form CMS-671 (12/02), incorporated by reference in this rule and available through the Centers for Medicare and Medicaid website: http://www.cms.hhs.gov/forms/, or by mail at: Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244-1850;

2. Form DA-113, Bed Classification for Licensure and Certification by Category (8-05), incorporated by reference in this rule and available through the department's website: www.dhss.mo.gov, or by mail at: Department of Health and Senior Services Warehouse, Attention General Services Warehouse, PO Box 570, Jefferson City, MO 65102-0570, telephone: (573) 526-3861.

(B) For Medicare, the application shall include:

1. Long Term Care Facility Application for Medicare and Medicaid;

2. Expression of Intermediary Preference Form (8-05), incorporated by reference in this rule and avail-able through the department's website: www.dhss.mo.gov, or by mail at: Department of Health and Senior Services Warehouse, Attention General Services Warehouse, PO Box 570, Jefferson City, MO 65102-0570, telephone: (573) 526-3861;

3. Form DA-113, Bed Classification for Licensure and Certification by Category;

4. Three (3) copies of Health Insurance Benefit Agreement, Form CMS-1561 (07/01), incorporated by reference in this rule and available through the Centers for Medicare and Medicaid website: http://www.cms.hhs.gov/forms/, or by mail at: Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244-1850;

5. Three (3) copies of Assurance of Compliance, Form HHS-690 (5/97), incorporated by reference in this rule and available through the Centers for Medicare and Medicaid website: http://www.cms.hhs.gov/forms, or by mail at the U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201, telephone: (202) 619-0257; Toll Free: 1 (877) 696-6775.

6. The forms incorporated by reference in subsections (2)(A) and (B) do not include any later amendments or additions.

(C) SNFs or NFs which are newly certified or which are undergoing a change of ownership shall submit an initial certification fee in the amount up to one thousand dollars ($1,000) as stipulated by the department in writing to the operator following receipt of the properly completed application material referenced in section (2). The amount for the initial certification fee shall be the prorated portion of one thousand dollars ($1,000) with prorating based on the month of receipt of the application in relation to the beginning of the

next federal fiscal year. This initial certification fee shall be nonrefundable and a facility shall not be certified until the fee has been paid.

(D) All SNFs or NFs certified to participate in the Medicaid or Medicare program(s) shall submit to the department an annual certification fee of one thousand dollars ($1,000) prior to October 1 of each year. If the fee is not received by that date each year, a late fee of fifty dollars ($50) per month shall be payable to the department. If payment of any fees due is not received by the department by the time the facility license expires or by December 31 of that year, whichever is earlier, the department shall notify the Division of Medical Services and the CMS recommending termination of the Medicaid or Medicare agreement as denial of license will occur as provided in 19 CSR 30-82.010 and section 198.022, RSMo.

(3) Application material shall be signed and dated and submitted to the department's SLTC licensure unit at least fourteen (14) working days prior to the date the facility is ready to be surveyed for compliance with federal regulations (Initial Certification Survey). The operator or authorized representative shall notify the appropriate department regional office by letter or by phone as to the date the facility will be ready to be surveyed. There shall be at least two (2) residents in the facility before a survey can be conducted. The facility shall already be licensed or with licensure in process shall be in compliance with all state rules.

(4) Any facility certified for participation as an NF in the Title XIX Medicaid program electing to participate in the Title XVIII Medicare program shall submit an application signed and dated by the operator or his or her authorized representative to the department's SLTC central office licensure unit. The department will recommend Medicare certification to the CMS effective the date the application material is received by the department or a subsequent date if requested by the provider, provided the facility was in compliance with all federal and state regulations for SNFs at the last survey conducted by the department and provided the facility's application is complete and has been approved by the Medicare fiscal intermediary.

(5) Any facility certified for participation in the Medicare program wishing to participate in the Medicaid program shall submit a signed and dated application to the department central office. The department will certify the facility for Medicaid participation effective the date the application is received by the department or a subsequent date requested by the provider, provided the facility was in compliance with all federal regulations at the last survey conducted by the department and the application is complete.

(6) For newly certified facilities, the facility will be certified for either Medicare or Medicaid participation effective the date the facility receives a license at the proper level or the date the facility achieves substantial compliance with the federal participation requirements, whichever is the later date. The application shall be completed. For certification in the Title XVIII (Medicare) program, the Medicare fiscal intermediary must approve the application and the CMS must concur with the department's recommendation.

(7) The department shall conduct federal surveys in SNFs, NFs and ICF/MR facilities, utilizing regulations and procedures contained in—

(A) *The State Operations Manual* (SOM) (HCFA Publication 7);

(B) The Survey and Certification Regional letters received by the department from the CMS;

(C) For SNFs and NFs, federal regulation 42 CFR chapter IV, part 483, subpart B; and

(D) For ICF/MR facilities, federal regulation 42 CFR chapter IV, part 483, subpart I.

(8) A facility, in its application, shall designate the number of beds to be certified and their location in the facility. A facility can be wholly or partially certified. If partially certified, the beds shall be in a distinct part of the facility and all beds shall be contiguous.

(9) If a facility certified to participate in the Title XIX (Medicaid) or Title XVIII (Medicare) program elects to change the size of its distinct part, it must submit a written request to the Licensure/Certification Unit or the ICF/MR Unit of the department, as applicable. The request shall specify the room numbers involved, the number of beds in each room and the facility cost reporting year end date. The request must include a floor diagram of the facility and a signed DA-113 form, Bed Classification for Licensure and Certification by Category. A facility is allowed two (2) changes in the size of its distinct part during the facility cost reporting year. This may be two (2) increases or one (1) increase and one (1) decrease. It may not be two (2) decreases. The first change can be done only at the beginning of the facility cost reporting year and the second change can be done effective at the beginning of a facility cost reporting quarter within that facility cost reporting year. All requests must be submitted to the Licensure/Certification Unit or the ICF/MR Unit of the department at least forty-five (45) days in advance. Any facility wishing to eliminate its distinct part to go to full certification may do so effective at the beginning of the next facility cost reporting quarter with forty-five (45) days notice. The distinct part may be reestablished only at the beginning of the next facility cost reporting year. A facility may change the location of the distinct part with thirty (30) days notice to the Licensure/Certification Unit or the ICF/MR Unit of the department.

(10) If a facility certified to participate in the Title XIX (Medicaid) or Title XVIII (Medicare) program undergoes a change of operator, the new operator shall submit an application as specified in section (2) of this rule. The application shall be submitted within five (5) working days of the change of operator. For applications made for the Title XIX (Medicaid) program, the department shall provide the application to the Division of Medical Services of the Department of Social Services so that a provider agreement can be negotiated and signed. For applications made for the Title XVIII (Medicare) program, the department shall provide the application to the CMS. Certification status will be retained unless or until formally denied.

(11) If it is determined by the department that a facility certified to participate in Medicaid or Medicare does not comply with federal regulations at the time of a federal survey, complaint investigation or state licensure inspection, the department shall take enforcement action using the regulations and procedures contained in the following sources:

(A) 42 CFR chapter IV, part 431, subparts D, E and F;

(B) 42 CFR chapter IV, part 442;

(C) 42 U.S.C. Section 1395i–3;

(D) 42 U.S.C. Section 1396(r);

(E) Sections 198.026 and 198.067, RSMo; and

(F) 13 CSR 70-10.015 and 13 CSR 70-10.030.

(12) If a facility certified to participate in the Medicaid Title XIX program has been decertified as a result of noncompliance with the federal requirements, the facility can be readmitted to the Medicaid program by submitting an application for initial participation in the Medicaid program. After having received the application, the department shall conduct

a survey at the earliest possible date to determine if the facility is in substantial compliance with all federal participation requirements. The effective date of participation will be the date the facility is found to substantially comply with all federal requirements.

(13) If a change in the administrator or the director of nursing of a facility occurs, the facility shall provide written notice to the department's SLTC central office licensure unit within ten (10) calendar days of the change. The notice shall show the effective date of the change, the identity of the new director of nursing or administrator and a copy of his or her license or the license number. Change of administrator information shall be submitted as a notarized statement by the operator in accordance with section 198.018, RSMo.

