Volume 46, Number 22
Pages 2107–2214
November 15, 2021

SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

JOHN R. ASHCROFT

SECRETARY OF STATE

MISSOURI REGISTER

The *Missouri Register* is published semi-monthly by

SECRETARY OF STATE

JOHN R. ASHCROFT

Administrative Rules Division

James C. Kirkpatrick State Information Center

600 W. Main

Jefferson City, MO 65101

(573) 751-4015

ISSN 0149-2942

The *Missouri Register* and *Code of State Regulations* (CSR) are available on the Internet. The Register address is sos.mo.gov/adrules/moreg/moreg and the CSR is sos.mo.gov/adrules/csr/csr. The Administrative Rules Division may be contacted by email at rules@sos.mo.gov.

The secretary of state's office makes every effort to provide program accessibility to all citizens without regard to disability. If you desire this publication in alternate form because of a disability, please contact the Division of Administrative Rules, PO Box 1767, Jefferson City, MO 65102, (573) 751-4015. Hearing impaired citizens should contact the director through Missouri relay, (800) 735-2966.

MISSOURI REGISTER

November 15, 2021

Vol. 46 No. 22 **Pages 2107–2214**

IN THIS ISSUE:

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
July 1, 2021	**August 2, 2021**	August 31, 2021	September 30, 2021
July 15, 2021	**August 16, 2021**	August 31, 2021	September 30, 2021
August 2, 2021	**September 1, 2021**	September 30, 2021	October 30, 2021
August 16, 2021	**September 15, 2021**	September 30, 2021	October 30, 2021
September 1, 2021	**October 1, 2021**	October 31, 2021	November 30, 2021
September 15, 2021	**October 15, 2021**	October 31, 2021	November 30, 2021
October 1, 2021	**November 1, 2021**	November 30, 2021	December 30, 2021
October 15, 2021	**November 15, 2021**	November 30, 2021	December 30, 2021
November 1, 2021	**December 1, 2021**	December 31, 2021	January 30, 2022
November 15, 2021	**December 15, 2021**	December 31, 2021	January 30, 2022
December 1, 2021	**January 3, 2022**	January 29, 2022	February 28, 2022
December 15, 2021	**January 18, 2022**	January 29, 2022	February 28, 2022
January 3, 2022	**February 1, 2022**	February 28, 2022	March 30, 2022
January 18, 2022	**February 15, 2022**	February 28, 2022	March 30, 2022
February 1, 2022	**March 1, 2022**	March 31, 2022	April 30, 2022
February 15, 2022	**March 15, 2022**	March 31, 2022	April 30, 2022

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please see the website at sos.mo.gov/adrules/pubsched.

HOW TO CITE RULES AND RSMO

RULES

The rules are codified in the *Code of State Regulations* in this system–

Title	CSR	Division	Chapter	Rule
3	*Code of*	10-	4	.115
Department	*State*	Agency	General area	Specific area
	Regulations	division	regulated	regulated

and should be cited in this manner: 3 CSR 10-4.115.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraphs 1., subparagraphs A., parts (I), subparts (a), items I. and subitems a.

The rule is properly cited by using the full citation; for example, 3 CSR 10-4.115, NOT Rule 10-4.115.

Citations of RSMo are to the *Missouri Revised Statutes* as of the date indicated.

Code and *Register* on the Internet

The *Code of State Regulations* and *Missouri Register* are available on the Internet.

The *Code* address is sos.mo.gov/adrules/csr/csr

The *Register* address is sos.mo.gov/adrules/moreg/moreg

These websites contain rulemakings and regulations as they appear in the *Code* and *Registers*.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) business days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 41—General Tax Provisions

EMERGENCY AMENDMENT

12 CSR 10-41.010 Annual Adjusted Rate of Interest. The department proposes to amend the purpose, emergency statement, section (1), and authority.

PURPOSE: This emergency amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2022.

EMERGENCY STATEMENT: The director of revenue is mandated to establish not later than October 22 annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percent. This emergency amendment is necessary to ensure public awareness and to preserve a compelling governmental interest requiring an early effective date in that the amendment informs the public of the established rate of interest to be paid on unpaid amounts of taxes for the 2020 calendar year. A proposed amendment, that covers the same material, is published in this issue of the ***Missouri Register****. The director has limited the scope of the emergency amendment to the circumstances creating the emergency. The director has followed procedures calculated to assure fairness to all interested persons and parties and has complied with protections extended by the* ***Missouri*** *and* ***United States Constitutions****. This emergency amendment was filed October 15, 2021, becomes effective January 1, 2022, and expires June 29, 2022.*

(1) Pursuant to section 32.065, RSMo, the director of revenue upon official notice of the average predominant prime rate quoted by commercial banks to large businesses, as determined and reported by the Board of Governors of the Federal Reserve System in the Federal Reserve Statistical Release H.15(519) for the month of September of each year has set by administrative order the annual adjusted rate of interest to be paid on unpaid amounts of taxes during the succeeding calendar year as follows:

Calendar Year	Rate of Interest on Unpaid Amounts of Taxes
1995	12%
1996	9%
1997	8%
1998	9%
1999	8%
2000	8%
2001	10%
2002	6%
2003	5%
2004	4%
2005	5%
2006	7%
2007	8%
2008	8%
2009	5%
2010	3%
2011	3%
2012	3%
2013	3%
2014	3%
2015	3%
2016	3%
2017	4%
2018	4%
2019	5%
2020	5%
2021	3%
2022	**3%**

AUTHORITY: section 32.065, RSMo 2016. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Oct. 15, 2021, effective Jan. 1, 2022, expires June 29, 2022. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the time the emergency is effective.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by adoption of the proposed rule:	**Classification by types of the business entities which would likely be affected:**	**Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:**
Any taxpayer with delinquent tax.	Any taxpayer with delinquent tax.	*This proposed amendment will not cost public entities more than five hundred dollars ($500) in the aggregate. The 2022 interest rate imposed on delinquent taxes is equal to that imposed in 2021.*

III. WORKSHEET

The proposed amendment establishes the rate of interest for 2022 at three percent (3%), which is equal to the rate in 2021.

This proposed amendment will not cost public entities more than five hundred dollars ($500) in the aggregate. Because the 2022 interest rate imposed on delinquent taxes is equal to the rate imposed in 2021, the interest rate will be the same on each $100 of delinquent taxes to public entities.

Interest on Delinquent Taxes Paid to Department of Revenue

	Current Rule 3.00%	**Proposed Amendment 3.00%**
Example:		
Past due tax amount	$100.00	$100.00
Interest Amount (%)	$3.00	$3.00
Total Amount Due	**$103.00**	**$103.00**

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the Director of Revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year, as set by the Board of Governors of the Federal Reserve, rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2021 is three point two five percent (3.25%). The actual bank prime loan rate noted by the Federal Reserve in 2020 was five point two five percent (5.25%).

FISCAL NOTE
PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by adoption of the proposed rule:	**Classification by types of the business entities which would likely be affected:**	**Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:**
Any taxpayer with delinquent tax.	Any taxpayer with delinquent tax.	*This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate. The 2022 interest rate imposed on delinquent taxes is equal to that imposed in 2021. The actual number of affected taxpayers is unknown.*

III. WORKSHEET

The proposed amendment establishes the rate of interest for 2022 at three percent (3%), which is equal to the rate in 2021.

This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate. Because the 2022 interest rate imposed on delinquent taxes is equal to the rate imposed in 2021, the interest rate will be the same on each $100 of delinquent taxes to private entities. The actual number of affected taxpayers is unknown.

Interest on Delinquent Taxes Paid to Department of Revenue

	Current Rule 3.00%	**Proposed Amendment 3.00%**
Example:		
Past due tax amount	$100.00	$100.00
Interest Amount (%)	$3.00	$3.00
Total Amount Due	**$103.00**	**$103.00**

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the Director of Revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year, as set by the Board of Governors of the Federal Reserve, rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2021 is three point two five percent (3.25%). The actual bank prime loan rate noted by the Federal Reserve in 2020 was five point two five percent (5.25%).

