CSR

Rules of
Department of Social Services
Division 15—Division of Aging
Chapter 9—Certification

Title		Page
13 CSR 15-9.010	General Certification Requirements	3
13 CSR 15-9.015	Resident Assessment Instrument	16
13 CSR 15-9.020	Prelong-Term Care Screening	16
13 CSR 15-9.030	Evaluation and Assessment Measures for Title XIX Recipients and Applicants in Long-Term Care Facilities	19

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 15—Division of Aging
Chapter 9—Certification

13 CSR 15-9.010 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), procedures to be followed by nursing facilities when requesting a nurse staffing waiver and requirements for notification of residents of right to appeal prior to transfer.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(1) Definitions.

(A) Alternate remedy, a sanction as a result of noncompliance with federal regulations imposed upon a facility participating in the Medicare or Medicaid program, as provided by federal statute, including denial of payment for new admission.

(B) Certification, the determination by the Division of Aging or the Health Care Financing Administration that a skilled nursing or intermediate care facility (SNF/ICF) is in compliance with all federal requirements and is approved to participate in the Medicaid or Medicare programs.

(C) Credible allegation of compliance letter, a letter submitted by a provider to the division, following a determination by the division that a facility is out of compliance with one (1) or more level A requirements, which indicates the facility has taken measures to correct the level A deficiencies and requests that a revisit be done.

(D) Denial of payment for new admissions, an alternate remedy recommended to the Division of Medical Services by the Division of Aging by which the facility shall not admit new Medicaid residents for a period of time specified by the division not to exceed a date six (6) months from the date of survey.

(E) Distinct part, a unit within a facility organized and operated to give a distinct type of care within a larger organization rendering other levels of care. This unit must be physically identifiable and be organized and operated distinguishably from the rest of the institution and must consist of all beds within that unit—such as a separate building, floor, wing, ward or several rooms at one end of a hall or one side of a corridor.

(F) Division, the Division of Aging (DA), Missouri Department of Social Services.

(G) HCFA, the Health Care Financing Administration section of the United States Department of Health and Human Services (HHS).

(H) ICF/MR, intermediate care facility for mentally retarded.

(I) Level A requirement, a major requirement contained in 42 CFR chapter IV part 483 subpart B with which a Medicaid- or Medicare-certified facility must be in compliance in order to be initially certified or remain certified.

(J) Medicaid, Title XIX of the federal Social Security Act.

(K) Medicare, Title XVIII of the federal Social Security Act.

(L) Nursing facility (NF), 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 Division of Aging.

(M) Reasonable assurance period, a period of between sixty and one hundred eighty (60—180) days during which a facility decertified from participating in the Medicaid or Medicare program, or both, must maintain compliance before it can be reconsidered for participation in the program from which decertified.

(N) Skilled nursing facility (SNF), an SNF licensed under Chapter 198, RSMo which has a signed agreement with the HCFA to participate in the Medicare program and which has been recommended for certification by the Division of Aging.

(O) Title XVIII, the Medicare program as provided for in the federal Social Security Act.

(P) Title XIX, the Medicaid program as provided for in the federal Social Security Act.

(2) An operator of a SNF or ICF licensed by the division wishing 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 wishing to be certified as an ICF/MR facility under Title XIX shall submit application materials to the division as required by federal law and shall comply with standards set forth by the United States Department of HHS in 42 CFR chapter IV, part 483, subpart B for nursing homes and 42 CFR part 483, subpart D for ICF/MR facilities, as appropriate.

(A) For Medicaid, the application shall include:

1. Form HCFA 671, Long Term Care Facility Application for Medicare and Medicaid;

2. Form HCFA 1513, Disclosure of Ownership and Control Interest Statement; and

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

(B) For Medicare, the application shall include:

1. Form HCFA 671, Long Term Care Facility Application for Medicare and Medicaid;

2. Form HCFA 1513, Disclosure of Ownership and Control Interest Statement;

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

4. Two (2) copies of form HCFA 1561, Health Insurance Benefit Agreement;

5. Two (2) copies of form HCFA 2572, Statement of Financial Solvency; and

6. Three (3) copies of form HHS 690, Assurance of Compliance.

(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 division in writing to the operator following receipt of the properly completed application material referenced in subsection (2)(A) or (2)(B). 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 not be certified until the fee has been paid. The facility shall complete all requirements for certification prior to the end of the federal fiscal year in which application was made. If not, an additional certification fee of one thousand dollars ($1,000) shall be submitted to the division by October 1 or the application shall be considered withdrawn.

(D) All SNFs or NFs licensed and certified prior to October 1, 1995 shall submit to the division the initial certification fee of one thousand dollars ($1,000) prior to October 1, 1995. Subsequently, in order to maintain certification in the Medicaid or Medicare program(s) all SNFs or NFs shall submit to the division 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 division. If payment of any fees due is not received by the division by the time the facility license expires or by December 31 of that year, whichever is earlier, the division shall notify the Division of Medical Services and the Health Care Financing Administration recommending termination of the Medicaid or Medicare agreement as denial of license will occur as provided in 13 CSR 15-10.010 and section 198.022, RSMo.

(3) Application material shall be signed and dated and submitted to the division's central office at least fourteen (14) working days prior to the date the facility is ready to be surveyed for compliance with federal regulations. The operator or authorized representative shall notify the appropriate division 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 wishing to participate in the Title XVIII Medicare program shall submit an application signed and dated to the division's central office. The division will recommend Medicare certification to the HCFA effective the date the application material is received by the division 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 division and provided the facility's application is complete.

(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 division's central office. The division will certify the facility for Medicaid participation effective the date the application is received by the division 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 division 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 administrator has signed an acceptable plan of correction for deficiencies cited at the survey, whichever is the later date. The facility shall be in compliance with state and federal regulations at the initial certification survey conducted by the division. The application shall be completed and, for certification in the Title XVIII (Medicare) program, the HCFA must concur with the division's recommendation.