(14) An NF may request a waiver of nurse staffing requirements to the extent the facility is unable to meet the requirements including the areas of twenty-four (24)-hour licensed nurse coverage, the use of a registered nurse for eight (8) consecutive hours seven (7) days per week and the use of a registered nurse as director of nursing.

(A) Requests for waivers shall be made in writing to the director of the Section for Long Term Care.

(B) Requests for waivers will be considered only from facilities licensed under Chapter 198, RSMo as ICFs which do not have a nursing pool agency that is within fifty (50) miles, within state boundaries, and which can supply the needed nursing personnel.

(C) The department shall consider each request for a waiver and shall approve or disapprove the request in writing postmarked within thirty (30) working days of receipt or, if additional information is needed, shall request from the facility the additional information or documentation within ten (10) working days of receipt of the request.

(D) Approval of a nurse waiver request shall be based on an evaluation of whether the facility has been unable, despite diligent efforts—including offering wages at the community prevailing rate for nursing facilities—to recruit the necessary personnel. Diligent effort shall mean prominently advertising for the necessary nursing personnel in a variety of local and out-of-the-area publications, including newspapers and journals within a fifty (50)-mile radius, and which are within state boundaries; contacts with nursing schools in the area; and participation in job fairs. The operator shall submit evidence of the diligent effort including:

1. Copies of newspapers and journal advertisements, correspondence with nursing schools and vocational programs, and any other relevant material;

2. If there is a nursing pool agency within fifty (50) miles which is within state boundaries and the agency cannot consistently supply the necessary personnel on a per diem basis to the facility, the operator shall submit a letter from the agency so stating;

3. Copies of current staffing patterns including the number and type of nursing staff on each shift and the qualifications of licensed nurses;

4. A current Resident Census and Condition of Residents, Form CMS-672 (10/98), incorporated by reference in this rule and available through the Centers for Medicare and Medicaid website: http://www.cms.hhs.gov/forms/, or by mail at: Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244-1850. This rule does not incorporate any subsequent amendments or additions;

5. Evidence that the facility has a registered nurse consultant required under 19 CSR 30-85.042 and evidence that the facility has made arrangements to assure registered nurse involvement in the coordination of the assessment process as required under 42 CFR 483.20(3);

6. Location of the nurses' stations and any other pertinent physical feature information the facility chooses to provide;

7. Any other information deemed important by the facility including personnel procedures, promotions, staff orientation and evaluation, scheduling practices, benefit programs, utilization of supplemental agency personnel, physician-nurse collaboration, support services to nursing personnel and the like; and

8. For renewal requests, the information supplied shall show diligent efforts to recruit appropriate personnel throughout the prior waiver period. Updates of prior submitted information in other areas are acceptable.

(E) In order to meet the conditions specified in federal regulation 42 CFR 483.30, the following shall be considered in granting approval:

1. There is assurance that a registered nurse or physician is available to respond immediately to telephone calls from the facility for periods of time in which licensed nursing services are not available;

2. There is assurance that if a facility requesting a waiver has or admits after receiving a waiver any acutely ill or unstable residents requiring skilled nursing care, the skilled care shall be provided in accordance with state licensure rule 19 CSR 30-85.042; and

3. The facility has not received a Class I notice of noncompliance in resident care within one hundred twenty (120) days of the waiver request or the department has not conducted an extended survey in the facility within one (1) year of the waiver request. Any facility which receives a Class I notice of noncompliance in resident care or an extended survey while under waiver status will not have the waiver renewed unless the problem has been corrected and steps have been taken to prevent recurrence. If a facility received more than one (1) Class I notice of noncompliance in resident care during a waiver period, the department will consider revocation of the waiver.

(F) The facility shall cooperate with the department in providing the proper documentation. For renewal requests, the request and proper documentation shall be submitted to the department at least forty-five (45) days prior to the ending date of the current waiver period. If any changes occur during a waiver period that affect the status of the waiver, a letter shall be submitted to the deputy director of institutional services within ten (10) days of the changes. The request for a waiver or renewal of a waiver shall be denied if the facility fails to abide by these previously mentioned time frames.

(G) If a waiver request is denied, the department shall notify the facility in writing and within twenty (20) days, the facility shall submit to the department a written plan for how the facility will recruit the required personnel. If appropriate personnel are not hired within two (2) months, the department shall initiate enforcement proceedings.

AUTHORITY: section 660.050 RSMo 2005. This rule originally filed as 13 CSR 15-9.010. Emergency rule filed Sept. 18, 1990, effective Oct. 1, 1990, expired Jan. 25, 1991. Original rule filed Nov. 2, 1990, effective June 10, 1991. Amended: Filed June 3, 1993, effective Dec. 9, 1993. Amended: Filed Feb. 1, 1995, effective Sept. 30, 1995. Amended: Filed May 11, 1998, effective Nov. 30, 1998. Amended: Filed Nov. 27, 2000, effective July 30, 2001. Emergency amendment filed July 13, 2001, effective July 30, 2001, expired Feb. 28, 2002. Moved to 19 CSR 30-81.010, effective Aug. 28, 2001. Amended: Filed July 13, 2001, effective Feb. 28, 2002. Amended: Filed Nov. 1, 2005, effective April 30, 2006.*

**Original authority: 660.050, RSMo 1984, amended 1988, 1992, 1993, 1994, 1995, 2001.*

19 CSR 30-81.015 Resident Assessment Instrument
(Rescinded September 30, 2012)

AUTHORITY: section 536.021, RSMo Supp. 1993. This rule originally filed as 13 CSR 15-9.015. Emergency rule filed Dec. 18, 1990, effective Dec. 31, 1990, expired April 29, 1991. Emergency rule filed May 7, 1991, effective May 17, 1991, expired Sept. 13, 1991. Original rule filed Dec. 18, 1990, effective June 10, 1991. Emergency amendment filed June 16, 1992, effective Aug. 1, 1992, expired Nov. 28, 1992. Amended: Filed June 16, 1992, effective Feb. 26, 1993. Emergency amendment filed May 14, 1993, effective June 1, 1993, expired Sept. 28, 1993. Emergency amendment filed July 14, 1993, effective July 25, 1993, expired Nov. 21, 1993. Amended: Filed May 14, 1993, effective Dec. 9, 1993. Moved to 19 CSR 30-81.015, effective Aug. 28, 2001. Rescinded: Filed March 1, 2012, effective Sept. 30, 2012.

19 CSR 30-81.020 Prelong-Term Care Screening
(Rescinded February 28, 2006)

AUTHORITY: sections 207.020 and 208.159, RSMo 1986 and 208.153, RSMo Supp. 1991. This rule was previously filed as 13 CSR 40-81.086 and 13 CSR 15-9.020. Emergency rule filed March 14, 1984, effective April 12, 1984, expired Aug. 8, 1984. Original rule filed March 14, 1984, effective Aug. 9, 1984. Amended: Filed Aug. 3, 1992, effective May 6, 1993. Moved to 19 CSR 30-81.020, effective Aug. 28, 2001. Rescinded: Filed Aug. 12. 2005, effective Feb. 28, 2006.*

19 CSR 30-81.030 Evaluation and Assessment Measures for Title XIX Recipients and Applicants

PURPOSE: This rule sets the requirements for the periodic evaluation and assessments of residents in long-term care facilities in relationship to evaluation and assessment processes, level-of-care needed by individuals, and appropriate placement of individuals in order to receive this care. The rule also includes the algorithm utilized for the department's Home and Community Based Services program for its level of care determination.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) For purposes of this rule only, the following definitions shall apply:

(A) Applicant—any resident or prospective resident of a certified long-term care facility who is seeking to receive inpatient Title XIX assistance;

(B) Certified long-term care facility—any long-term care facility which has been approved to participate in the inpatient program and receives Title XIX funding for eligible recipients;

(C) Initial assessment forms—the forms utilized to collect information necessary for a level-of-care determination pursuant to 19 CSR 30-81.030 and designated Forms DHSS-DRL-109 (10-20), Nursing Facility Level of Care Assessment and DHSS-DRL-110 (10-20), Level One Nursing Facility Pre-Admission Screening for Mental Illness/Intellectual Disability or Related Condition, included herein;

(D) Inpatient Title XIX assistance—Title XIX payments for intermediate or skilled nursing care in a certified long-term care facility;