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 2—Income Maintenance

EMERGENCY AMENDMENT

13 CSR 40-2.015 Authorized Representatives. The division is amending subsection (2)(D) and adding section (19).

*PURPOSE: This emergency amendment adds the Adult Expansion Group (AEG) to the list of groups that constitute "MO HealthNet programs" for purposes of this rule. This amendment also incorporates three (3) federal regulations and one subpart of the **Code of Federal Regulations** (CFR). First, the rule governing authorized representatives (42 CFR 435.923). Second, the rule governing the privacy and security of personally identifiable information (45 CFR 155.260), which authorized representatives must honor. Third, the rule governing the entities who may receive a reassigned claim from a Medicaid provider (42 CFR 447.10). Finally, the amendment incorporates the subpart in federal rules – 42 CFR 431 Subpart F - on safeguarding information on Medicaid participants. Authorized representatives must agree to adhere to these rules as a condition of their representation.*

*EMERGENCY STATEMENT: This emergency amendment adds the Adult Expansion Group (AEG) to the list of groups that constitute "MO HealthNet programs" for purposes of this rule, in accordance with Article IV Section 36(c) of the **Missouri Constitution**. Section 36(c) requires the department to implement these changes by July 1, 2021, but implementation was stopped due to a lack of funding for the program. On July 22, 2021, the Missouri Supreme Court ordered the Circuit Court of Cole County to issue an order requiring the Department of Social Services to implement Article IV Section 36(c). On August 10, 2021, the Circuit Court ordered the Department to do this as of July 1, 2021. As a result of this ruling, an emergency amendment is necessary in order to carry out the Court's order within the allowable time frame, and the Family Support Division has a compelling governmental interest in implementing that order, which includes adding the AEG to the list of participating MO HealthNet groups. If this emergency rule is not enacted, the department would not be in compliance with the **Missouri Constitution** and the Circuit Court's order. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The Family Support Division believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed October 5, 2021, becomes effective October 20, 2021, and expires April 17, 2022.*

(2) For purposes of this rule, the following terms shall mean:

(D) "MO HealthNet programs" shall mean the MO HealthNet benefits provided to participants under the MO HealthNet programs including, but not limited to, MO HealthNet for the Aged, Blind, and Disabled (MHABD) program, MO HealthNet for Families (MHF) program, **the Adult Expansion Group (AEG) pursuant to Article IV Section 36(c) of the *Missouri Constitution*,** MO HealthNet for Kids (MHK) program, MO HealthNet for Pregnant Women (MPW) program, and Uninsured Woman's Health Services (UWHS) program. MO HealthNet programs also include presumptive eligibility for any of the above programs; and

(19) This rule hereby incorporates by reference the following provisions and definitions from the *Code of Federal Regulations* (CFR) listed below as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, and which is located on the website of the U.S. Government Publishing Office at https://www.govinfo.gov/app/collection/CFR. This rule does not incorporate any subsequent amendments or additions:

(A) 42 CFR 435.923, October 20, 2021;

(B) 42 CFR 431 Subpart F, October 20, 2021;

(C) 45 CFR 155.260, October 20, 2021; and

(D) 42 CFR 447.10, October 20, 2021.

*AUTHORITY: sections **207.010, 207.022,** 208.991, **and 660.017,** RSMo [Supp. 2013] **2016**. Original rule filed June 30, 2015, effective Dec. 30, 2015. Emergency amendment filed Oct. 5, 2021, effective Oct. 20, 2021, expires April 17, 2022. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

*PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the time the emergency is effective. The overall implementation of Article IV, Section 36(c) of the **Missouri Constitution**, pursuant to which the division is amending this regulation, is estimated to cost 1.85 billion dollars ($1,850,000,000), which includes 282.2 million dollars ($282,200,000) in GR/Other funding and 1.57 billion dollars ($1,570,000,000) in federal financial participation annually starting in fiscal year 2022.*

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 7—Family Healthcare

EMERGENCY AMENDMENT

13 CSR 40-7.010 Scope and Definitions. The division is amending subsection (1)(K).

*PURPOSE: This emergency amendment adds the Adult Expansion Group to the list of populations that fall under Family MO HealthNet programs, pursuant to Article IV, Section 36(c) of the **Missouri Constitution**.*

*EMERGENCY STATEMENT: This emergency amendment adds the Adult Expansion Group (AEG) to the list of groups that constitute "Family MO HealthNet programs" for purposes of this rule, in accordance with Article IV Section 36(c) of the **Missouri Constitution**. Section 36(c) requires the department to implement these changes by July 1, 2021, but implementation was stopped due to a lack of funding for the program. On July 22, 2021, the Missouri Supreme Court ordered the Circuit Court of Cole County to issue an order requiring the Department of Social Services to implement Article IV Section 36(c). On August 10, 2021, the Circuit Court ordered the Department do this as of July 1, 2021. As a result of this ruling, an emergency amendment is necessary in order to carry out the Court's order within the allowable time frame, and the Family Support Division has a compelling governmental interest to implement that order, which includes adding the AEG to the list of participating MO HealthNet groups. If an emergency is not enacted, the department would not be in compliance with the **Missouri Constitution** and the Circuit Court's order. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The Family Support Division believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed October 5,*

2021, becomes effective October 20, 2021, and expires April 17, 2022.

(1) Definitions.

(K) "Family Mo HealthNet programs" means MO HealthNet benefits provided to participants under the MO HealthNet for Families (MHF) program, **the Adult Expansion Group (AEG) pursuant to Article IV, Section 36(c) of the *Missouri Constitution*,** MO HealthNet for Kids (MHK) program, MO HealthNet for Pregnant Women (MPW) program, and Uninsured Woman's Health Services (UWHS) program. Family MO HealthNet programs also include presumptive eligibility for any of the above programs.

*AUTHORITY: sections 207.022 and 660.017, RSMo 2016. Original rule filed July 31, 2013, effective Feb. 28, 2014. Amended: Filed Oct. 1, 2018, effective May 30, 2019. Emergency amendment filed Oct. 5, 2021, effective Oct. 20, 2021, expires April 17, 2022. A proposed amendment covering the same material is published in this issue of the **Missouri Register**.*

*PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the time the emergency is effective. The overall implementation of Article IV, Section 36(c) of the **Missouri Constitution**, pursuant to which the division is amending this regulation, is estimated to cost 1.85 billion dollars ($1,850,000,000), which includes 282.2 million dollars ($282,200,000) in GR/Other funding and 1.57 billion dollars ($1,570,000,000) in federal financial participation annually starting in fiscal year 2022.*

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 7—Family Healthcare

EMERGENCY AMENDMENT

13 CSR 40-7.050 Presumptive Eligibility. The department is amending sections (1), (2), and (4).

*PURPOSE: This emergency amendment allows qualified hospitals to make Medicaid presumptive eligibility determinations for the Adult Expansion Group (AEG), per Article IV Section 36(c) of the **Missouri Constitution**. The State is legislatively mandated to implement these changes by July 1, 2021. Applicable federal regulations require state Medicaid agencies to offer qualified hospitals the opportunity to make presumptive eligibility determinations for this Medicaid population.*

*EMERGENCY STATEMENT: This emergency amendment allows qualified hospitals to make Medicaid presumptive eligibility determinations for the Adult Expansion Group (AEG), per Article IV Section 36(c) of the **Missouri Constitution**. The State is legislatively mandated to implement these changes by July 1, 2021. Applicable federal regulations require state Medicaid agencies to offer qualified hospitals the opportunity to make presumptive eligibility determinations for this Medicaid population. In order for the State to be in compliance with these requirements within the mandated timeframe, an emergency amendment is necessary. If an emergency is not enacted, the Family Support Division would not be in compliance with the **Missouri Constitution**. As a result, the department finds a compelling governmental interest which requires this emergency amendment. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The Family Support Division believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed October 5, 2021, becomes effective October 20, 2021, and expires April 17, 2022.*

(1) The department shall provide MO HealthNet benefits *[to individuals]* during a period of presumptive eligibility for individuals who have been determined eligible for MO HealthNet benefits on the basis of preliminary information by a presumptive eligibility qualified entity in accordance with this rule**, and pursuant to Sections 435.1100, 435.1101, 435.1102, 435.1103, and 435.1110 of Title 42, *Code of Federal Regulations*, which is incorporated by reference and made part of this rule as published by the Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, and available at its website https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435?toc=1, October 20, 2021. This rule does not incorporate any subsequent amendments or additions**.