(7) The division shall conduct federal surveys for both the initial and recertification purposes in SNFs, NFs and ICF/MR facilities, utilizing regulations and procedures contained in—

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

(B) The Health Standards and Quality Regional letters received by the division from the HCFA regional office in Kansas City;

(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 D.

(8) A facility, in its application, shall designate the number of beds to be certified and the location in their 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 wishes to reduce or increase the number of beds in the facility which are certified, a written request shall be submitted to the licensure/certification unit of the division or the ICF/MR unit of the Department of Social Services, as applicable. The request shall specify the room numbers involved, the number of beds in each room and the effective date. Bed increases shall be limited to two (2) increases per facility fiscal year. Requests for bed decreases or changes in location may be made at any time. Prior to approval of the request, the request shall be reviewed and approved by the appropriate division regional office and the facility shall complete and sign a new DA-113 form, Bed Classification for Licensure and Certification by Category.

(10) If a facility certified to participate in the Title XIX (Medicaid) program wishes to decertify a bed(s) for a temporary period to assist a resident(s) who is applying for benefits under the division of assets provisions of the federal Catastrophic Health Care Act of 1988, a written request shall be submitted to the licensure/certification unit of the division. The request shall specify the room number(s) and number of beds per room and that the purpose is to implement the division of assets provision of the Medicare Catastrophic Health Care Act. It shall also specify that the decrease is temporary and shall indicate the beginning and ending date of the temporary period. The beds decertified need not be contiguous.

(11) 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 division 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 division shall provide the application to the HCFA. Certification status will be retained unless or until formally denied.

(12) If it is determined by the division 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, a revisit will be conducted approximately forty (40) days following the completion of the federal survey, complaint investigation or state licensure inspection to determine if the facility has achieved compliance if the facility submits to DA a credible allegation of compliance letter. The credible allegation of compliance letter must be received by the division within thirty-five (35) days of the completion date of the survey. If the facility is not in compliance with federal regulations following the revisit or had not submitted a credible allegation of compliance letter within thirty-five (35) days of the survey completion date, the division shall take enforcement action as provided in sections 198.026 and 198.067, RSMo and in 42 U.S.C. 1396(r). This includes decertification and the alternate remedies as given in sections 1819(h) and 1919(h) of the Social Security Act. If a facility has been found out of compliance with any of the level A requirements, quality of care, quality of life, residents' rights, and resident behavior and facility practices on three (3) consecutive surveys, the alternate remedies, denial of payment for new admissions and state monitoring will automatically be imposed and will continue until the facility has demonstrated to the satisfaction of the state that it is in compliance with federal requirements and that it will remain in compliance.

(13) If a facility certified to participate in the Medicaid Title XIX or Title XVIII Medicare program has been decertified as a result of noncompliance with federal regulations, the facility can be readmitted only when the reasons for the decertification no longer exist, there is reasonable assurance that they will not recur and all state and federal statutory and regulatory requirements are fulfilled. If the facility operator requests readmission of the facility into certified status, the operator shall submit a letter to the division alleging that the reasons for the decertification no longer exist. If the information provided in the letter is sufficient, a revisit will be conducted by the division staff, concentrating on the areas that caused the decertification action. If the facility has achieved compliance, a time frame, referred to as reasonable assurance period, will be established. The reasonable assurance period will be between sixty and one hundred eighty (60—180) days and will be determined based upon the provider's compliance history and correction of deficiencies on which decertification was based. For Title XIX Medicaid, the reasonable assurance period will be set by the division. For Title XVIII Medicare, it will be set by the HCFA. The facility shall maintain compliance without recurrence of the deficiencies which were the basis for decertification during the reasonable assurance period. Division staff will monitor the facility to assure the facility maintains compliance. Just prior to the end of the reasonable assurance period, the division shall conduct a full federal survey. If the facility is found not in compliance or does not maintain compliance during the reasonable assurance period, the decertification shall remain in effect.

(14) If a facility certified to participate in the Title XIX Medicaid or Title XVIII Medicare program has been placed under an alternate remedy as a result of noncompliance with federal regulations, the alternate remedy can be lifted only if the facility has corrected all level A deficiencies. To request a revisit, the facility shall submit a credible allegation of compliance letter to the division. If the letter is approved, a revisit will be conducted by division staff. If it has been determined that for Title XIX Medicaid, compliance has been achieved with all level A requirements, the division will lift the alternate remedy; for Title XVIII Medicare, the results of the revisit will be submitted to the HCFA for a decision. For a facility that is Medicare/Medicaid-certified, the HCFA decision is binding for both Medicare and Medicaid. If the facility fails to achieve compliance, the division will proceed with decertification actions as specified in sections 1819(h) and 1919(h) of the Social Security Act and sections (12) and (13) of this rule.

(15) If a change in the administrator or the director of nursing of a facility occurs, the facility shall provide written notice to the division's central office at the time of the change. The notice shall indicate the effective date of the change, the identity of the new director of nursing or administrator and a copy of his/her license or the license number. A change of administrator is also part of the licensure application process; therefore, the information shall be submitted as a notarized statement by the operator in accordance with section 198.018, RSMo.

(16) 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 deputy director, Division of Aging.

(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 division shall consider each request for a waiver and shall approve or disapprove the request in writing 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.

(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 form HCFA 672, Resident Census and Conditions of Residents;

5. Evidence that the facility has a registered nurse consultant required under 13 CSR 15-14.042(36)(B) 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 20(c)(1)(ii);

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 13 CSR 15-14.042(6); 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 division 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 Division of Aging will consider revocation of the waiver.

(F) The facility shall cooperate with the Division of Aging in providing the proper documentation. For renewal requests, the request and proper documentation shall be submitted to the Division of Aging 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 division shall notify the facility in writing and within twenty (20) days, the facility shall submit to the division a written plan for how the facility will recruit the required personnel. If appropriate personnel are not hired within two (2) months, the division shall initiate enforcement proceedings.