(E) Level-of-care assessment—the determination of level-of-care need based on an assessed point count value for each category cited in subsection (4)(B) of this rule;

(F) Level-of-care determination—the decision whether an individual qualifies for long-term care facility care;

(G) Long-term care facility—a skilled nursing facility (SNF), an intermediate care facility (ICF), or a hospital which provides skilled nursing care or intermediate nursing care in a distinct part or swing bed under Chapter 197, RSMo;

(H) Recipient—any resident in a certified long-term care facility who is receiving inpatient Title XIX assistance;

(I) Reevaluation of level-of-care—the periodic assessment of the recipients' continued eligibility and need for continuation at the previously assigned level-of-care. Periodic assessment includes but is not limited to the following:

1. Assessment of new admissions to a long-term care facility;

2. Assessment of a change in mental and/or physical status for a resident who is being readmitted to a long-term care facility after transfer to an acute care facility, and the previous DHSS-DRL-109 (10-20), Nursing Facility Level of Care Assessment or DHSS-DRL-110 (10-20), Level One Nursing Facility Pre-Admission Screening for Mental Illness/Intellectual Disability or Related Condition forms do not reflect the resident's current care needs; and

3. Assessment of DHSS-DRL-109 (10-20), Nursing Facility Level of Care Assessment or DHSS-DRL-110 (10-20), Level One Nursing Facility Pre-Admission Screening for Mental Illness/Intellectual Disability or Related Condition forms as requested by Department of Social Services, Family Support Division;

(J) Resident—a person seventeen (17) years or older who by reason of aging, illness, disease, or physical or mental infirmity receives or requires care and services furnished by a long-term care facility and who resides in, is cared for, treated or accommodated in such long-term care facility for a period exceeding twenty-four (24) consecutive hours; and

(K) The department—Department of Health and Senior Services.

(2) Initial Level-of-Care Determination Requirements.

(A) In accordance with 42 CFR sections 456.370 and 483.104, the department or its designated agents, or both, will conduct a review and assessment of the evaluations made by the attending physician for an applicant in or seeking admission to a long-term care facility. The review and assessment shall be conducted using the criteria in section (5) of this rule.

(B) The initial level-of-care determination shall be completed for the following:

1. All applicants prior to or on admission to a long-term care facility; and

2. When an applicant or recipient has been discharged from a long-term care facility for more than sixty (60) days.

(C) A referring individual shall fill out and submit electronically using the department's online database system available at: https://health.mo.gov/seniors/nursinghomes/pasrr.php. the required documentation contained in forms DHSS-DRL-109 (10-20), Nursing Facility Level of Care Assessment and DHSS-DRL-110 (10-20), Level One Nursing Facility Pre-Admission Screening for Mental Illness/Intellectual Disability or Related Condition.

(D) The department shall complete the assessment within ten (10) working days of receipt of all documentation required by section (5) of this rule unless further evaluation by the State Mental Health Authority is required by 42 CFR 483.100 to 483.138.

(E) The department shall provide written

notice to the individual or referring entity if Level II screening is referred to the Department of Mental Health. The referring entity shall notify the applicant or recipient of the results of the screening.

(3) Level-of-Care Reevaluation Requirements.

(A) The level-of-care reevaluation is applicable for recipients who are eligible for placement in a long-term care facility. The level-of-care reevaluation shall be completed for the following:

1. When a significant change has occurred in the resident's physical, mental, or psychosocial status for a resident diagnosed with mental illness and/or intellectual disability or related condition; or

2. As requested by Department of Social Services, Family Support Division or the Department of Mental Health.

(B) A referring individual shall fill out and submit electronically using the department's online database system available at: https://health.mo.gov/seniors/nursinghomes/pasrr.php. the required documentation contained in forms DHSS-DRL-109 (10-20), Nursing Facility Level of Care Assessment and DHSS-DRL-110 (10-20), Level One Nursing Facility Pre-Admission Screening for Mental Illness/Intellectual Disability or Related Condition.

(C) The department shall provide written notice to the individual or referring entity if Level II screening is referred to the Department of Mental Health. The referring entity shall notify the applicant or recipient of the results of the screening.

(4) Level-of-Care Criteria for Long-Term Care Facility Care—Qualified Title XIX Recipients and Applicants.

(A) Individuals will be assessed with the ultimate goal to achieve placement for these individuals in the least restrictive environment possible, yet enable them to receive all services required by their physical/mental condition.

(B) The specific areas which will be considered when determining an individual's ability or inability to function in the least restrictive environment are—behavioral, cognition, mobility, eating, toileting, bathing, dressing and grooming, rehabilitative services, treatments, meal preparation, medication management, and safety.

(C) To qualify for intermediate or skilled nursing care, an applicant or recipient shall exhibit physical impairment, which may be complicated by mental impairment or mental impairment which may be complicated by physical impairment, severe enough to require intermediate or skilled nursing care.

(5) Assessed Needs Point Designations Requirements.

(A) Applicants or recipients will be assessed for level-of-care by the assignment of a point count value for each category cited in subsection (4)(B) of this rule.

(B) Points will be assessed for the amount of assistance required, the complexity of the care, and the professional level of assistance necessary, based on the level-of-care criteria.

(C) For individuals seeking admission to a long-term care facility on or after July 15, 2021, the applicant or recipient will be determined as eligible for Title XIX-funded long-term care services if he or she is determined to need care with an assessed point level of eighteen (18) points or above, using the assessment procedure as required in this rule.

(D) For individuals seeking admission to a long-term care facility on or after July 15, 2021, an applicant with less than eighteen (18) points will be determined as ineligible for Title XIX-funded long-term care services, unless the applicant qualifies as otherwise provided in subsection (5)(E) of the rule.

(E) An applicant or recipient will be considered eligible for inpatient Title XIX assistance regardless of the total point count if the applicant or recipient is unable to meet physical/mental requirements for residential care facility (RCF) and assisted living facility (ALF) residency as specified by section 198.073, RSMo. In order to determine if an applicant or recipient is unable to meet RCF and ALF residency, the following criteria shall be applied:

1. For RCF residency an applicant or recipient shall be physically and mentally capable of negotiating a normal path to safety. In order to meet this requirement, an applicant or recipient, without staff assistance, must be able to reach and go through a required exit door to the outside building by—

A. Responding to verbal direction or the sound of an alarm;

B. Being prepared to leave the facility within five (5) minutes of being alerted of the need to evacuate;

C. If using a wheelchair, the resident shall be able to transfer into the wheelchair and propel it or reach the assistive device, and open all doors without staff assistance; and

D. If using another assistive device, such as a walker or cane, they shall be able to reach and utilize the assistive device without staff assistance.

2. For ALF residency, the applicant or recipient cannot be admitted or retained if they meet the following criteria:

A. Exhibit behaviors that present a reasonable likelihood of serious harm to himself or herself or others;

B. Require physical restraints;

C. Require chemical restraints;

D. Require skilled nursing services as defined in subsection 198.073.4, RSMo for which the facility is not licensed or able to provide;

E. Require more than one (1) person to simultaneously physically assist the resident with any activity of daily living, with the exception of bathing and transferring; or

F. Is bedbound or similarly immobilized due to a debilitating or chronic condition.

(F) Points will be assigned to each category, as required by subsection (4)(B) of this rule, in multiples of three (3) according to the following requirements:

1. Behavioral is defined as the applicant or recipient's repeated behavioral challenges that affect their ability to function in the community. The applicants or recipients who exhibit uncontrolled behavior that is dangerous to themselves or others must be transferred immediately to an appropriate facility. Determine if the applicant or recipient: receives monitoring for a mental condition, exhibits one (1) of the following mood or behavior symptoms: wandering, physical abuse, socially inappropriate or disruptive behavior, inappropriate public sexual behavior or public disrobing, resists care or exhibits one (1) of the following psychiatric conditions: abnormal thoughts, delusions, hallucinations. The applicant or recipient can receive up to nine (9) points in this category. The applicant or recipient will receive—

A. Zero (0) points if assessed with a stable mental condition and no mood or behavior symptoms observed and no reported psychiatric conditions;

B. Three (3) points if assessed with a stable mental condition monitored by a physician or licensed mental health professional at least monthly or behavior symptoms exhibited in the past, but not currently present or psychiatric conditions exhibited in the past, but not recently present;

C. Six (6) points if assessed with an unstable mental condition monitored by a physician or licensed mental health professional at least monthly, or behavior symptoms are currently exhibited, or psychiatric conditions are recently exhibited; or

D. Nine (9) points if assessed with an unstable mental condition monitored by a physician or licensed mental health professional at least monthly and behavior symptoms are currently exhibited or psychiatric conditions are currently exhibited.