(2) For the purposes of this rule—

(A) **"**Presumptive eligibility**"** means temporary MO HealthNet benefits for children under the age of nineteen (19) (pursuant to 42 U.S.C. sections 1396a(47) and 1396r-1a and 42 CFR sections 435.1102 and 435.1110), parents and other caretaker relatives (pursuant to 42 CFR sections 435.1103 and 435.1110), former foster care children (pursuant to 42 CFR sections 435.1103 and 435.1110), pregnant women (pursuant to 42 U.S.C. sections 1396a(47) and 1396r-1 and 42 CFR sections 435.1103 and 435.1110), *[and]* individuals with breast cancer or cervical cancer (pursuant to 42 U.S.C. sections 1396a(47) and 1396r-1b and 42 CFR sections 435.1103 and 435.1110**), and adults between ages nineteen (19) and sixty-four (64) (pursuant to 42 CFR 435.1110),** allowing them to receive MO HealthNet benefits before they have applied for MO HealthNet benefits through the division;

(B) **"**Qualifying hospital**"** has the same meaning as in 42 CFR 435.1110(b);

(C) **"**Federally qualified health center**"** has the same meaning as in 42 U.S.C. section 1396(l)(2)(B);

(D) **"**Rural health clinic**"** has the same meaning as in 42 U.S.C. section 1395x(aa)(2);

(E) **"**Presumptive eligibility qualified entity**"** means a MO HealthNet provider organization responsible for screening individuals/families regarding presumptive eligibility for MO HealthNet benefits.

1. For presumptive eligibility determinations for children under the age of nineteen (19), **"**presumptive eligibility qualified entity**"** means a federally qualified health center, rural health clinic, or qualifying hospital that meets the requirements for a "qualified entity" in 42 U.S.C. section 1396r–1a(b)(3)(A).

2. For presumptive eligibility determinations for pregnant women, **"**presumptive eligibility qualified entity**"** means a county health department, federally qualified health center, rural health clinic, or qualifying hospital that meets the requirements for a "qualified provider" in 42 U.S.C. section 1396r–1(b)(2).

3. For presumptive eligibility determinations for parents and caretaker relatives, **"**presumptive eligibility qualified entity**"** means a qualifying hospital as provided in section 42 CFR 435.1110.

4. For presumptive eligibility determinations for breast and cervical cancer treatment, **"**presumptive eligibility qualified entity**"** means a Show-Me Healthy Women Provider which has a participation agreement with the Missouri Department of Health and Senior Services that meets the requirements for a "qualified entity" in 42 U.S.C. section 1396r–1b(b)(2).

5. For presumptive eligibility determinations for former foster care children, **"**presumptive eligibility qualified entity**"** means a

qualifying hospital.

6. For presumptive eligibility determinations for adults between ages nineteen (19) and sixty-four (64), "presumptive eligibility qualified entity" means a qualifying hospital.

(4) A presumptive eligibility qualified entity shall make presumptive eligibility determinations subject to the requirements listed below:

(H) In making a presumptive eligibility determination, the presumptive eligibility qualified entity shall apply preliminary eligibility criteria established by applicable law and regulation, using forms provided by the division, and shall approve an application for presumptive eligibility only if the following requirements are met:

1. For children under the age of nineteen (19)—

A. The child must meet the same requirements for income and United States and Missouri residency required for regular Medicaid coverage for children under nineteen (19); and

B. There can be no more than one (1) presumptive eligibility period within a twelve- (12-) month period starting with the effective date of the initial presumptive eligibility period;

2. For parents and caretaker relatives—

A. Individuals must be parents or other caretaker relatives (as defined in 42 CFR 435.4), including pregnant women, of a dependent child (as defined in 42 CFR 435.4) under age eighteen (18);

B. The individual must meet the same requirements for income and United States and Missouri residency required for regular Medicaid coverage for parents; and

C. There can be no more than one (1) presumptive eligibility period within a twelve- (12-) month period starting with the effective date of the initial presumptive eligibility period;

3. For pregnant women—

A. The individual must be pregnant;

B. The woman must meet the same requirements for income and United States and Missouri residency required for regular Medicaid coverage for pregnant women or for coverage under the Show-Me Healthy Baby program; and

C. The individual must not have already received benefits under a MO HealthNet presumptive eligibility program during the current pregnancy;

4. For breast and cervical cancer treatment—

A. The individual must be diagnosed with breast or cervical cancer by a Show-Me Healthy Women Provider unless the participant is diagnosed by a MO HealthNet provider while currently receiving MO HealthNet benefits;

B. The woman must meet the same requirements for income and United States and Missouri residency required for regular coverage under the Breast and Cervical Cancer Coverage program; and

C. There can be no more than one (1) presumptive eligibility period within a twelve- (12-) month period starting with the effective date of the initial presumptive eligibility period;

5. For former foster care children—

A. The individual must be in foster care under the responsibility of the state of Missouri as of their eighteenth birthday or within thirty (30) days prior to their eighteenth birthday;

B. The individual must be under the age of twenty-six (26) years old;

C. The individual must not be eligible for another MO HealthNet benefits group;

D. The individual must have been covered by MO HealthNet while they were in foster care;

E. The individual must be a Missouri resident; and

F. There can be no more than one (1) presumptive eligibility period within a twelve- (12-)

month period starting with the effective date of the initial presumptive eligibility period; **and**

6. For adults between ages nineteen (19) and sixty-four (64)-

A. The individual must meet the requirements for income and United States and Missouri residency required for regular MO HealthNet coverage for adults between ages nineteen (19) and sixty-four (64) pursuant to 42 CFR 435.1103 and 435.1110; and

B. There can be no more than one (1) presumptive eligibility period within a twelve- (12-) month period starting with the effective date of the initial presumptive eligibility period.

*AUTHORITY: sections 207.022[, RSMo Supp. 2014, section] 208.151.1(22),] **and 660.017,** RSMo [Supp. 2013] **2016, and section 208.151.1(22), RSMo Supp. 2021**. Original rule filed March 31, 2016, effective Sept. 30, 2016. Amended: Filed April 5, 2021. Emergency amendment filed Oct. 5, 2021, effective Oct. 20, 2021, expires April 17, 2022. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

*PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the time the emergency is effective. The overall implementation of Article IV, Section 36(c) of the **Missouri Constitution**, pursuant to which the division is amending this regulation, is estimated to cost 2.71 billion dollars ($2,710,000,000), which includes 258.5 million dollars ($258,000,000) in state funding and 2.45 billion dollars ($2,450,000,000) in federal financial participation annually starting in fiscal year 2022.*

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 90—Home Health Program

EMERGENCY AMENDMENT

13 CSR 70-90.010 Home Health-Care Services. The MO HealthNet Division is adding subsection (2)(C), amending sections (7) and (8), and adding section (9).