AUTHORITY: section 536.021, RSMo Supp. 1997. 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.*

**Original authority 1975, amended 1976, 1989, 1992, 1993, 1994, 1997.*

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF AGING

BED CLASSIFICATION FOR LICENSURE AND CERTIFICATION BY CATEGORY

NAME OF FACILITY		DATE	FOR OFFICIAL USE ONLY BEDS CERTIFIED
CITY	COUNTY		TOTAL LICENSED BEDS

ROOM IDENTIFICATION				LICENSURE				CERTIFICATION		
FLOOR NO.	WING OR UNIT	ROOM NO. **	NO. OF BEDS	RCFI	RCFII	ICF	SNF	XVIII SNF	XIX NF	XIX ICF/MR
TOTAL BEDS								PAGE	OF	

Place an "X" under the category in which the bed is licensed and **certified.** If a bed is certified in more than one category, put an "X" under each category certified. ** Designate Isolation Rooms by placing an "X" beside the room number.	ADMINISTRATOR'S SIGNATURE ▶

MO 886-1098 (10-90)

DA-113 (10-90)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB No 0938-0086

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (HCFA-1513)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete Part II(a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V	- 42CFR 51a.144
Title XVIII	- 42CFR 420.200-206
Title XIX	- 42CFR 455.100-106
Title XX	- 45CFR 228.72-73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original and second and third copies to the State agency; retain the first copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the from. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I (a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

(b) **For Regional Office Use Only.** If the yes box is checked for Item VII the Regional Office will enter the 5-digit number assigned by HCFA to chain organizations.

Item II - Self-explanatory.

Item III - List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownerwhip interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV-VII - Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV-VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V - If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI - If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII - A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII - If yes, list the actual number of beds in the facility now and the previous number.

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0086

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

(a). Name of Entity	D/B/A	Provider No.	Vendor No.	Telephone No.
Street Address		City, County, State		Zip Code

(b) *(To be completed by HCFA Regional Office)* Chain Affiliate No. ☐☐☐☐☐ LB1

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

☐ Yes ☐ No LB2

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

☐ Yes ☐ No LB3

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

☐ Yes ☐ No LB4

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN
		LB5

(b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation LB6
☐ Unincorporated Associations ☐ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

☐ Yes ☐ No LB7

Name	Address	Provider Number

Form HCFA-1513 (5-86) Page 1

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0086

IV. (a) Has there been a change in ownership or control within the last year?
If yes, give date ____________ ☐ Yes ☐ No LB8

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? ____________ ☐ Yes ☐ No LB9

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? ____________ ☐ Yes ☐ No LB10

V. Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations ____________ ☐ Yes ☐ No LB11

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?
☐ Yes ☐ No LB12

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
Name EIN # ☐ Yes ☐ No LB13

Address

LB14

VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain?
(If YES, list Name, Address of Corporation and EIN)
Name EIN # ☐ Yes ☐ No LB18

Address

LB19

VIII. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?
☐ Yes ☐ No LB15

If yes, give year of change ____________
Current beds ____________ LB16 Prior beds ____________ LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed)	Title
Signature	Date

Remarks

Form HCFA-1513 (5-86) Page 2

ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

______________________________ (hereinafter called the "Applicant")
Name of Applicant (type or print)

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this Assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this Assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this Assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance, and that the United States shall have the right to seek judicial enforcement of this Assurance. This Assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the Applicant.

Date ______________ ______________________________
Applicant (type or print)

By ______________________________
Signature and Title of Authorized Official

____

____
Applicant's mailing address

NOTE: If this form is not returned with the application for financial assistance, return it to DHHS, Office for Civil Rights, 330 Independence Ave., S.W., Washington, D.C. 20201

HHS-441 (Rev. 12/82)

U.S. GOVERNMENT PRINTING OFFICE: 1990 0—944-760

STATEMENT OF FINANCIAL SOLVENCY

For the purpose of establishing eligibility for payment under Title XVIII of the Social Security Act,
hereinafter referred to as the provider of services, hereby states and declares:

1. That the provider of services has not been adjudged insolvent or bankrupt in a State or Federal court; and
2. That a court proceeding to make a judgment of bankruptcy or insolvency with respect to the provider of services is not pending in a State or Federal court.

In addition, the provider of services agrees to inform the Secretary of Health and Human Services, through the Health Care Financing Administration Regional Office, immediately if prior to the acceptance of the Health Insurance Benefits Agreement by the Secretary of Health and Human Services, a court proceeding to make a judgment of insolvency or bankruptcy is instituted with respect to the provider of services.

FOR PROVIDER OF SERVICES BY:

NAME OF AUTHORIZED OFFICIAL *(Please type)*	TITLE
SIGNATURE OF AUTHORIZED OFFICIAL	DATE

Form HCFA-2572 (4-81)

*U.S. Government Printing Office: 1988-241-188/91165

HEALTH INSURANCE BENEFIT AGREEMENT

(AGREEMENT WITH PROVIDER PURSUANT TO SECTION 1866 OF THE SOCIAL SECURITY ACT, AS AMENDED AND TITLE 42 CODE OF FEDERAL REGULATIONS (CFR) CHAPTER IV, PART 489)

AGREEMENT
BETWEEN
THE SECRETARY OF HEALTH AND HUMAN SERVICES
AND

____

doing business as (D/B/A) ____________________

In order to receive payment under Title XVIII of the Social Security Act, ______________________________

D/B/A ______________________________ as the provider of services, agrees to conform to the provisions of Section 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME (SIGNATURE)

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME (SIGNATURE)

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME (SIGNATURE)

TITLE	DATE

Form HCFA-1561 (10-90)

★U.S.GPO:1991-0-281-872/23685

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

SKILLED NURSING FACILITY AND INTERMEDIATE CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Name of Facility:	Provider Number:		Standard Survey F1 __/__/__ to F2 __/__/__ Extended Survey F53 __/__/__ to F54 __/__/__	
Street Address:	City:	County:	State:	Zip Code:
Telephone Number: F3	State/County Code: F4		State/Region Code: F5	