2. Cognition is defined as the applicant

or recipient's performance in remembering, making decisions, organizing daily self-care activities, as well as understanding others and making self- understood. Determine if the applicant or recipient has an issue in one (1) or more of the following areas: cognitive skills for daily decision making, memory or recall ability (short-term, procedural, situational memory), disorganized thinking/awareness, mental function varies over the course of the day, or ability to understand others or to be understood. The applicant or recipient can receive up to eighteen (18) points in this category. The applicants or recipients with "no discernable consciousness, coma" are presumed to meet nursing facility level of care. The applicant or recipient will receive—

A. Zero (0) points if assessed with no issues with cognition and no issues with memory, mental function, or ability to be understood or to understand others;

B. Three (3) points if assessed as displaying difficulty making decisions in new situations or occasionally requires supervision in decision making and has issues with memory, mental function, or ability to be understood or to understand others;

C. Six (6) points if assessed as displaying consistent unsafe or poor decision making requiring reminders, cues, or supervision at all times to plan, organize, and conduct daily routines, and has issues with memory, mental function, or ability to be understood or understand others; or

D. Nine (9) points if assessed as rarely or never has the capability to make decisions or displaying consistent unsafe or poor decision making or requires total supervision requiring reminders, cues, or supervision at all times to plan, organize, and conduct daily routines, and rarely or never understood by or able to understand others.

3. Mobility is defined as the amount of assistance needed by the applicant or recipient to move from one (1) place or position to another. Determine the applicant or recipient's primary mode of locomotion and the amount of assistance the applicant or recipient needs with: locomotion—how one moves walking or wheeling, if wheeling how much assistance is needed once in the chair, or bed mobility—transition from lying to sitting, turning, etc. The applicant or recipient can receive up to eighteen (18) points in this category. The applicants or recipients who score in the "totally dependent on others to move or those that are bedbound" are presumed to meet nursing facility level of care. The applicant or recipient will receive—

A. Zero (0) points if assessed as independently mobile, in that the applicant or recipient requires no assistance for transfers or mobility or only has set up or supervision needed;

B. Three (3) points if assessed as requiring limited or moderate assistance, in that the applicant or recipient performs more than fifty percent (50%) of tasks independently; or

C. Six (6) points if assessed as requiring maximum assistance, in that the applicant or recipient needs assistance from two (2) or more individuals or more than fifty percent (50%) weight-bearing assistance or totally dependent for bed mobility.

4. Eating is defined as the amount of assistance needed by applicant or recipient to eat and drink, including special nutritional requirements or a specialized mode of nutrition. Determine the amount of assistance the applicant or recipient needs with eating and drinking. Includes intake of nourishment by other means [e.g. tube feeding or total parenteral nutrition (TPN)]. Determine if the participant requires a physician ordered therapeutic diet. The applicant or recipient can receive up to eighteen (18) points in this category. The applicants or recipients "totally dependent on others to eat" are presumed to meet nursing facility level of care. The applicant or recipient will receive—

A. Zero (0) points if assessed as independent in dietary needs, in that the applicant or recipient requires no assistance to eat and has no physician ordered diet;

B. Three (3) points if assessed as requiring minimum assistance, in that the applicant or recipient requires physician ordered therapeutic diet, or set up, supervision, or limited assistance is needed with eating;

C. Six (6) points if assessed as requiring moderate assistance with eating, in that the applicant or recipient performs more than fifty percent (50%) of tasks independently; or

D. Nine (9) points if assessed as requiring maximum assistance with eating, in that the applicant or recipient requires an individual to perform more than fifty percent (50%) for assistance.

5. Toileting is defined as the amount of assistance needed by the applicant or recipient to complete all tasks related to toileting including the actual use of the toilet room (or commode, bedpan, urinal), transferring on/off the toilet, cleansing self, adjusting clothes, managing catheters/ostomies, and managing incontinence episodes. The applicant or recipient can receive up to nine (9) points in this category. The applicant or recipient will receive—

A. Zero (0) points if assessed as requiring no assistance, or requires only set up or supervision needed;

B. Three (3) points if assessed as requiring limited or moderate assistance, in that applicant or recipient performs more than fifty percent (50%) of tasks independently;

C. Six (6) points if assessed as requiring maximum assistance, in that applicant or recipient needs two (2) or more individuals, or more than fifty percent (50%) weight-bearing assistance; or

D. Nine (9) points if assessed as requiring total dependence on others.

6. Bathing is defined as the amount of assistance needed by the applicant or recipient to complete a full body shower or bath. Determine the amount of assistance the applicant or recipient needs with bathing. Bathing includes: taking a full body bath/shower and the transferring in and out of the bath/shower. The applicant or recipient can receive up to six (6) points in this category. The applicant or recipient will receive—

A. Zero (0) points if assessed as no assistance required, or requiring only set up or supervision needed;

B. Three (3) points if assessed as requiring limited or moderate assistance, in that applicant or recipient performs more than fifty percent (50%) of tasks independently; or

C. Six (6) points if assessed as requiring maximum assistance, in that the applicant or recipient requires two (2) or more individuals, more than fifty percent (50%) weight-bearing assistance, or total dependence on others.

7. Dressing and grooming is defined as the amount of assistance needed by the applicant or recipient to dress, undress, and complete daily grooming tasks. Dressing may also include specialized devices such as prosthetics, orthotics, etc. The applicant or recipient can receive up to six (6) points in this category. The applicant or recipient will receive—

A. Zero (0) points if assessed as requiring no assistance, or requiring only set up or supervision needed;

B. Three (3) points if assessed as requiring limited or moderate assistance, in that applicant or recipient performs more than fifty percent (50%) of tasks independently; or

C. Six (6) points if assessed as requiring maximum assistance, in that applicant or recipient requires two (2) or more individuals, more than fifty percent (50%) of weight-bearing assistance, or total dependence on others.

8. Rehabilitative services is defined as the restoration of a former or normal state of health through medically-ordered therapeutic

services either directly provided by or under the supervision of a licensed qualified professional. Rehabilitative services include physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and audiology. If ordered by the physician, each resident must have an individually planned and implemented program with written goals and response/progress documented. Points will be determined by intensity of required services and the applicant's or recipient's potential for rehabilitation as determined by the rehabilitation evaluation. The applicant or recipient will receive—

A. Zero (0) points if assessed as requiring no ordered rehabilitative services;

B. Three (3) points, if assessed as requiring minimal-ordered rehabilitative services of one (1) time per week;

C. Six (6) points if assessed as requiring moderate-ordered rehabilitative services of two (2) or three (3) times per week; or

D. Nine (9) points if assessed as requiring maximum-ordered rehabilitative services of four (4) times per week or more.

9. Treatments are defined as a physician ordered medical care or management that requires additional hands on assistance. The scoring for treatments will be zero (0) or six (6). The applicant or recipient with the identified treatments will receive six (6) points. The applicant or recipient will receive—

A. Zero (0) points if no treatments are ordered by the physician; or

B. Six (6) points if assessed as requiring one (1) or more of the physician ordered treatments requiring daily attention by a licensed professional. These treatments could include: catheter/ostomy care, alternate modes of nutrition (tube feeding or TPN), suctioning, ventilator/respirator, and wound care (skin must be broken).

10. Meal preparation is defined as the amount of assistance needed to prepare a meal based on the applicant's or recipient's capacity to complete the task. This includes planning, assembling ingredients, cooking, and setting out the food and utensils. The applicant or recipient can receive up to six (6) points in this category. The applicant or recipient will receive—

A. Zero (0) points if assessed as requiring no assistance, or requiring only set up or supervision needed;

B. Three (3) points if assessed as requiring limited or moderate assistance, in that applicant or recipient performs more than fifty percent (50%) of tasks; or

C. Six (6) points if assessed as requiring maximum assistance in that the individual performs more than fifty percent (50%) of tasks for the applicant or recipient, or requires total dependence on others.