*PURPOSE: This amendment allows the adult expansion group described in Article IV Section 36(c) of the **Missouri Constitution** to receive habilitative services through the Missouri Home Health Program, and updates the incorporated by reference dates.*

*EMERGENCY STATEMENT: This emergency amendment allows the expanded adult population to receive habilitative services, per Article IV Section 36(c) of the **Missouri Constitution**. The State was legislatively mandated to implement these changes by July 1, 2021, but implementation was stopped due to a lack of funding for the program. On July 22, 2021, the Missouri Supreme Court ordered the Circuit Court of Cole County to issue an order requiring the Department of Social Services to implement Article IV Section 36(c). On August 10, 2021, the Circuit Court issued an order enjoining the department from denying MO HealthNet enrollment to persons eligible for coverage under Article IV Section 36(c) as of July 1, 2021. As a result of this ruling, an emergency amendment is necessary in order to carry out the Court's order within the allowable time frame, and the MO HealthNet Division has a compelling governmental interest to implement that order, which includes providing Home Health services to qualified adult expansion participants. Since Article IV Section 36(c) was passed in August 2020, the department has been developing a package of coverage that will meet the federal requirements for this program. Article IV Section 36(c) requires the department to adhere to 42 USC 1396a(k)(1) or section 2001(a)(2) of the Patient Protection and Affordable Care Act (ACA). Under the ACA, the home health services identified by this amendment must be a part of the package of benefits that will be available to the adult expansion group, and. Also, extending these benefits to the adult expansion group will*

*enable the department to secure a 90% federal medical assistance percentage, which is also required by Article IV Section 36(c). In order for the State to be in compliance with these requirements within the mandated timeframe, an emergency amendment is necessary. If an emergency is not enacted, the MO HealthNet Home Health program would not be in compliance with the court order or the **Missouri Constitution**. As a result, the MO HealthNet Division finds a compelling governmental interest which requires this emergency amendment. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The MO HealthNet Division believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed October 5, 2021, becomes effective October 20, 2021, and expires April 17, 2022.*

(2) Home health services include the following services and items:

(C) Physical, occupational, or speech therapy when the following conditions are met:

1. The participant is age nineteen (19) or over and under age sixty-five (65) and enrolled under the Medicaid eligibility criteria for the adult expansion group as described in Article IV Section 36(c) of the *Missouri Constitution*; and

2. Physical, occupational, or speech therapy is a habilitative service that will help the individual keep, learn, or improve skills and functioning for daily living, in accordance with limitations set forth in section (9) of this rule.

*[(C)]***(D)** Intermittent home health aide; and

*[(D)]***(E)** Supplies identified as specific and necessary to the delivery of a participant's nursing care and prescribed in the plan of care. Supplies are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one (1) individual, that are required to address an individual medical disability, illness, or injury. Medical supplies are classified as—

1. Routine—medical supplies used in small quantities for patients during the usual course of most home visits; or

2. Non-routine—medical supplies needed to treat a patient's specific illness or injury in accordance with the physician's plan of care and meet further conditions discussed in more detail below.

(7) To be reimbursed by MO HealthNet, all home health services and supplies must be provided in accordance with a written plan of care authorized by the participant's physician. The criteria for the development of the written plan of care and changes to the written plan of care through interim order(s) are described in the *MO HealthNet Division Home Health Provider Manual*. The *MO HealthNet Division Home Health Provider Manual* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at http://manuals.momed.com/manuals/, *[December 10, 2019]* **September 24, 2021**. This rule does not incorporate any subsequent amendments or additions. Plans of care and interim order(s) are to be maintained in the client record.

(8) Skilled therapy services **as described in subsection (2)(B)** will be considered reasonable and necessary for treatment if the conditions of paragraphs (8)(A)1.–4. are met.

(9) The combination of physical, occupational, and speech therapy as described in subsection (2)(C) of this rule is limited to a total of twenty (20) visits inclusive of services from all MO HealthNet providers per year.

*AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. [2019] **2021**. This rule was previously filed as 13 CSR 40-81.056. Original rule filed April 14, 1982, effective July 11, 1982. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 5, 2021, effective Oct. 20, 2021, expires April 17, 2022. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the time the emergency is effective. There is no fiscal impact to fee-for-service. Adult expansion group participants will be enrolled in managed care and this service will be provided through the managed care health plan, and the costs of those services are included in the capitation payments that MHD makes to the managed care providers. There is an estimated overall fiscal impact, which would be for managed care, as follows: Home health agencies: $0 fiscal impact anticipated for proposed changes; and MO HealthNet: $10,594,584.90 anticipated across all MHD programs, and $2,648,646.22 fiscal impact anticipated for the Home Health program.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

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

EMERGENCY AMENDMENT

19 CSR 30-81.030 Evaluation and Assessment Measures for Title XIX Recipients and Applicants. The department is amending section (1), adding sections (7) and (8), and adding forms DA-124 A/B, DA-124 C ATT and DA-124 C.

PURPOSE: This amendment adds the level-of-care evaluation and assessment requirements back that were effective prior to October 31, 2021, in order for those individuals who would have qualified for Title XIX funded services prior to October 31, 2021, to be eligible to receive services funded through the American Rescue Plan Act. This amendment also changes the purpose to include the second level-of-care determination to be utilized from October 31, 2021, until the funding from the American Rescue Plan Act (temporary enhanced federal medical assistance percentage) has been expended.

*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. **The rule includes a second level-of-care determination to be utilized from October 31, 2021, until the funding from the American Rescue Plan Act (temporary enhanced federal medical assistance percentage) has been expended.***

EMERGENCY STATEMENT: This emergency amendment adds the level-of-care evaluation and assessment requirements back that were effective prior to October 31, 2021, in order for those individuals who would have qualified for Title XIX funded services prior to October 31, 2021, to be eligible to receive services funded through the American Rescue Plan Act. The American Rescue Plan Act authorizes states to earn a temporary enhanced federal medical assistance percentage (FMAP) for home and community based services. As a result, Missouri is eligible to claim an additional ten percent (10%) enhanced FMAP on all home and community based services provided from April 1, 2021, through March 31, 2022. With this additional

*funding, the department is creating a dual level-of-care assessment in which applicants for home and community based services and long-term care facility care are assessed under the new level-of-care assessment that will begin on October 31, 2021, and the old level-of-care assessment which was set to end on October 31, 2021. The dual level-of-care assessment will be utilized by the Department from October 31, 2021, until the date that all of the temporary enhanced FMAP funds from the American Rescue Plan Act of 2021 are expended. During the level of care transformation project, the department projected that there would be an equal number of home and community based applicants who would be able to qualify under the new level-of-care assessment and those who would no longer qualify under the new level-of-care assessment. However, with the additional funds from the American Rescue Plan Act, the department can continue to provide services to those home and community based applicants who qualify for the old level-of-care assessment, but who would have no longer qualified for home and community based services under the new level-of-care assessment which will take effect on October 31, 2021. Additionally, new home and community based applicants can qualify under the old and new level-of-care assessments. The department anticipates being able to serve an additional 3,154 newly eligible individuals based on the dual level-of-care system by the end of the 2022 fiscal year. These individuals can receive home and community based services to assist them with activities of daily living and instrumental activities of daily living to be able to remain in their homes instead of having to enter long-term care facilities. This amendment is an emergency because the Centers for Medicare and Medicaid Services will not authorize the state/Department to be able to utilize the FMAP funds without bringing back the old level-of-care assessment that was effective when the American Rescue Plan Act was passed by the federal government. Additionally, this funding will allow those individuals who will no longer qualify for level-of-care as of October 31, 2021, under the new level-of-care assessment to be able to continue receiving home and community based services thus allowing these indidviduals to remain in their homes instead of having to enter costly long-term care facilities. As a result, the department finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed October 15, 2021, becomes effective October 29, 2021, and expires April 26, 2022.*

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

(H) Pro re nata (PRN)—medication or treatment ordered by a physician to be administered as needed, but not regularly scheduled;

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

(J) Redetermination 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 DA-124 A/B or C forms do not reflect the resident's current care needs; and

3. Assessment of DA-124 forms as requested by the Department of Social Services, Family Support Division.

*[(I)]***(K)** 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)]***(L)** 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)]***(M)** The department—Department of Health and Senior Services.

(7) Dual level of care assessments to be performed to determine level-of-care need from October 31, 2021, until the date that all of the temporary enhanced federal medical assistance percentage funds from the American Rescue Plan Act of 2021 are expended.