A. 01 Skilled Nursing Facility (SNF)
02 Intermediate Care Facility (ICF)
03 SNF/ICF
04 Nursing Facility (NF) [ ] F6

B. Is this facility hospital based?
1 Yes 2 No [ ] F7
If yes, indicate
Hospital Provider Number F8 ____

C. If "01" or "03" in "A" is selected, indicate the type of program participation requested:
1 Medicare 2 Medicaid 3 Both
[ ] F9

Ownership				
[ ] F10	← FOR PROFIT →	[ ] Individual (01)	[ ] Partnership (02)	[ ] Corporation (03)
	← NONPROFIT →	[ ] Church Related (04)	[ ] Nonprofit Corporation (05)	[ ] Other Nonprofit (06)
	← GOVERNMENT →	[ ] State (07)	[ ] City (09)	[ ] Hospital District (11)
		[ ] County (08)	[ ] City/County (10)	[ ] Federal (12)

Owned or leased by Multi-Facility Organization? 1 Yes 2 No [ ] F11

Name of Multi-Facility Organization: F12

Dedicated Special Care Units (show number of beds for all that apply)

F13 ____ AIDS	F14 ____ Alzheimer's Desease	F15 ____ Dialysis
F16 ____ Disabled Children/Young Adults	F17 ____ Head Trauma	F18 ____ Hospice
F19 ____ Huntington's Disease	F20 ____ Ventilator/Respiratory Care	F21 ____ Other Specialized Rehabilitation

Does the facility currently have an organized residents group? (483.15 (c)(1)) 1 Yes 2 No [ ] F22

Does the facility currently have an organized group of family members of residents? (483.15 (c)(2)) 1 Yes 2 No [ ] F23

Does the facility conduct experimental research (483.10 (b)(4)) 1 Yes 2 No [ ] F24

FORM HCFA-671 (1-90)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FACILITY STAFFING (HOURS WORKED)

	Tag #	A Services provided 1 2 3	B Full-time staff (35+ hours/week)	C Part-time staff (<35 hours/week)	D Contract
Administration (483.75 (e)(2))	F25				
Physician Services:	F26				
Medical Director (483.75 (k))	F27				
Other Physician (483.40 (a)(2)/(d))	F28				
Nursing Services: (483.28 / 483.29)	F29				
Registered Nurses	F30				
Licensed Practical/Vocational Nurses	F31				
Nurse Aides/Orderlies	F32				
Pharmacists: (483.60 (d))	F33				
Dietary Services:	F34				
Dietitian (483.35 (a))	F35				
Food Service Workers (483.35 (b))	F36				
Therapeutic Services:	F37				
Occupational Therapists (483.45 (a))	F38				
Occupational Therapy Assistants/Aides (483.45 (a))	F39				
Physical Therapists (483.45 (a))	F40				
Physical Therapy Assistants/Aides (483.45 (a))	F41				
Activities Therapists (483.15 (f)(2))	F42				
Medical Social Workers (483.15 (g))	F43				
Speech-Language Pathologists (483.45 (a))	F44				
Dentists (483.55 (d))	F45				
Podiatrists (483.25 (k)(7))	F46				
Mental Health Services	F47				
Vocational Services	F48				
Clinical Labs	F49				
Diagnostic X-ray	F50				
Administration and Storage of Blood	F51				
Housekeeping Services	F52				

Name of person completing form: Time:

Signature: Date:

13 CSR 15-9.015 Resident Assessment Instrument

PURPOSE: This rule designates the resident assessment instrument to be used by nursing facilities certified under the Title XIX (Medicaid) program and Title XVIII (Medicare) program for all residents in certified beds.

Editor's Note: The secretary of state has determined that it would be unduly cumbersome to publish in entirety the 146-page Health Care Financing Administration's resident assessment instrument which is being adopted by the Division of Aging for use in Missouri in federally certified facilities. The division has filed a copy with the secretary of state and it is available at a cost established by state law or it is also available directly from the division at no cost for a single copy.

(1) Effective January 1, 1991 a resident assessment instrument (RAI) shall be utilized by all nursing facilities (NFs) certified under Title XIX (Medicaid) and Title XVIII (Medicare) to perform uniform resident assessments for all residents in certified beds, regardless of payment source, as required by Title 42 U.S.C. Section 1396(r)(3)(A) of the Social Security Act.

(2) The RAI utilized shall be the one designated by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (HHS). It is comprised of three (3) parts—

(A) The utilization guidelines, which are instructions concerning when and how to use the RAI;

(B) The minimum data set (MDS) of core elements and definitions, which is a minimum set of screening and assessment elements, including common definitions and coding categories, needed to comprehensively assess an individual nursing home resident. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies; and

(C) The resident assessment protocols (RAPs), which are structured frameworks for organizing MDS elements and additional clinically relevant information about an individual that contributes to care planning.

(3) Resident assessments shall be documented on the MDS and the RAPs shall be utilized.

(4) Frequency of Assessments.

(A) A newly admitted resident to a certified bed shall have an assessment within fourteen (14) days of admission to the facility.

(B) Each resident in a certified bed shall have an updated assessment within fourteen (14) days after a significant change in the resident's physical or mental condition.

(C) Each resident shall be examined quarterly and the MDS core elements specified in the utilization guidelines shall be reviewed and any changes documented.

(D) Each resident in a certified bed shall have a full annual assessment no later than twelve (12) months following the last full assessment. Residents in certified beds on October 1, 1990 shall have a full assessment completed by October 1, 1991.

(5) The division shall provide each certified facility with a copy of the RAI, including guidelines for completion. Facilities may then duplicate the RAI or purchase the instrument either in paper or computerized form from a private supplier for use when performing assessments.

(6) A paper copy of all MDSs and RAP summary sheets completed for each resident shall be in the resident's record. A facility may document on the MDS form additional information regarding a resident which is not included in the standard MDS, or may use a version of the MDS which has special codes or notations, but if information is added, the additional information shall be either in an appendix or the facility shall provide a copy of the MDS in its standard form without the additional information for use in review. All MDSs and RAP summary sheets completed within the last two (2) years must be easily retrievable from the resident's record if requested by a representative of the Division of Aging or the federal survey and certification agency.