11. Medication management is defined as the amount of assistance needed by the applicant or recipient to safely manage their medication regimen. Assistance may be needed due to a physical or mental disability. Determine the amount of assistance the applicant or recipient needs to safely manage their medications. The applicant or recipient can receive up to six (6) points in this category. The applicant or recipient will receive—

A. Zero (0) points if assessed as requiring no assistance;

B. Three (3) points if assessed as requiring setup help needed or supervision needed, or requires limited or moderate assistance, in that applicant or recipient performs more than fifty percent (50%) of tasks; or

C. Six (6) points if assessed as requiring maximum assistance, in that the individual performs more than fifty percent (50%) of tasks for the applicant or recipient, or requires total dependence on others.

12. Safety is defined as the identification of a safety risk associated with vision impairment, falling, problems with balance, past institutionalization, and age. Determine if the applicant or recipient exhibits any of the following risk factors: vision impairment, falling, or problems with balance - balance is moving to standing position, turning to face the opposite direction, dizziness, or unsteady gait. The applicant or recipient can receive up to eighteen (18) points in this category. After determination of a preliminary score, institutionalization and age will be considered to determine the final score. Three (3) points can be added to the accumulated score if the applicant or recipient is aged seventy-five (75) years or older and/or has been institutionalized in the last five (5) years in a long-term care facility, mental health residence, psychiatric hospital, inpatient substance abuse, or settings for persons with intellectual disabilities and only to the specified points category listed. The applicants or recipients who score eighteen (18) points are presumed to meet nursing facility level of care. The applicant or recipient will receive—

A. Zero (0) points if assessed with no difficulty or some difficulty with vision, and no falls in the last ninety (90) days, and no recent problems with balance;

B. Three (3) points if assessed with severe difficulty with vision (sees only lights and shapes), or has fallen in the last ninety (90) days, or has current problems with balance, or has a preliminary score of zero (0) and is aged seventy-five (75) years or older or has been institutionalized;

C. Six (6) points if assessed with no vision or has fallen in the last ninety (90) days and has current problems with balance, or assessed with a preliminary score of zero (0) and is aged seventy-five (75) years or older and has been institutionalized, or assessed with a preliminary score of three (3) points and is aged seventy-five (75) years or older or has been institutionalized;

D. Nine (9) points if assessed with a preliminary score of six (6) points and has been institutionalized; or

E. Eighteen (18) points if assessed with a preliminary score of six (6) points and is aged seventy-five (75) years or older or assessed with a preliminary score of three (3) points and is aged seventy-five (75) years or older and has been institutionalized.

(6) Level of Care Determination for Home and Community Based Services Program. The department uses level of care determination for Home and Community Based Services (HCBS). The department utilizes the InterRAI Home Care Assessment System (HC), © InterRAI. Questions are scored within the InterRAI assessment using an algorithm, included herein. The HCBS assessment process is outlined in 19 CSR 15-7.021, 19 CSR 15-8.200, and 13 CSR 70-91.010.

STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES

NURSING FACILITY LEVEL OF CARE ASSESSMENT

All questions on this form must be answered- write N/A if not applicable. Blank areas will result in return of document and delay in payment.

SECTION A.	INDIVIDUAL'S IDENTIFYING INFORMATION
NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX)	DATE OF BIRTH:
DCN (MEDICAID NUMBER):	SSN NUMBER:
RACE:	GENDER:

SECTION B.	CURRENT LOCATION/PROPOSED PLACEMENT
REASON FOR SUBMITTING APPLICATION:	
INDIVIDUAL'S CURRENT PHYSICAL LOCATION:	
NAME OF PROPOSED SKILLED NURSING FACILITY:	FACILITY ID NUMBER:
ADMIT DATE TO NF:	DISCHARGE DATE FROM NF:

SECTION C. **RECENT MEDICAL INCIDENTS (I.E., CVA, SURGERY, FRACTURE, HEAD INJURY, ETC., AND GIVE DATES)**

INDICATE THE DIAGNOSES RELEVANT TO APPLICANT'S FUNCTIONAL AND/OR SKILLED NURSING NEEDS

☐ See Attached

SECTION D. **ASSESSED NEEDS**

BEHAVIORAL:
- Determine if the applicant or recipient:
  - Receives monitoring for mental condition
  - Exhibits one of the following mood or behavior symptoms - wandering, physical abuse, socially inappropriate or disruptive behavior, inappropriate public sexual behavior or public disrobing; resists care
  - Exhibits one of the following psychiatric conditions - abnormal thoughts, delusions, hallucinations

Date of the last consult completed by a physician or licensed mental health professional:

Behavioral Symptoms (Check one box for each)

None	Min	Mod	Max	
☐	☐	☐	☐	Withdrawn/Depressed
☐	☐	☐	☐	Suspicious/Paranoid
☐	☐	☐	☐	Wanders
☐	☐	☐	☐	Hallucinations/Delusions
☐	☐	☐	☐	Abnormal Thought Process
☐	☐	☐	☐	Aggressive (Physical/Verbal)
☐	☐	☐	☐	Suicidal/Homicidal Ideation
☐	☐	☐	☐	Restraints
☐	☐	☐	☐	Sexually Inappropriate
☐	☐	☐	☐	Controlled with Medications

COMMENT:

◯ 0 pts	Stable mental condition **AND** no mood or behavior symptoms observed **AND** no reported psychiatric conditions
◯ 3 pts	Stable mental condition monitored by a physician or licensed mental health professional at least monthly **OR** behavior symptoms exhibited in past, but not currently present **OR** psychiatric conditions exhibited in past, but not recently present
◯ 6 pts	Unstable mental condition monitored by a physician or licensed mental health professional at least monthly **OR** behavior symptoms are currently exhibited **OR** psychiatric conditions are recently exhibited
◯ 9 pts	Unstable mental condition monitored by a physician or licensed mental health professional at least monthly **AND** behavior symptoms are currently exhibited **OR** psychiatric conditions are currently exhibited

	COGNITION: • Determine if the applicant or recipient has an issues in one or more of the following areas: • Cognitive skills for daily decision making • Memory or recall ability (short-term, procedural, situational memory) • Disorganized thinking/awareness - mental function varies over the course of the day • Ability to understand others or to be understood

ORIENTATION: ☐ Person ☐ Place ☐ Time ☐ Situation	MEMORY:
LEVEL OF SUPERVISION:	ABILITY TO MAKE A PATH TO SAFETY: ☐ No ☐ Yes
HEARING IMPAIRMENT: ☐ No ☐ Yes	SPEECH IMPAIRMENT: ☐ No ☐ Yes
COMMENT:	

◯ 0 pts	No issues with cognition **AND** no issues with memory, mental function, or ability to be understood/understand others
◯ 3 pts	Displays difficulty making decisions in new situations or occasionally requires supervision in decision making **AND** has issues with memory, mental function, or ability to be understood/understand others
◯ 6 pts	Displays consistent unsafe/poor decision making requiring reminders, cues or supervision at all times to plan, organize and conduct daily routines **AND** has issues with memory, mental function, or ability to be understood/understand others
◯ 9 pts	Rarely or never has the capability to make decisions **OR** displays consistent unsafe/poor decision making or requires total supervision requiring reminders, cues or supervision at all times to plan, organize and conduct daily routines **AND** rarely or never understood/able to understand others
◯ 18 pts	TRIGGER: No discernible consciousness, coma

	MOBILITY: • Determine the applicant or recipient's primary mode of locomotion • Determine the amount of assistance the applicant or recipient needs with: • Locomotion - how moves walking or wheeling, if wheeling how much assistance is needed once in the chair • Bed Mobility - transition from lying to sitting, turning, etc.

COMMENT:

◯ 0 pts	No assistance needed **OR** only set up or supervision needed
◯ 3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
◯ 6 pts	Maximum assistance needed, i.e. applicant or recipient needs two (2) or more individuals or more than 50% weight-bearing assistance **OR** total dependent for bed mobility
◯ 18 pts	TRIGGER: Applicant or recipient is bedbound **OR** totally dependent on the others for locomotion

	EATING: • Determine the amount of assistance the applicant or recipient needs with eating and drinking. Includes intake of nourishment by other means (e.g. tube feeding or total parenteral nutrition (TPN). • Determine if the participant requires a physician ordered therapeutic diet.