(A) The department is eligible to receive an additional ten (10) percent enhanced federal medical assistance percentage for home and community based services provided from April 1, 2021 through March 31, 2022, through the American Rescue Plan Act of 2021. This funding will allow the department to determine level-of-care need under the department's previous scoring system directly prior to the department's level-of-care transformation which takes effect on October 31, 2021, through formal rulemaking. Therefore, if an individual does not qualify for level-of-care under the current eighteen (18) points level-of-care assessment as set forth in sections (5) and (6) of this rule from October 31, 2021, until the date that all of the temporary enhanced federal medical assistance percentage funds from the American Rescue Plan Act of 2021 are expended; then individuals shall also be assessed using a twenty-four (24) points level-of-care assessment as set forth in section (8) of this rule. An individual may qualify for level-of-care need under either of these level of care assessments from October 31, 2021, until the date that all of the temporary enhanced federal medical assistance percentage funds from the American Rescue Plan Act of 2021 are expended.

(8) Second level-of-care determination to be performed from October 31, 2021, until the date that all of the temporary enhanced federal medical assistance percentage funds from the American Rescue Plan Act of 2021 are expended.

(A) Initial Determination of Level-of-Care Needs Requirements.

1. For the purpose of making a determination of level-of-care need and 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 subsection (8)(D) of this rule.

2. The department shall complete the assessment within ten (10) working days of receipt of all documentation required by subsection (8)(D) in this rule unless further evaluation by the State Mental Health Authority is required by 42 CFR 483.100 to 483.138.

(B) Redetermination of Level-of-Care Requirements.

1. Redetermination of level-of care of individual recipients who are eligible for placement in long-term care facilities shall be conducted by the department through a review and assessment of the DA-124A/B (10-21) Initial Assessment – Social And Medical, DA-124C (10-21) Level One Nursing Facility Pre-Admission Screening For Mental Illness/Intellectual Disability or Related Condition, and DA-124C ATT (10-21) Notice To Applicant included herein and any documenation provided by the resident's attending physician. A referring individual shall fill out and submit the forms to the department at COMRU@health.mo.gov.

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

1. 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.

2. The specific areas which will be considered when determining an individual's ability or inability to function in the least restrictive environment are—mobility, dietary, restorative services, monitoring, medication, behavioral, treatments, personal care and rehabilitative services.

3. 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.

(D) Assessed Needs Point Designations Requirements.

1. Applicants or recipients will be assessed for level-of-care by the assignment of a point count value for each category cited in subsection (8)(C)2 of this rule.

2. 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. If the applicant's or recipient's records show that the applicant's or recipient's attending physician has ordered certain care, medication or treatments for an applicant or recipient, the department will assess points for a PRN order if the applicant or recipient has actually received or required that care, medication, or treatment within the thirty (30) days prior to review and evaluation by the department.

3. For individuals seeking admission to a long-term care facility on or after October, 31, 2021, the applicant or recipient will be determined to be qualified for long-term care facility care if he or she is determined to need care with an assessed point level of twenty-four (24) points or above, using the assessment procedure as required in subsection (8)(D)7 of this rule.

4. For individuals seeking admission to a long-term care facility on or after October 31, 2021, an applicant with twenty-one (21) points or lower will be assessed as ineligible for Title XIX-funded long-term care in a long-term care facility, unless the applicant qualifies as otherwise provided in sections (5), (6) or (8)(D)5 or 6 in this rule.

5. Applicants or recipients may occasionally require care or services, or both, which could qualify as long-term care facility services. In these instances, a single nursing service requirement may be used as the qualifying factor, making the individual eligible for long-term care facility care regardless of the total point count. The determining factor will be the availability of professional personnel to perform or supervise the qualifying care services. Qualifying care services may include, but are not limited to

A. Administration of levine tube or gastrostomy tube feedings;

B. Nasopharyngeal and tracheotomy aspiration;

C. Insertion of medicated or sterile irrigation and replacement catheters;

D. Administration of parenteral fluids;

E. Inhalation therapy treatments;

F. Administration of injectable medications other than insulin, if required other than on the day shift; and

G. Requirement of intensive rehabilitation services by a professional therapist at least five (5) days per week.

6. 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) or assisted living facility (ALF) residency as specified by section 198.073, RSMo.

7. Points will be assigned to each category, as required by subsection (8)(C)2 in this rule, in multiples of three (3) according to the following requirements:

A. Mobility is defined as the individual's ability to move from place-to-place. The applicant or recipient will receive—

(I) Zero (0) points if assessed as independently mobile, in that the applicant or recipient requires no assistance for transfers or mobility. The applicant or recipient may use assistive devices (cane, walker, wheelchair) but is consistently capable of negotiating without assistance of another individual;

(II) Three (3) points if assessed as requiring minimum assistance, in that the applicant or recipient is independently mobile once the applicant or recipient receives assistance with transfers, braces or prosthesis application or other assistive devices, or a combination of these (example, independent use of wheelchair after assistance with transfer). This category includes individuals who are not consistently independent and need assistance periodically;

(III) Six (6) points if assessed as requiring moderate assistance, in that the applicant or recipient is mobile only with direct staff assistance. The applicant or recipient must be assisted even when using canes, walker or other assistive devices; and

(IV) Nine (9) points if assessed as requiring maximum assistance, in that the applicant or recipient is totally dependent upon staff for mobility. The applicant or recipient is unable to ambulate or participate in the ambulation process, requires positioning, supportive device, application, prevention of contractures or pressure sores and active or passive range of motion exercises;

B. Dietary is defined as the applicant's or recipient's nutritional requirements and need for assistance or supervision with meals. The applicant or recipient will receive—

(I) Zero (0) points if assessed as independent in dietary needs, in that the applicant or recipient requires no assistance to eat. The applicant or recipient has physician's orders for a regular diet, mechanically altered diet or requires only minor modifications (example, limited desserts, no salt or sugar on tray);

(II) Three (3) points if assessed as requiring minimum assistance, in that the applicant or recipient requires meal supervision or minimal help, such as cutting food or verbal encouragement. Calculated diets for stabilized conditions shall be included;

(III) Six (6) points if assessed as requiring moderate assistance, in that the applicant or recipient requires help, including constant supervision during meals, or actual feeding. Calculated diets for unstable conditions are included; and

(IV) Nine (9) points if assessed as requiring maximum assistance, in that the applicant or recipient requires extensive assistance for special dietary needs or with eating, which could include enteral feedings or parenteral fluids;

C. Restorative services are defined as specialized services provided by trained and supervised individuals to help applicants or recipients obtain and/or maintain their optimal highest practicable functioning potential. Each applicant or recipient must have an individual overall plan of care developed by the provider with written goals and response/progress documented. Restorative services may include, but are not limited to: applicant or recipient teaching program (self-transfer, self-administration of medications, self-care), range of motion, bowel and bladder program, remotivational therapy, validation therapy, patient/family program and individualized activity program. The applicant or

recipient will receive—

(I) Zero (0) points if restorative services are not required;

(II) Three (3) points if assessed as requiring minimum services in order to maintain level of functioning;

(III) Six (6) points if assessed as requiring moderate services in order to restore the individual to a higher level of functioning; and

(IV) Nine (9) points if assessed as requiring maximum services in order to restore to a higher level of functioning. These are intensive services, usually requiring professional supervision or direct services;

D. Monitoring is defined as observation and assessment of the applicant's or recipient's physical and/or mental condition. This monitoring could include assessment of—routine laboratory work, including but not limited to, evaluating digoxin and coumadin levels, measurement and evaluation of blood glucose levels, measurement and evaluation of intake and output of fluids the individual has received and/or excreted, weights and other routine monitoring procedures. The applicant or recipient will receive—

(I) Zero (0) points if assessed as requiring only routine monitoring, such as monthly weights, temperatures, blood pressures and other routine vital signs and routine supervision;

(II) Three (3) points if assessed as requiring minimal monitoring, in that the applicant or recipient requires periodic assessment due to mental impairment, monitoring of mild confusion, or both, or periodic assessment of routine procedures when the recipient's condition is stable;