(7) All resident assessments shall be performed and the MDSs and RAPs shall be completed in accordance with the utilization guidelines, the definitions and all other directions as given on the forms.

(8) Whenever a resident assessment is completed on any resident in a Medicaid- or Medicare-certified bed, a legible copy of the fully completed MDS portion of the RAI shall be sent to the division within thirty (30) calendar days of completion. Forms shall be sent to: Missouri Division of Aging, Attention: MDS Unit, P.O. Box 1337, Jefferson City, MO 65102. The forms shall be submitted by each facility as a group once per month for all residents assessed in the last thirty (30) days and submitted in paper form unless the facility has requested in writing and has received written permission from the division to submit the MDS information on a properly formatted computer disk by mail or electronically.

(9) Effective June 1, 1993, all facilities shall send to the Missouri Division of Aging, to either the Attention of the MDS Unit, P.O. Box 1337, Jefferson City, MO 65102 or the appropriate regional Division of Aging office, at the same time the monthly MDS form or MDS data are being mailed, a list of names of all residents who have died or who have been discharged from the facility (and not readmitted) during the preceding month. In addition, included with the mailing at the end of June, the facility shall submit a list of those residents who have died or who were discharged from the facility since August 1, 1992. This listings shall include the complete name of the resident, as well as some specific identifying information for each, such as the Social Security number, the birthdate or the department client number (DCN).

AUTHORITY: section 536.021, RSMo Supp. 1993. 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.*

**Original authority 1975, amended 1976, 1989, 1992, 1993.*

13 CSR 15-9.020 Prelong-Term Care Screening

PURPOSE: This rule establishes the requirement and procedure for screening by the Division of Aging of Medicaid-eligible and potentially Medicaid-eligible individuals considering long-term care, in order to acquaint them at the earliest possible time with all services available to them, to determine on a preliminary basis their level-of-care need and to permit an effective evaluation by a Division of Aging worker of the resources available in the home, family and community, as required by 42 CFR 456.370(c)(7).

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

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

(A) Initial Assessment Form means the Division of Aging form utilized to collect information necessary for a determination of level-of-care need pursuant to 13 CSR 15-9.030, designated Form DA-124;

(B) Intermediate care facility (ICF) as defined in section 198.006, RSMo;

(C) Long-term care facility means an ICF, a skilled nursing facility (SNF), as defined in section 198.006, RSMo, or a hospital providing skilled or intermediate nursing care in a distinct part under Chapter 197, RSMo;

(D) Make a referral means a contact by telephone, referring the name and address of the potential Medicaid recipient and any other available pertinent information about the potential Medicaid recipient;

(E) Medicaid agency means the single state agency administering or supervising the administration of the Missouri State Medicaid plan;

(F) Medical assistance means benefits provided under section 208.152, RSMo;

(G) Participation in the Medicaid program means the ability and authority to provide services to eligible Medicaid recipients and to receive payment from the Medicaid program for the services;

(H) Potential Medicaid resident means any individual who—a) has already been determined by the Division of Family Services to be eligible for Medical Assistance benefits, b) has applied to the Division of Family Services for Medical Assistance benefits or c) has less than one thousand dollars ($1000) in cash and liquid assets if single or less than two thousand dollars ($2000) in cash and liquid assets if married;

(I) Provider means an SNF, an ICF or a hospital providing skilled or intermediate nursing care in a distinct part under Chapter 197, RSMo which has been certified to participate in the Medicaid program;

(J) Resident as defined in section 198.006, RSMo; and

(K) Skilled nursing facility, or SNF, as defined in section 198.006, RSMo.

(2) All providers shall make a referral to the toll-free Division of Aging hotline (1-800-392-0210) within one (1) working day after the facility is initially contacted by or on behalf of a potential Medicaid resident unless the potential Medicaid resident is, at the time of the initial contact—

(A) Residing in another long-term care facility as a Medicaid resident;

(B) In a hospital and had been in a long-term care facility as a Medicaid resident immediately prior to the hospitalization;

(C) In a hospital and hospital staff can document they have made a referral to the Division of Aging;

(D) Residing in a state hospital for the mentally ill operated under Chapter 630, RSMo or a state habilitation center operated under Chapter 630, RSMo; and

(E) A child (seventeen (17) years of age or under).

(3) In order to document that referrals to the Division of Aging have been made as required by this rule, providers shall provide the following information, with regard to each resident applying for Medicaid benefits, on the Initial Assessment Form:

(A) The date the provider was initially contacted by or on behalf of the resident concerning admission to an long-term care facility;

(B) The date the resident was initially admitted to the provider's facility;

(C) The date a referral was made to the Division of Aging and the screening referral number assigned by the Division of Aging hotline when the referral was made; and

(D) If the provider did not make a referral to the Division of Aging, an explanation of why no referral was made.

(4) When the provider makes a referral to the Division of Aging, the Division of Aging will contact the potential Medicaid resident or his/her guardian within five (5) working days of the date of the referral. The Division of Aging will provide the potential Medicaid resident with information regarding services available to meet the individual's needs in the home, if the services are available and with information regarding long-term care facilities. If the individual or his/her guardian wishes to receive services in a home-based setting, the Division of Aging will evaluate the individual to determine the potential availability of alternative services and advise the individual or guardian that if s/he wish to obtain financial assistance for these services, s/he will need to apply for Title XIX benefits at the respective County Division of Family Services Office. Once the application is made, services may be authorized by the Division of Aging. If the individual or his/her guardian has no objection, the individual's relatives and other significant persons, including the attending physician, may be included in discussions. If the person wants to enter an long-term care facility s/he will be given a Division of Aging DA-13 form with documentation of the screening referral number to give to the provider to verify that alternatives to long-term care facility care have been presented.

(5) The Medicaid agency may terminate or suspend the participation in the Medicaid program of a provider determined to have demonstrated a consistent pattern or practice of failing to comply with this rule. The Medicaid agency shall offer a provider the opportunity for a hearing as required by 42 CFR sections 431.151—431.154.