DIET ORDERED BY PHYSICIAN:
COMMENT:

◯ 0 pts	No assistance needed **AND** no physician ordered diet
◯ 3 pts	Physician ordered therapeutic diet **OR** set up, supervision, or limited assistance needed with eating
◯ 6 pts	Moderate assistance needed with eating, i.e. applicant or recipient performs more than 50% of the task independently
◯ 9 pts	Maximum assistance needed with eating, i.e. applicant or recipient requires an individual to perform more than 50% for assistance
◯ 18 pts	TRIGGER: Totally dependent on others

	TOILETING: • Determine the amount of assistance the applicant or recipient needs with toileting. Toileting includes: the actual use of the toilet room (or commode, bedpan, or urinal), transferring on/off the toilet, cleansing self, adjusting clothes, managing catheters/ ostomies, and managing incontinence episodes.

COMMENT:

◯ 0 pts	No assistance needed **OR** only set up or supervision needed
◯ 3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
◯ 6 pts	Maximum assistance needed, i.e. applicant or recipient needs two (2) or more individuals, or more than 50% of weight-bearing assistance
◯ 9 pts	Total dependence on others

	BATHING: • Determine the amount of assistance the applicant or recipient needs with bathing. Bathing includes: taking a full body bath/shower and the transferring in and out of the bath/shower.
COMMENT:	
◯ 0 pts	No assistance needed **OR** only set up or supervision needed
◯ 3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
◯ 6 pts	Maximum assistance, i.e. applicant or recipient requires two (2) or more individuals, more than 50% of weight-bearing assistance **OR** total dependence on others
	DRESSING AND GROOMING: • Determine the amount of assistance needed by the applicant or recipient to dress, undress and complete daily grooming tasks
COMMENT:	
◯ 0 pts	No assistance needed **OR** only set up or supervision needed
◯ 3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
◯ 6 pts	Maximum assistance, i.e. applicant or recipient requires two (2) or more individuals, more than 50% of weight-bearing assistance **OR** total dependence on others
	REHABILITATIVE SERVICES: • Determine if the applicant or recipient has the following medically ordered rehabilitative services: Physical therapy/Occupational therapy/Speech therapy/Cardiac rehabilitation/Audiology.
TYPE OF PHYSICIAN-ORDERED REHABILITATIVE SERVICES AND FREQUENCY:	
COMMENT:	
◯ 0 pts	None of the above therapies ordered
◯ 3 pts	Any of the above therapies ordered 1 time per week
◯ 6 pts	Any of the above therapies ordered 2-3 times per week
◯ 9 pts	Any of the above therapies ordered 4 or more times per week
	TREATMENTS: • Determine if the applicant or recipient requires any of the following treatments: • Catheter/Ostomy care • Alternate modes of nutrition (tube feeding, TPN) • Suctioning • Ventilator/respirator • Wound care (skin must be broken)
TYPE OF PHYSICIAN-ORDERED TREATMENT/COMMENT:	
◯ 0 pts	None of the above treatments were ordered by the physician
◯ 6 pts	One or more of the above treatments was ordered by the physician requiring daily attention by a license professional
	MEAL PREPARATION: • Determine the amount of assistance the applicant or recipient needs to prepare a meal. This includes planning, assembling ingredients, cooking, and setting out the food and utensils.
COMMENT:	
◯ 0 pts	No assistance needed **OR** only set up or supervision needed
◯ 3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks
◯ 6 pts	Maximum assistance, i.e. an individual performs more than 50% of tasks for the applicant or recipient **OR** total dependence on others
	MEDICATION MANAGEMENT: • Determine the amount of assistance the applicant or recipient needs to safely manage their medications. Assistance may be needed due to a physical or mental disability.
COMMENT:	
◯ 0 pts	No assistance needed
◯ 3 pts	Set up help needed **OR** supervision needed **OR** limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks
◯ 6 pts	Maximum assistance needed, i.e. an individual performs more than 50% of tasks for the applicant or recipient **OR** total dependence on others

SAFETY:
- Determine if the individual exhibits any of the following risk factors:
  - Vision Impairment
  - Falling
  - Problems with balance. Balance is moving to standing position, turning to face the opposite direction, dizziness, or unsteady gait
- After determination of preliminary score, history of institutionalization and age will be considered to determine final score.
  - Institutionalization in the last 5 years - long-term care facility, mental health residence, psychiatric hospital, inpatient substance abuse, or settings for persons with intellectual disabilities.
  - Aged - 75 years and over.

DATE OF LAST FALL:	TYPE OF INSTITUTIONALIZATION:

TIMEFRAME OR DATE ADMITTED TO INSTITUTION:

COMMENT:

◯ 0 pts	No difficulty or some difficulty with vision **AND** no falls in last 90 days **AND** no recent problems with balance
◯ 3 pts	Severe difficulty with vision (sees only lights and shapes) **OR** has fallen in the last 90 days **OR** has current problems with balance **OR** preliminary score of 0 **AND** Age **OR** Institutionalization
◯ 6 pts	No vision **OR** has fallen in last 90 days **AND** has current problems with balance **OR** Preliminary score of 0 **AND** Age **AND** Institutionalization **OR** Preliminary score of 3 **AND** Age **OR** Institutionalization
◯ 9 pts	Preliminary score of 6 **AND** Institutionalization
◯ 18 pts	TRIGGER: Preliminary score of 6 **AND** Age **OR** Preliminary Score of 3 **AND** Age **AND** Institutionalization

SECTION E. REFERRING INDIVIDUAL COMPLETING APPLICATION

FIRST AND LAST NAME:

POSITION/TITLE:	TYPE OF ENTITY:		
NAME OF ENTITY:	TELEPHONE NUMBER:	EXT:	FAX NUMBER:
EMAIL ADDRESS:	DATE REFERRAL COMPLETED:		

CHECK IF SAME AS REFERRING INDIVIDUAL OR COMPLETE CONTACT PERSON IF LEVEL II SCREENING INDICATED: ☐	TELEPHONE NUMBER:	EXT:
EMAIL:	FAX NUMBER:	

Central Office Use Only (DRL/COMRU)

Level of Care Determination by DRL Central Office

MEETS LEVEL OF CARE ☐ Yes ☐ No

SIGNATURE	DATE

MO 580-3350 (12-2020)

DHSS-DRL-109 (10-20)

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR SERVICES AND REGULATION

LEVEL ONE NURSING FACILITY PRE-ADMISSION SCREENING FOR MENTAL ILLNESS/INTELLECTUAL DISABILITY OR RELATED CONDITION

SECTION A. INDIVIDUAL'S IDENTIFYING INFORMATION

NAME (LAST, FIRST, MIDDLE, INITIAL, SUFFIX)		DATE OF BIRTH
DCN (MEDICAID NUMBER)		SSN NUMBER
RACE	GENDER	
EDUCATION LEVEL		OCCUPATION

SECTION B. INDIVIDUAL'S CONTACT INFORMATION

PREVIOUS RESIDENCE TYPE		
STREET ADDRESS		
CITY	STATE	ZIP CODE

LEGAL GUARDIAN OR DESIGNATED CONTACT PERSON INFORMATION

☐ None ☐ Legal Guardian ☐ Designated Contact Person

RELATIONSHIP	FIRST NAME	LAST NAME
E-MAIL		
STREET ADDRESS		

CITY	STATE	ZIP	TELEPHONE

SECTION C. REFERRING INDIVIDUAL COMPLETING APPLICATION

FIRST NAME	LAST NAME
POSITION/TITLE	TYPE OF ENTITY
NAME OF ENTITY	PHONE NUMBER
EMAIL ADDRESS	FAX NUMBER

SECTION D. LEVEL ONE SCREENING CRITERIA FOR SERIOUS MENTAL ILLNESS

1. Does the individual show any signs or symptoms of a Major Mental Illness? ☐ Yes ☐ No

   Signs/Symptoms: _____

2. Does the individual have a current, suspected or history of a Major Mental Illness as defined by the Diagnostic & Statistical Manual of Mental Disorders (DSM) current edition? ☐ Yes ☐ No

☐ Schizophrenia	☐ Schizoaffective Disorder	☐ Bipolar Disorder
☐ Psychotic Disorder	☐ Major Depressive Disorder	☐ Obsessive-Compulsive Disorder
☐ Dysthymic Disorder	☐ Panic Disorder	☐ PTSD
☐ Conversion Disorder	☐ Personality Disorder	☐ Mood Disorder
☐ Somatic Symptom Disorder	☐ Dissociative Identity Disorder	☐ Anorexia Nervosa or other eating disorders
☐ Anxiety Disorder	☐ Delusional Disorder	

☐ Other Mental Disorder in the DSM: _____

3. Does the individual have any area of impairment due to serious mental illness? ☐ Yes ☐ No
(Record YES if any of the subcategories below are checked)

☐ None

☐ Interpersonal Functioning:
The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationship and social isolation.