(III) Six (6) points if assessed as requiring moderate monitoring, in that the applicant or recipient requires recurring assessment of routine procedures due to the applicant's or recipient's unstable physical or mental condition; and

(IV) Nine (9) points if assessed as requiring maximum monitoring, which is intensive monitoring usually by professional personnel due to applicant's or recipient's unstable physical or mental condition;

E. Medication is defined as the drug regimen of all physician-ordered legend medications, and any physician-ordered nonlegend medication for which the physician has ordered monitoring due to the complexity of the medication or the condition of the applicant or recipient. The applicant or recipient will receive—

(I) Zero (0) points if assessed as requiring no medication, or has not required PRN medication within the thirty (30) days prior to review and evaluation by the department;

(II) Three (3) points if assessed as requiring any regularly scheduled medication and the applicant or recipient exhibits a stable condition;

(III) Six (6) points if assessed as requiring moderate supervision of regularly scheduled medications, requiring daily monitoring by licensed personnel; and

(IV) Nine (9) points if assessed as requiring maximum supervision of regularly scheduled medications, a complex medication regimen, unstable physical or mental status or use of medications requiring professional observation and assessment, or a combination of these;

F. Behavioral is defined as an individual's social or mental activities. The applicant or recipient will receive—

(I). Zero (0) points if assessed as requiring little or no behavioral assistance. Applicant or recipient is oriented and memory intact;

(II). Three (3) points if assessed as requiring minimal behavioral assistance in the form of supervision or guidance on a periodic basis. Applicant or recipient may display some memory lapses or occasional forgetfulness due to mental or developmental disabilities, or both. Applicant or recipient generally relates well with others (positive or neutral) but needs occasional emotional support;

(III) Six (6) points if assessed as requiring moderate behavioral assistance in the form of supervision due to disorientation, mental or developmental disabilities or uncooperative behavior; and

(IV) Nine (9) points if assessed as requiring maximum behavioral assistance in the form of extensive supervision due to psychological, developmental disabilities or traumatic brain injuries with resultant confusion, incompetency, hyperactivity, hostility, severe depression, or other behavioral characteristics. This category includes residents who frequently exhibit bizarre behavior, are verbally or physically abusive, or both, or are incapable of self-direction. Applicants or recipients who exhibit uncontrolled behavior that is dangerous to themselves or others must be transferred immediately to an appropriate facility;

G. Treatments are defined as a systematized course of nursing procedures ordered by the attending physician. The applicant or recipient will receive—

(I) Zero (0) points if no treatments are ordered by the physician;

(II) Three (3) points if assessed as requiring minimal type-ordered treatments, including nonroutine and preventative treatments, such as whirlpool baths and other services;

(III) Six (6) points if assessed as requiring moderate type-ordered treatments requiring daily attention by licensed personnel. These treatments could include: daily dressings, PRN oxygen, oral suctioning, catheter maintenance care, treatment of stasis or pressure sore ulcers, wet/moist packs, maximist and other such services; and

(IV) Nine (9) points if assessed as requiring maximum type-ordered treatments of an extensive nature requiring provision, direct supervision, or both, by professional personnel. These treatments could include: intratrachial suctioning; insertion or maintenance of suprapubic catheter; continuous oxygen; new or unregulated ostomy care; dressings of deep draining lesions more than once daily; care of extensive skin disorders, such as advanced pressure sore or necrotic lesions; infrared heat and other services;

H. Personal care is defined as activities of daily living, including hygiene; personal grooming, such as dressing, bathing, oral and personal hygiene, hair and nail care, shaving; and bowel and bladder functions. Points will be determined based on the amount of assistance required and degree of assistance involved in the activity. The applicant or recipient will receive—

(I) Zero (0) points if assessed as requiring no assistance with personal care in that the applicant or recipient is an independent, self-care individual. No assistance is required with personal grooming; the applicant or recipient has complete bowel and bladder control;

(II) Three (3) points if assessed as requiring minimal assistance with personal care, in that the applicant or recipient requires assistance with personal grooming, and/or exhibits infrequent incontinency (once a week or less);

(III) Six (6) points if assessed as requiring moderate assistance with personal care, in that the applicant or recipient requires assistance with personal grooming, requiring close supervision or exhibits frequent incontinency (incontinent of bladder daily but has some control or incontinent of bowel two (2) or three (3) times per week), or a combination of these; and

(IV) Nine (9) points if assessed as requiring maximum assistance with personal care, in that the applicant or recipient requires total personal care to be performed by another individual, and/or exhibits continuous incontinency all or most of the time; and

I. Rehabilitation 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 qualified professional. Rehabilitation services include, but are

not limited to: physical therapy, occupational therapy, speech therapy, 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—

(I) Zero (0) points if assessed as requiring no ordered rehabilitation services;

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

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

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

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

INITIAL ASSESSMENT - SOCIAL AND MEDICAL

FSD CO. NO.	☐ CASH
LOAD NO.	☐ XIX

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.

A. SOCIAL ASSESSMENT

1. PERSON'S NAME (LAST, FIRST, MI)	2. DCN	3. DOB	4. SOCIAL SECURITY NUMBER

5. SEX

6. RACE

7. EDUCATION LEVEL
☐ GRADE SCHOOL ☐ HIGH SCHOOL
☐ COLLEGE ☐ OTHER

8. OCCUPATION

9. DATE ADMITTED TO NF

10. CURRENT LOCATION (ADDRESS)

11. Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable? ☐ Yes ☐ No

If yes, would you like to receive information and assistance regarding the agency's veteran services? ☐ Yes ☐ No

12. NAME OF PROPOSED NURSING FACILITY PLACEMENT, PHONE #

13. PERSON'S LEGAL GUARDIAN ☐ OR DESIGNATED CONTACT PERSON ☐
NAME _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE _____

B. MEDICAL ASSESSMENT

Attach additional sheets of information if necessary.

1. HEIGHT	2. WEIGHT
3. B/P	4. PULSE
5. DATE OF LAST MEDICAL EXAM	

6. RECENT MEDICAL INCIDENTS (i.e., CVA, SURGERY, FRACTURE, HEAD INJURY, ETC., AND GIVE DATE)
_____
RESIDUAL EFFECTS: _____

7. SPECIAL LAB TESTS AND FREQUENCY
_____
_____

8. PRESCRIPTION DRUGS (DOSAGE AND FREQUENCY, INCLUDING PRNS; SHOULD CORRELATE WITH DIAGNOSES)

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

9. LIST ALL DIAGNOSES (SHOULD CORRELATE WITH MEDICATIONS) (INCLUDE PSYCH DX)

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

10. POTENTIAL PROBLEM AREAS AND/OR ADDITIONAL COMMENTS
_____
_____
_____
_____

11. STABILITY
☐ 1. IMPROVING
☐ 2. STABLE
☐ 3. DETERIORATING
☐ 4. UNSTABLE

12. LEVEL OF CARE REQUESTED BY PERSON'S PHYSICIAN (CHECK ONE) ☐ NF ☐ RCF ☐ ICFMR ☐ MH ☐ SUPPLEMENTAL NC ☐ HOME CARE

13. MENTAL STATUS (CHECK ALL THAT APPLY)
☐ ORIENTED TO: ☐ person, ☐ place, ☐ time
☐ THINKS CLEARLY
☐ LETHARGIC
☐ ALERT
☐ MEMORY: ☐ good, ☐ fair, ☐ poor

14. BEHAVIORAL INFORMATION (CHECK ONE BOX FOR EACH)

NONE	MIN	MOD	MAX	
☐	☐	☐	☐	CONFUSED
☐	☐	☐	☐	WITHDRAWN
☐	☐	☐	☐	HYPERACTIVE
☐	☐	☐	☐	WANDERS
☐	☐	☐	☐	SUSPICIOUS
☐	☐	☐	☐	COMBATIVE
☐	☐	☐	☐	SUPERVISED FOR SAFETY
☐	☐	☐	☐	CAUSES MGT. PROBLEMS
☐	☐	☐	☐	CONTROLLED WITH MEDICATION(S)

15. FUNCTIONAL IMPAIRMENT (CHECK ALL THAT APPLY AND GIVE RATIONALE)
☐ VISION _____
☐ HEARING _____
☐ SPEECH _____
☐ AMBULATION _____
☐ MANUAL DEXTERITY _____
☐ TOILETING _____
☐ PATH TO SAFETY _____

16. ASSESSED NEEDS (CHECK APPROPRIATE BOX FOR EACH; GIVE RATIONALE PLUS AMOUNT OF STAFF ASSISTANCE NEEDED. (YOU MUST USE GUIDE #1 ON BACK.)