(6) The Medicaid agency may withhold or recoup Medicaid payments to a provider for services provided to a resident from the time of admission to a provider's facility until the recipient is determined eligible for ICF or SNF level-of-care if the provider failed to make a referral of that resident to the Division of Aging as required by this rule. This recoupment or withholding shall be accomplished utilizing the procedures, and after providing prior notice to the provider, set out at 13 CSR 70-3.030(5) and 13 CSR 70-10.005(9). Providers from whom payments have been withheld or recouped pursuant to this section shall not charge or attempt to charge the resident or his/her responsible party for the amount withheld or recouped by the Medicaid agency.

(7) The Medicaid agency shall not impose the sanctions provided for in section (5) or withhold or recoup in accordance with section (6) of this rule as a result of any failure to make a referral where the provider made a good faith effort to determine whether the resident in question was a potential Medicaid resident but received incorrect or incomplete information.

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. 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.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986; 208.159, RSMo 1979; and 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991.*

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF AGING

LTACS CLIENT REPORT

INITIAL	CORR.	UPDATE	REASS.	CLOSE	REASON

A. CLIENT INFORMATION

NAME	STREET ADDRESS	CITY	ZIP

DCN	SSN	R	S	DOB	CO	LA	REF	INC	INC TYPE	XIX

DEINST MM YY	MON	MEDS	TRTS	REST	REHB	PC	BEH	MOB	DIET	LOC	ENV	G/B	TLTG	SH/TR	HOUS	SUPS	FIN	ANE	GDN	ALZ	BLD

B. TITLE XIX SERVICES

SERV	OPEN	CLOSE	SERV	OPEN	CLOSE	DA-II EXPIRES	DATE OF PAS

REASON FOR CLOSING TXIX

C. NON-TITLE XIX PURCHASED SERVICES

FIRST PROVIDER NAME	PROVIDER NO	SECOND PROVIDER NAME	PROVIDER NO.

FUND	SERV	UNITS	OPEN	CLOSE	PROV	FUND	SERV	UNITS	OPEN	CLOSE	PROV

D. MISCELLANEOUS

SSBG CO-PAY MM YY	DATE OF DA-2	CASELOAD NO.	SIGNATURE	DATE

E. COMMENTS

MO 886-1165 (8-88) **DISTRIBUTION: WHITE**/PROVIDER **CANARY**/CENTRAL OFFICE **PINK**/CASE RECORD **GOLDENROD**/SUPERVISOR DA-13 (8/88)

13 CSR 15-9.030 Evaluation and Assessment Measures for Title XIX Recipients and Applicants in Long-Term Care Facilities

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.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(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 determination of level-of-care need—the original decision whether an individual qualifies for either intermediate nursing care or skilled nursing care;

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

(E) Inspection of care (IoC)—a formal review conducted at least annually for each Title XIX recipient in a certified long-term care facility to assure services are adequate to meet health, rehabilitation and social needs of the recipient;

(F) Intermediate care facility (ICF)—as defined in section 198.006, RSMo;

(G) Intermediate nursing care—twenty-four (24)-hour care provided under the daily supervision of a licensed practical nurse or a registered nurse;

(H) 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 distinct part or swing bed under Chapter 197, RSMo;

(I) Plan I facility—an ICF facility which has made private utilization review arrangements through a committee of professionals not directly involved with the facility;

(J) Plan II facility—an ICF facility which has no private utilization review arrangements and must be reviewed by the state;

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

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

(M) Redetermination of level-of-care—the periodic assessment of the recipients' continued eligibility and need for continuation at the previously assigned level-of-care;

(N) Resident—as defined in section 198.006, RSMo;

(O) Skilled nursing care—is a twenty-four (24)-hour care requiring specialized judgment by licensed nursing personnel provided under the daily supervision of a registered nurse;

(P) Skilled nursing facility (SNF)—as defined in section 198.006, RSMo; and

(Q) Utilization review (UR)—a review of all inpatient Title XIX recipients who are residents in long-term care facilities to assure the recipients are receiving appropriate levels of care and continued stay is necessary.

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

(A) The Division of Aging staff or its designated agents, or both, will conduct a review and assessment of the evaluations made by the attending physician pursuant to 42 CFR Section 456.270 for an applicant in or seeking admission to an SNF, or of the evaluation made by the interdisciplinary team pursuant to 42 CFR Section 456.370 for an applicant in or seeking admission to an ICF, for the purpose of making an initial determination of level-of-care need. The review and assessment shall be conducted in accordance with 42 CFR Sections 456.271 and 456.371 for applicants in or seeking admission to an SNF or ICF respectively and the assessment criteria in section (5) of this rule and it shall be completed within ten (10) working days from receipt by the Division of Aging central office of the completed evaluation required under 42 CFR Section 456.270 or 456.370. No Title XIX payment for intermediate or skilled nursing care services in a certified long-term care facility may be made prior to completion of the review and assessment process.

(3) IoC and UR.

(A) The Division of Aging will be responsible for performing medical review functions required under 42 U.S.C. 1396.

(B) The Division of Aging will conduct onsite annual inspections of care of all inpatient Title XIX recipients in long-term care facilities certified by the Division of Aging as specified in 42 CFR 456.600—456.657.

(C) The Division of Aging will conduct semiannual utilization reviews of all inpatient Title XIX recipients in Plan II facilities. Plan I facilities shall conduct UR every six (6) months of all inpatient Title XIX ICF recipients. SNFs shall conduct UR on each skilled recipient at least every thirty (30) days for the first ninety (90) days and at least every ninety (90) days after that. The facilities shall notify the Division of Aging if there is any change in level-of-care of any recipient.

(D) Redetermination of level-of-care of individual recipients in long-term care facilities will be established by the Division of Aging through a review of the ongoing records and notations made by the resident's physician regarding care needed as well as by considering the individual's functional ability as indicated in sections (4) and (5).

(4) Level-of-Care Criteria for Intermediate and Skilled Nursing 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—mobility, dietary, restorative services, monitoring, medication, behavioral, treatments, personal care and rehabilitative services.

(C) To qualify for 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 skilled nursing care.