☐ Adaptation to Change:
The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, self-injurious, self-mutilation, suicidal (ideation, gestures, threats or attempts), physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability or requires intervention by mental health or judicial system.

☐ Concentration/Persistence/and Pace:
The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors or requires assistance in the completion of these tasks.

4. Within the last 2 years has the individual: (Record YES if Either/Both of the two subcategories below are checked) ☐ Yes ☐ No

☐ Experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g. had inpatient psychiatric care; was referred to a mental health crisis/screening center; has attended partial care/hospitalization or has received Program of Assertive Community Treatment (PACT) or Integrated Case Management Services); and/or

☐ Due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community or intervention by housing or law enforcement officials?

Check yes, if treatment history for the past two years is unknown or treatment was unavailable but otherwise appropriate to consider individual positive for serious mental illness.

5. Does the individual have a substance related disorder?
☐ No ☐ Yes

Is the need for a skilled nursing facility placement associated with substance abuse?
☐ No ☐ Yes

When did the most recent substance abuse occur?
☐ N/A ☐ 1-30 days ☐ 31-90 days ☐ Unknown

6. Does the individual have a diagnosis of Major Neurocognitive Disorder (MNCD) i.e., dementia or Alzheimer's? ☐ Yes ☐ No

Were any of the following criteria used to establish the basis for the MNCD: ☐ N/A ☐ Yes ☐ No

Standardized Mental Status Exam (type)_____ Date Completed_____ Score _____

☐ Neurological Exam
☐ History and Symptoms
☐ Other Diagnostics: Specify_____

Has the Physician documented MNCD as the primary diagnosis OR that MNCD is more progressed than a co-occurring mental illness diagnosis? (Provide documentation if answered yes) ☐ N/A ☐ Yes ☐ No

SECTION E. LEVEL ONE SCREENING CRITERIA FOR INTELLECTUAL DISABILITY OR RELATED CONDITION

1. Is the individual known or suspected to have a diagnosis of Intellectual Disability that originated prior to age 18? ☐ Yes ☐ No

If Yes, indicated diagnosis: _____

2a. Does the individual have a suspected diagnosis or history of an Intellectual Disability/Related Condition? ☐ Yes ☐ No

☐ Autism
☐ Epilepsy/Seizure/Convulsions
☐ Down Syndrome
☐ Prader-Willi Syndrome
☐ Muscular Dystrophy
☐ Paraplegia
☐ Cerebral Palsy (CP)
☐ Head Injury/Traumatic Brain Injury (TBI)
☐ Spina Bifida
☐ Deaf or Blind
☐ Fetal Alcohol Syndrome
☐ Quadriplegia
☐ Other Related Conditions:_____

2b. Did the Other Related Condition develop before age 22? ☐ N/A ☐ Unknown ☐ Yes ☐ No

Age/Date: _____
(Please provide the date/age of onset for each Related Condition indicated)

2c. Likely to continue indefinitely? ☐ N/A ☐ Yes ☐ No

2d. Results in substantial functional limitation in three or more major life activities (Impacted prior to the age of 22)?

☐ No Functional Limitations ☐ Self-Care
☐ Capacity for Independent Living ☐ Mobility
☐ Learning ☐ Understanding and Use of Language
☐ Self-Direction

SECTION F. SPECIAL ADMISSION CATEGORIES

☐ **1 — Terminal Illness**

Expected to result in death in six months or less

Diagnosis: _____

Currently on Hospice: ☐ Yes (Provide hospice order) ☐ No

☐ **2 — Serious Physical Illness**

Severe/end stage disease (or physical condition)

Diagnosis: _____

☐ **3 — Respite Care**

Stays not more than thirty (30) days to provide relief for in-home caregivers

The client is going to be short term: ☐ Yes ☐ No

Reason for Respite Care: _____

☐ **4 — Emergency Provisional Admission**

Must be hotlined. Stays not more than 7 days to protect person from serious physical harm to self and others

Hotline must be reported to the Adult Abuse and Neglect Hotline (1-800-392-0210 or https://apps4.mo.gov/APS_Portal/)

Reason for Hotline: _____

☐ **5 — Direct Transfer from a Hospital**

Stays not more than thirty (30) days for the condition for which the person is currently receiving hospital care.

Must include the hospital history and physical

The client is going to be short term: ☐ Yes ☐ No

Reason for Transfer: _____

What is the plan after 30 days? _____

SECTION G. PHYSICIAN'S AUTHORIZATION AND SIGNATURE

I attest that the information on these forms is complete and correct as known to me.

☐ Applicant is not currently a danger to self and others ☐ Applicant is currently a danger to self and others

PHYSICIAN SIGNATURE	DATE
DISCIPLINE	LICENSE NUMBER

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Missouri Department Of Health And Senior Services
Home and Community Based Services
InterRAI Home Care Assessment System (HC), © InterRAI
Level of Care Algorithm

Behavioral:

E3a - Wandering
E3c - Physical Abuse
E3d - Socially Inappropriate / Disruptive
E3e - Inappropriate Public Sexual Behavior
E3f - Resists Care
J3g - Abnormal Thought Process
J3h - Delusions
J3i - Hallucinations
N7b - Mental Condition

If (N7b=1)
OR (E3a =1)
OR (E3c=1)
OR (E3d=1)
OR (E3e=1)
OR (E3f=1)
OR (J3g=1)
OR (J3h=1)
OR (J3i=1)
Then LOC = 3

If (N7b=2 **or** N7b=3)
OR (E3a=2 **or** E3a=3)
OR (E3c=2 **or** E3c=3)
OR (E3d=2 **or** E3d=3)
OR (E3e=2 **or** E3e=3)
OR (E3f=2 **or** E3f=3)
OR (J3g=2 **or** J3g=3 **or** J3g=4)
OR (J3h=2 **or** J3h=3 **or** J3h=4)
OR (J3i=2 **or** J3i=3 **or** J3i=4)
Then LOC = 6

If (N7b=2 **or** N7b=3)
AND
(E3a=3)
OR (E3c=3)
OR (E3d=3)
OR (E3e=3)
OR (E3f=3)
OR (J3g=3 **or** J3g=4)
OR (J3h=3 **or** J3h=4)
OR (J3i=3 **or** J3i=4)
Then LOC = 9

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Cognition:

C1 - Cognitive Skills
C2a - Short Term Memory
C2b - Procedural Memory
C2c - Situational Memory
C3c - Mental Function
D1 - Making Self Understood
D2 - Ability to Understand Others

If (C1=1 **or** C1=2)
AND
(C2a=1)
OR (C2b=1)
OR (C2c=1)
OR (C3c=1 **or** C3c=2)
OR (D1=2 **or** D1=3 **or** D1=4)
OR (D2=2 **or** D2=3 **or** D2=4)
Then LOC = 3

If (C1=3)
AND
(C2a=1)
OR (C2b=1)
OR (C2c=1)
OR (C3c=1 **or** C3c =2)
OR (D1=3)
OR (D2=3)
Then LOC = 6

If (C1=3)
AND
(D1=4)
OR (D2=4)
OR
(C1=4)
Then LOC = 9

If (C1=5)
Then LOC = 18 *TRIGGER

Mobility:

G2f - Locomotion
G2i - Bed Mobility
G3a - Primary mode of locomotion

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If (G2f=3 **or** G2f=4)
OR
(G2i=3 **or** G2i=4)
Then LOC = 3

If (G2f=5)
OR
(G2i=5 **or** G2i=6)
Then LOC = 6

If (G3a=3)
OR
(G2f=6)
Then LOC = 18 *TRIGGER

Eating:

G2j - Eating
K2e - Therapeutic Diet

If (G2j=1 **or** G2j=2 **or** G2j=3)
OR
(K2e=1)
Then LOC = 3

If (G2j=4)
Then LOC = 6

If (G2j=5)
Then LOC = 9

If (G2j=6)
Then LOC = 18 *TRIGGER

Toileting:

G2g - Transfer Toilet
G2h - Toilet Use

If (G2g=3 **or** G2g=4)
OR
(G2h=3 **or** G2h=4)
Then LOC = 3

If (G2g=5)
OR

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(G2h=5)
Then LOC = 6

If (G2g=6)
OR
(G2h=6)
Then LOC = 9

Bathing:

G2a - Bathing

If (G2a=3 **or** G2a=4)
Then LOC = 3

If (G2a=5 **or** G2a=6)
Then LOC = 6

Dressing and Grooming:

G2b - Personal Hygiene
G2c - Dressing Upper Body
G2d - Dressing Lower Body

If (G2b=3 **or** G2b=4)
OR
(G2c =3 **or** G2c=4)
OR
(G2d=3 **or** G2d=4)
Then LOC = 3

If (G2b=5 **or** G2b=6)
OR
(G2c=5 **or** G2c=6)
OR
(G2d=5 **or** G2d=6)
Then LOC = 6

Rehabilitation:

N3ea - Physical Therapy
N3fa - Occupational Therapy
N3ga - Speech-Language Pathology and Audiology Services
N3ia - Cardiac Rehabilitation

If (N3ea = 1)
OR

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(N3fa = 1)
OR
(N3ga = 1)
OR
(N3ia = 1)
Then LOC = 3

If (N3ea = 2 **or** N3ea = 3)
OR
(N3fa = 2 **or** N3fa = 3)
OR
(N3ga = 2 **or** N3ga = 3)
OR
(N3ia = 2 **or** N3ia = 3)
Then LOC = 6

If (N3ea = 4 **or** N3ea = 5 **or** N3ea = 6 **or** N3ea = 7)
OR
(N3fa = 4 **or** N3fa = 5 **or** N3fa = 6 **or** N3fa = 7)
OR
(N3ga = 4 **or** N3ga = 5 **or** N3ga = 6 **or** N3ga = 7)
OR
(N3ia = 4 **or** N3ia = 5 **or** N3ia = 6 **or** N3ia = 7)
Then LOC = 9

Treatments:

H1	-	Bladder Continence
H2	-	Urinary Collection Device
H3	-	Bowel Continence
K3	-	Mode of Nutrition
L1	-	Pressure Ulcer Severity
L3	-	Presence of Skin Ulcer
L4	-	Major Skin Problems
L5	-	Skin Tears or Cuts
N2g	-	Suctioning
N2h	-	Tracheostomy Care
N2j	-	Ventilator or Respirator
N2k	-	Wound Care

If (H1=1)
OR
(H2=1 **or** H2=2 **or** H2=3)
OR
(H3=1)
OR
(K3=5 **or** K3=6 **or** K3=7 **or** K3=8)

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OR
(N2g=1 **or** N2g=2 **or** N2g=3 **or** N2g=4)
OR
(N2h=1 **or** N2h=2 **or** N2h=3 **or** N2h=4)
OR
(N2j=1 **or** N2j=2 **or** N2j=3 **or** N2j=4)
OR
(N2k=1 **or** **N2k**=2 **or** N2k=3 **or** N2k=4)
AND
(L1=2 **or** L1=3 **or** L1=4 or L1=5 **or** L1=6)
OR
(L3=1)
OR
(L4=1)
OR
(L5=1)
Then LOC = 6

Medication Management:

G1d - Managing Medications

If (G1d=1 **or** G1d=2 **or** G1d=3 **or** G1d=4)
Then LOC = 3

If (G1d=5 **or** G1d=6)
Then LOC = 6

Meal Preparation:

G1a - Meal Prep

If (G1a=3 **or** G1a=4)
Then LOC= 3

If (G1a=5 **or** G1a=6)
Then LOC = 6

Safety:

Part I – Determine if the individual exhibits any of the following risk factors.

D4 – Vision
J1 – Falls
J3a – Problem frequency to move to standing position
J3b – Problem frequency to turn to face opposite direction
J3c – Problem frequency for dizziness

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J3d – Problem frequency for unsteady gait

If
(D4=3)
OR
(J1=1 **or** J1=2 **or** J1=3)
OR
(J3a=2 **or** J3a=3 **or** J3a=4)
OR
(J3b=2 **or** J3b=3 **or** J3b=4)
OR
(J3c=2 **or** J3c=3 **or** J3c=4)
OR
(J3d=2 **or** J3d=3 **or** J3d=4)
Then LOC = 3

If (D4=4)
OR (J1=1 **or** J1=2 **or** J1=3 **or** D4=3)
AND
(J3a=2 **or** J3a=3 **or** J3a=4)
OR
(J3b=2 **or** J3b=3 **or** J3b=4)
OR
(J3c=2 **or** J3c=3 **or** J3c=4)
OR
(J3d=2 **or** J3d=3 **or** J3d=4)
Then LOC = 6

Part II – After calculating the score in part 1, determine if the individual is age 75 or greater or has been previously institutionalized in the last 5 years in one of the settings outlined below. If so, increase the score as outlined to calculate the final safety score. If they do not have either of the additional risk factors, use the score calculated in part 1.

A3 - Birthdate
B4a - Long Term Care Facility
B4b - RCF/ALF
B4c - Mental Health Residence
B4d - Psychiatric Hospital or Unit
B4e - Settings for Persons with Intellectual Disability

If Safety Score of 0
AND
A3=Age of 75 or greater
OR
(B4a=1 **or** B4b=1 **or** B4c=1 **or** B4d=1 **or** B4e=1)
Then LOC = 3

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If Safety score of 0
AND
A3=Age of 75 or greater
AND
(B4a=1 **or** B4b=1 **or** B4c=1 **or** B4d=1 **or** B4e=1)
Then LOC =6

If Safety Score of 3
AND
A3=Age of 75 or greater
OR
(B4a=1 **or** B4b=1 **or** B4c=1 **or** B4d=1 **or** B4e=1)
Then LOC = 6

If Safety score of 6
AND
(B4a=1 **or** B4b=1 **or** B4c=1 **or** B4d=1 **or** B4e=1)
Then LOC=9

If Safety Score of 3
AND
A3=Age of 75 or greater
AND
(B4a=1 **or** B4b=1 **or** B4c=1 **or** B4d=1 **or** B4e=1)
Then LOC = 18 *TRIGGER

If Safety score of 6
AND
A3=Age of 75 or greater
Then LOC = 18 *TRIGGER

AUTHORITY: sections 192.006, 192.2000, and 198.079, RSMo 2016. This rule was previously filed as 13 CSR 40-81.084 and 13 CSR 15-9.030. Original rule filed Aug. 9, 1982, effective Nov. 11, 1982. Emergency rescission filed Nov. 24, 1982, effective Dec. 4, 1982, expired March 10, 1983. Rescinded: Filed Nov. 24, 1982, effective March 11, 1983. Readopted: Filed Dec. 15, 1982, effective March 11, 1983. Emergency amendment filed Dec. 21, 1983, effective Jan. 1, 1984, expired April 11, 1984. Emergency amendment filed March 14, 1984, effective April 12, 1984, expired June 10, 1984. Amended: Filed March 14, 1984, effective June 11, 1984. Moved to 19 CSR 30-81.030, effective Aug. 28, 2001. Emergency amendment filed June 20, 2005, effective July 1, 2005, expired Dec. 27, 2005. Amended: Filed June 20, 2005, effective Dec. 30, 2005. Emergency amendment filed July 5, 2017, effective July 15, 2017, expired Feb. 22, 2018. Amended: Filed July 5, 2017, effective Feb. 28, 2018. Amended: Filed Jan. 12, 2021, effective Oct. 31, 2021.*

**Original authority: 192.006, RSMo 1993, amended 1995; 192.2000, RSMo 1984, amended 1988, 1992, 1993, 1994, 1995, 2001, 2014; and 198.079, RSMo 1979, amended 2007.*