NONE	MIN	MOD	MAX	
☐	☐	☐	☐	1. MOBILITY _____
☐	☐	☐	☐	2. DIETARY _____
☐	☐	☐	☐	3. RESTORATIVE SERVICES _____
☐	☐	☐	☐	4. MONITORING _____
☐	☐	☐	☐	5. MEDICATION _____
☐	☐	☐	☐	6. BEHAVIOR/MENTAL COND. _____
☐	☐	☐	☐	7. TREATMENTS _____
☐	☐	☐	☐	8. PERSONAL CARE _____
☐	☐	☐	☐	9. REHAB. SERVICES _____

17. POTENTIAL FOR REHAB ☐ GOOD ☐ FAIR ☐ POOR

18. PATIENT REFERRED BY	19. FORM COMPLETED BY	
NAME OF INDIVIDUAL OR AGENCY	SIGNATURE OF INDIVIDUAL ▸	
ADDRESS	TELEPHONE NUMBER	
TELEPHONE	FAX NUMBER	DATE

CENTRAL OFFICE USE ONLY

LEVEL OF CARE DETERMINATION BY DIVISION DRL CENTRAL OFFICE

☐ 1 NF ☐ 2 IID ☐ 3 MH ☐ 4 SNC ☐ 5 NONE

NEXT EVALUATION DATE	SIGNATURE DATE
STATE PHYSICAN'S CONSULTANT ▸	

GUIDE #1 - ASSESSED NEEDS:

1. MOBILITY - individual's ability to move from place to place. Do they require assistive device, physical assist with transfer, mobile only with physical assist or unable to ambulate and/or totally dependent?
2. DIETARY - individual's nutritional requirements and need for assist and/or supervision with meals. Do they have a special diet, require tray set up, cueing, feeding or on tube feedings or IV fluids?
3. RESTORATIVE - specialized services provided to help individual obtain/maintain optimal function potential. Is individual receiving ROM, B & B program, RO, frequency, and amount of assistance required?
4. MONITORING - Observation and assessment of individual's physical and mental condition. This may include routine lab work, I & O, clinitest, acetest, weights and other routine procedures.
5. MEDICATION - A drug regimen of all physician ordered legend and non-legend drugs for which a physician has ordered monitoring due to complexity of drug or condition of individual.
6. BEHAVIORAL - individual's social or mental activities. Does individual require supervision/guidance or assist due to their behavior? Are they alert, oriented, disoriented, uncooperative, abusive or incapable of self-direction?
7. TREATMENTS - a systematized course of nursing procedures ordered by the attending physician. What is the treatment and how often is it ordered? Is the treatment non-routine and preventive, require daily attention by a professional or require extensive direct supervision?
8. PERSONAL CARE - activities of daily living, including hygiene, personal grooming (dressing, bathing, oral hygiene, hair and nail care, shaving), and bowel and bladder function. Does daily care require supervision, close supervision or total care?
9. REHABILITATION - restoration of former or normal state of health through medically ordered therapeutic services either directly provided by or under the supervision of a qualified professional, which may include PT, OT, ST and audiology. What type of rehab is individual receiving and how often do they receive it?

NOTE: Refer to 19 CSR 30-81.030 for complete details of point count system.

GUIDE #2 - INSTRUCTIONS (for Pre-Admission Screenings):

A. NURSING FACILITY ADMISSIONS FROM HOSPITALS–

1. If the person is hospitalized and will or MAY seek placement in a Medicaid certified bed within a skilled or intermediate nursing facility upon discharge, the hospital completes the Level One (I) Screening (DA-124C form) as soon as possible. If a Level Two (II) Screening is then indicated, the hospital also completes the DA-124A/B form **(all questions must be answered)**. Email both forms to: COMRU@health.mo.gov. NOTE: The hospital must take immediate action since the Level II Screening process takes 7-9 working days to complete. The physician's signature, discipline, license number and date are ALWAYS required.

2. In Missouri, Federal & State regulations require that Level II Screenings be completed PRIOR to nursing facility placement EXCEPT when a person qualifies for a SPECIAL ADMISSION CATEGORY (follow directions on DA-124C form). NOTE: COMRU nurse may require copy of History & Physical.

B. NURSING FACILITY ADMISSIONS FROM HOME OR RCF OR ALF–

1. Skilled/intermediate nursing facilities receiving persons directly from home should assist families in completing the Level I Screening (DA-124C) with instructions for them to obtain the family physician's signature. If a Level II Screening is indicated, completion of the DA-124A/B follows, as outlined in section A, #1 and 2.

2. EMERGENCY ADMISSIONS FROM HOME OR RCF OR ALF–If the person is a danger to himself or others, or if protective oversight is necessary, call the Adult Abuse and Neglect Hotline, 1-800-392-0210. Explain the emergency and ask that a DHSS Worker review the client for EMERGENCY admission to a skilled/intermediate nursing facility. Complete the DA-124A/B & C forms and contact COMRU immediately (573-522-3092). If the emergency occurs at night or on a weekend, do the same and contact COMRU at open of next business day before emailing the forms. If the person will require more than 7 days in a nursing facility, notify COMRU immediately.

3. All Medicaid certified beds, including swing beds, within skilled/intermediate nursing facilities MUST have a completed DA-124C form. If the person is PRIVATE PAY and their Level I Screening does NOT indicate the need for a Level II Screening, the DA-124C form is kept in their chart (on file) until they apply for Medicaid. At that time, a current DA-124A/B form is completed, attached to the original DA-124C form, and mailed to the same address as in section A, #1.

C. NURSING FACILITY TRANSFERS–

1. When persons transfer from one skilled/intermediate nursing facility to another, the sending facility furnishes a copy of their DA-124A/B & C forms to the receiving facility. The receiving facility then notifies their local FSD office of the transfer.

2. When persons transfer from one skilled/intermediate nursing facility to another and application for Medicaid is not indicated, the ORIGINAL DA-124C form must follow to the next facility.

D. TRANSFERS FROM A FACILITY TO A HOSPITAL TO ANOTHER FACILITY–

1. When the person transfers from one skilled/intermediate facility to a hospital, then to another skilled/intermediate facility, hospitals must consider the following prior to placement:

a. If the person did not need a Level II Screening prior to placement at the sending facility, no new forms are indicated if this hospital stay does not exceed 60 days (unless a current Level I Screening indicates the need for a Level II Screening).

b. If the person had a Level II Screening prior to placement at the sending facility, but is being hospitalized for acute medical treatment, no new forms are necessary if the hospital stay does not exceed 60 days.

E. PERSON IS DISCHARGED HOME BUT UNABLE TO STAY–

1. If person is out of facility less than 60 days, no new forms are required. Notify local FSD office of person's readmission.

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

NOTICE TO APPLICANT

APPLICANT'S NAME

Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable?
☐ Yes ☐ No

If yes, would you like to receive information and assistance regarding the agency's veteran services?
☐ Yes ☐ No

Federal Law (Section 1919(b) of the Social Security Act) requires a mental health screening for all persons seeking admission to a Medicaid certified nursing home. The purpose of this law, known as the Nursing Home Reform Act, is to ensure persons with mental health related conditions are placed in appropriate living arrangements where both their physical and mental health needs may be treated.