(D) To qualify for intermediate level-of-care, an applicant or recipient shall exhibit physical or mental impairment, or both, which requires intermediate nursing care.

(5) Assessed Needs Point Designations.

(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 cited in subsections (4)(C) and (D) of this rule.

(C) The higher point value will be assessed, unless the lower point value can be justified.

(D) An applicant or recipient will be determined to be qualified for skilled nursing care if s/he is determined to need care with an assessed point level of fifty-four (54) points or above, using the assessment procedure as stated in this section.

(E) An applicant or recipient will be determined to be qualified for intermediate nursing care if s/he is determined to need care with an assessed point level of eighteen to forty-eight (18—48) points using the assessment procedure as stated in this section.

(F) Applicants or recipients with twelve (12) points or lower will normally be assessed as ineligible for Title XIX-funded intermediate or skilled nursing services in an long-term care facility, unless they qualify as otherwise provided in subsection (5)(H) or (J), or both, of this rule.

(G) A special central office review will be conducted by Division of Aging administrative staff and medical staff for applicants or recipients assessed at fifty-one (51) points (between skilled care and intermediate care) and applicants or recipients assessed at fifteen (15) points (between intermediate care and lower levels of care).

(H) Applicants or recipients may occasionally require care or services, or both, which could qualify as skilled nursing services. In these instances, it may be that a single nursing service requirement will be used as the qualifying factor, making the person eligible for skilled nursing care regardless of the total point count. The determining factor will be the availability of professional personnel to perform or supervise the services. These special qualifying care services may include, but are not limited to:

1. Administration of levine tube or gastrostomy tube feedings;
2. Nasopharyngeal and tracheotomy aspiration;
3. Insertion of medicated or sterile irrigation and replacement catheters;
4. Administration of parenteral fluids;
5. Inhalation therapy treatments;
6. Administration of injectable medications other than insulin, if required other than on the day shift; and
7. Requirement of intensive rehabilitation services by a professional therapist at least five (5) days per week.

(I) If the provider's records show that the resident's attending physician has ordered certain care, medication or treatments for an applicant or recipient, the Division of Aging staff will—a) assess points for a PRN order only if the applicant or recipient has actually received or required that care, medication or treatment at some time during the prior thirty (30) days or b) assess points for other ordered care, medications or treatments, unless a state physician consultant determines with reasonable medical certainty, after consultation with the attending physician, that the ordered care, medication or treatment is no longer needed by the recipient.

(J) 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 adult boarding facility/residential care facility (ABF/RCF) residency as specified by section 198.073, RSMo. In order to meet this requirement, an applicant or recipient must be able to reach and go through a required exit door on the floor where the resident is located by—

1. Responding to verbal direction or the sound of an alarm;
2. Moving at a reasonable speed; and
3. If using a wheelchair or other assistive device, such as a walker or cane, being able to transfer into the wheelchair or reach the assistive device without staff assistance.

(K) Points will be assigned to each category, as stated in subsection (4)(B) of this rule, in multiples of three (3) according to the following guide:

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

A. Zero (0) points if considered to be independently mobile, in that the applicant or recipient requires no assistance. The applicant or recipient may use assistive devices (cane, walker, wheelchair) but is consistently capable of negotiating without assistance;

B. Three (3) points if considered to require minimum assistance, in that the applicant or recipient is independently mobile once the applicant or recipient receives assistance with transfers, braces, prothesis or other assistive devices, or a combination of these (example, independent use of wheelchair after assistance with transfer). This category includes persons who are not consistently independent and need assistance periodically;

C. Six (6) points if considered to require moderate assistance, in that the applicant or recipient is mobile only with direct assistance. The applicant or recipient must be assisted even when using canes, walker or other devices; and

D. Nine (9) points if considered to require maximum assistance, in that the applicant or recipient is totally dependent. The applicant or recipient is unable to ambulate or participate in the process, requires positioning, supportive devices, prevention of contractures or *decubiti* and active or passive exercises;

2. 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—

A. Zero (0) points if considered to be independent in dietary needs, in that the applicant or recipient requires no assistance to eat. The applicant or recipient has regular diet, mechanically altered or only minor modifications (example, limited desserts, no salt or sugar on tray);

B. Three (3) points if considered to require 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 are included;

C. Six (6) points if considered to require 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

D. Nine (9) points if considered to require maximum assistance, in that the applicant or recipient requires extensive assistance for special dietary needs, which could include tube feedings, parenteral fluids and the like;

3. Restorative services are defined as specialized services provided to help applicants or recipients obtain or maintain, or both, their optimal 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, reality orientation, patient/family program and individualized activity program. The applicant or recipient will receive—

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

B. Three (3) points if considered to require minimum services in order to maintain level of functioning;

C. Six (6) points if considered to require moderate services in order to restore to a higher level of functioning; and

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

4. Monitoring is defined as observation and assessment of the applicant's or recipient's physical or mental condition, or both. This monitoring could include assessment of—routine lab work (digoxin levels), clinitest and acetest, intake and output, weights and other routine procedures. The applicant or recipient will receive —

A. Zero (0) points if considered to require only routine monitoring, such as monthly weights, temperatures, blood pressures and routine supervision;

B. Three (3) points if considered to require 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;

C. Six (6) points if considered to require moderate monitoring, in that the applicant or recipient requires regular assessment of routine procedures due to applicant's or recipient's unstable physical or mental condition; and

D. Nine (9) points if considered to require maximum monitoring which is intensive monitoring usually by professional personnel due to applicant's or recipient's unstable physical or mental condition;

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

A. Zero (0) points if considered to require no medication, or little medication in the form of irregular use of PRN medication;

B. Three (3) points if considered to require any regularly scheduled medication and exhibits a stable condition;

C. Six (6) points if considered to require moderate supervision of regularly scheduled medications, requiring daily monitoring by licensed personnel; and

D. Nine (9) points if considered to require maximum supervision of regularly scheduled medications, complex drug regime, unstable condition or use of drugs requiring professional observation and assessment, or a combination of these;