You are seeking admission to a Medicaid certified bed. Even though you may have completed screenings required by Missouri Department of Health and Senior Services, the nursing facility may **not** admit you to a Medicaid certified bed until all required mental health screenings are done.

The mental health screening is divided into two parts. The first screening (Level I) is done by the nursing home as part of the admission process or by a hospital before a patient is discharged. If the Level I screening suggests that you have a mental health need, a full evaluation (Level II) must be done by the Department of Mental Health.

This notice is to tell you that your Level I screening indicates that you may have a mental health service need. This means:

☐ 1. You may **not** be admitted to the nursing facility until there is a determination that nursing home placement is appropriate.

☐ 2. Due to the seriousness of your physical illness, you may be admitted to the nursing home. A full evaluation will be done later to determine if nursing home placement is appropriate.

☐ 3. Due to your need for **Respite Care**, you may be admitted to the nursing facility for no more than 30 days without a full evaluation if nursing home placement is appropriate.

☐ 4. Due to your need for **Emergency Care** for protection, you may be admitted to the nursing facility for no more than 7 days without a full evaluation to determine if nursing home placement is appropriate.

☐ 5. Your physician has certified that you are likely to require less than 30 days of nursing facility services for the condition for which you are currently receiving hospital care. If it becomes apparent that you will stay longer than 30 days, a full evaluation must be done at that time to determine that continued nursing home placement is appropriate.

Full Mental Health Evaluation

If a full mental health evaluation must be done, persons employed or contracted by the Department of Mental Health will contact you. The purpose of the full evaluation is to see if you:

1) have a mental health condition as defined by the Nursing Home Reform Act,

2) need nursing home level of care or another living arrangement, and

3) need special mental health services that the nursing home is unable to provide, or

4) need lessor intensity mental health services that the nursing home is mandated by law to provide.

You, or your legal representative, will be given the results of the full evaluation and appeal rights. If the results show that nursing home care is not right for your physical and mental health needs, the Department of Health and Senior Services and Department of Mental Health will give you information about other services that may better meet your needs.

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

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

Completion of this form is mandatory for all persons applying for admission to a Medicaid certified bed to determine appropriateness of the nursing facility placement.

SECTION A. IDENTIFYING INFORMATION

1. PERSON'S NAME *(LAST, FIRST, MI)*	2. DCN	3. SSN	4. DOB	5. SEX	6. RACE

7. PERSON'S MAILING ADDRESS *(STREET, CITY, STATE, ZIP)*	8. COUNTY	9. TELEPHONE NUMBER

10. Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable? ☐ Yes ☐ No
If yes, would you like to receive information and assistance regarding the agency's veteran services? ☐ Yes ☐ No

11. NAME AND ADDRESS OF PROPOSED FACILITY	TELEPHONE NUMBER

12. CHECK THE APPROPRIATE RESPONSE DESCRIBING THE PERSON'S ***PRIOR*** LIVING ARRANGEMENTS
☐ IN OWN HOME OR OTHER NON-INSTITUTIONAL SETTING ☐ RESIDENTIAL CARE FACILITY ☐ NURSING FACILITY
☐ GROUP HOME ☐ OTHER _____
☐ HOSPITAL: (GIVE REASON FOR HOSPITAL ADMISSION HERE) _____

SUBMITTING FAC	CONTACT	TELEPHONE NUMBER

SECTION B. LEVEL ONE SCREENING CRITERIA FOR SERIOUS MENTAL ILLNESS

1. DOES THIS PERSON SHOW ANY SIGNS OR SYMPTOMS OF MAJOR MENTAL DISORDER?
☐ NO ☐ YES - LIST HERE: _____
• GO TO NEXT QUESTION

2. HAS THIS PERSON EVER BEEN DIAGNOSED AS HAVING A MAJOR MENTAL DISORDER? **YOU MUST USE GUIDE #3 ON BACK.**
☐ NO ☐ YES - DX: _____
• GO TO NEXT QUESTION

3. IS THE **PRIMARY** REASON FOR NURSING FACILITY PLACEMENT DUE TO DEMENTIA, INCLUDING ALZHEIMER'S DISEASE OR RELATED DISORDER? **USE GUIDE #4 ON BACK.**
☐ NO - IF NO, GO TO THE NEXT QUESTION
☐ YES - IF YES, GIVE DX AND SKIP TO SECTION C #1 & #2.
DX: _____

4. HAS THE PERSON HAD SERIOUS PROBLEMS IN LEVEL(S) OF FUNCTIONING IN THE LAST SIX MONTHS? **YOU MUST USE GUIDE #5 ON BACK.**
☐ NO ☐ YES
• GO TO NEXT QUESTION

5. HAS THE PERSON RECEIVED INTENSIVE PSYCHIATRIC TREATMENT IN THE PAST TWO YEARS? **YOU MUST USE GUIDE #6 ON BACK.**
☐ NO ☐ YES
• GO TO NEXT SECTION (C).

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

1. IS THE PERSON KNOWN OR SUSPECTED TO HAVE INTELLECTUAL DISABILITY THAT ORIGINATED PRIOR TO AGE 18?
☐ NO ☐ YES - DX: _____
• GO TO NEXT QUESTION

2. IS THE PERSON KNOWN OR SUSPECTED TO HAVE A RELATED CONDITION? **YOU MUST USE GUIDE #7 ON BACK.**
☐ NO ☐ YES - DX: _____
• THIS COMPLETES THE LEVEL I SCREENING. IF YOU CHECKED YES ON #4 OR 5 IN SECTION B, A LEVEL II SCREENING IS INDICATED FOR SERIOUS MENTAL ILLNESS. IF YOU CHECKED YES ON #1 OR 2 IN SECTION C, A LEVEL II SCREENING IS INDICATED FOR INTELLECTUAL DISABILITY OR RELATED CONDITION. GO TO NEXT SECTION (D).

SECTION D. SPECIAL ADMISSION CATEGORIES (to be used only when a Level II Screening is indicated)

DOES THE PERSON'S CONDITION QUALIFY HIM/HER FOR A SPECIAL ADMISSION CATEGORY? ☐ NO ☐ YES
IF YES, CHECK ONLY ONE OF THE FOLLOWING, **IF IT APPLIES. YOU MUST USE GUIDE #8 ON BACK.**
☐ 1. TERMINAL ILLNESS - expected to result in death in six months or less.
☐ 2. SERIOUS PHYSICAL ILLNESS - **severe/end stage** disease (or physical condition) as listed on back.
☐ 3. RESPITE CARE - stays not more than thirty days to provide relief for in-home caregivers.
☐ 4. EMERGENCY PROVISIONAL ADMISSION - **Must be hotlined**. Stays not more than 7 days to protect person from serious physical harm to self or others.
☐ 5. DIRECT TRANSFER FROM A HOSPITAL - stays not more than 30 days for the condition for which the person is currently receiving hospital care.

SECTION E. PERMISSION TO PERFORM SCREENING

I HAVE RECEIVED NOTICE THAT I MAY NEED FURTHER EVALUATION BEFORE NURSING FACILITY PLACEMENT AND DO HEREBY AUTHORIZE THE RELEASE OF ANY PERTINENT MEDICAL/PSYCHIATRIC RECORDS TO THE STATE OF MISSOURI OR ITS LEGALLY AUTHORIZED REPRESENTATIVES.

SIGNATURE OF PERSON OR LEGAL GUARDIAN GRANTING CONSENT	DATE
X	X

WITNESS #1 (IF SIGNED BY MARK)	WITNESS #2 (IF SIGNED BY MARK)

SECTION F. PHYSICIAN'S AUTHORIZATION AND SIGNATURE (Always required)

I ATTEST THAT THE INFORMATION ON THIS FORM IS COMPLETE AND CORRECT AS KNOWN TO ME.

PHYSICIAN'S SIGNATURE, **MUST INCLUDE DISCIPLINE, AND LICENSE NUMBER**	DATE
X	X

MO 580-3374 (10-2021) DA-124C (10-21)