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

A. Zero (0) points if considered to require little or no behavioral assistance. Applicant or recipient is oriented and memory intact;

B. Three (3) points if considered to require 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;

C. Six (6) points if considered to require moderate behavioral assistance in the form of supervision due to disorientation, mental or developmental disabilities or uncooperative behavior; and

D. Nine (9) points if considered to require 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;

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

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

B. Three (3) points if considered to require minimal type-ordered treatments, including nonroutine and preventative treatments, such as whirlpool baths and other services;

C. Six (6) points if considered to require 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 *decubitus* ulcers, wet/moist packs, maximist and other such services; and

D. Nine (9) points if considered to require 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 *decubiti* or necrotic lesions; infrared heat and other services;

8. Personal care is defined as activities of daily living, including hygiene; personal grooming, such as dressing, bathing, oral 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—

A. Zero (0) points if considered to require 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;

B. Three (3) points if considered to require minimal assistance with personal care, in that the applicant or recipient requires assistance with personal grooming, exhibits infrequent incontinency, or both;

C. Six (6) points if considered to require moderate assistance with personal care, in that the applicant or recipient requires assistance with personal grooming, requiring close supervision or exhibits frequent incontinency, or a combination of these; and

D. Nine (9) points if considered to require maximum assistance with personal care, in that the applicant or recipient requires total personal care to be performed by another person, exhibits continuous incontinency, or both; and

9. 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 applicant's or recipient's potential for rehabilitation as indicated by the rehabilitation evaluation. The applicant or recipient will receive—

A. Zero (0) points if considered to require no ordered rehabilitation services;

B. Three (3) points, if considered to require minimal-ordered rehabilitation services of one (1) time per week;

C. Six (6) points if considered to require moderate-ordered rehabilitative services of two (2) or three (3) times per week; and

D. Nine (9) points if considered to require maximum-ordered rehabilitative services of four (4) times per week or more.

AUTHORITY: sections 207.020 and 208.159, RSMo 1986 and 208.153, RSMo Supp. 1991. This rule was previously filed as 13 CSR 40-81.084. 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.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991; and 208.159, RSMo 1979.*

STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES - DIVISION OF AGING

NURSING FACILITY PRE-ADMISSION SCREENING/RESIDENT REVIEW FOR MENTAL ILLNESS/MENTAL RETARDATION OR RELATED CONDITION

PURPOSE — COMPLETION OF THIS FORM IS MANDATORY FOR ALL PERSONS RESIDING IN OR APPLYING TO RESIDE IN MEDICAID CERTIFIED FACILITIES AFTER 1/1/89 TO DETERMINE APPROPRIATENESS OF THE NURSING FACILITY PLACEMENT.

A. IDENTIFYING INFORMATION

FOR STATE OFFICE USE ONLY

1. PERSON'S NAME (LAST, FIRST, MIDDLE)			DCN CASE NUMBER	DMH NUMBER
2. SOCIAL SECURITY NUMBER	3. SEX ☐ MALE ☐ FEMALE	RACE	4. DATE OF BIRTH	5. NAME OF NURSING FACILITY (IF KNOWN)
6. CURRENT STREET ADDRESS				PERSON'S PHONE NUMBER
7. CITY	8. STATE	9. ZIP	10. COUNTY	11. DAYTIME PHONE NUMBER FOR KEY INFORMANT

12. CHECK THE APPROPRIATE RESPONSE DESCRIBING THE PERSON'S CURRENT LIVING ARRANGEMENTS:

☐ IN HOME ☐ WITH RELATIVE OR FRIEND ☐ NURSING FACILITY OR OTHER RESIDENTIAL FACILITY

☐ HOSPITAL ☐ OTHER (SPECIFY): ______

13. IS THE PERSON:

☐ A POTENTIAL ADMISSION OR TRANSFER TO A CERTIFIED BED? (PREADMISSION SCREENING)

☐ A CURRENT RESIDENT IN A CERTIFIED BED? (ANNUAL REVIEW)
IF THE PERSON IS CURRENTLY RESIDING IN A CERTIFIED BED, INDICATE THE MONTH AND YEAR THE PERSON ENTERED THE CERTIFIED NURSING BED ______

IS IT LIKELY THAT THIS INDIVIDUAL WILL REMAIN INSTITUTIONALIZED FOR 30 DAYS OR LONGER? ☐ YES ☐ NO

B. EXEMPTION CATEGORIES

CHECK ALL OF THE FOLLOWING WHICH DESCRIBE THE PERSON:

☐ 14. HAS A PRIMARY DIAGNOSIS OF DEMENTIA (INCLUDING ALZHEIMER'S DISEASE OR RELATED DISORDER) MADE BY A PHYSICIAN BASED ON A NEUROLOGICAL EXAMINATION.

☐ 15. REFERRED TO THE NURSING FACILITY AFTER RELEASE FROM AN ACUTE CARE HOSPITAL FOR A CONVALESCENT STAY, I.E., A PERIOD NOT TO EXCEED 120 DAYS AS A PART OF A MEDICALLY PRESCRIBED PERIOD OF RECOVERY.

☐ 16. CERTIFIED BY A PHYSICIAN TO BE TERMINALLY ILL AND REQUIRING CONTINUOUS NURSING CARE AND/OR MEDICAL SUPERVISION AND TREATMENT DUE TO PHYSICAL CONDITION.

☐ 17. COMATOSE, VENTILATOR DEPENDENT, FUNCTIONS AT THE BRAIN STEM LEVEL, OR HAS A DIAGNOSIS OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE, SEVERE PARKINSON'S DISEASE, HUNTINGTON'S DISEASE, AMYOTROPHIC LATERAL SCLEROSIS, OR CONGESTIVE HEART FAILURE.

IF ONE OR MORE OF THE ABOVE CATEGORIES WAS CHECKED, THE INDIVIDUAL MAY BE ADMITTED OR CONTINUE TO RESIDE IN A CERTIFIED BED.

PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM.

C. SCREENING CRITERIA FOR MENTAL ILLNESS

18. HAS THE PERSON RECEIVED TREATMENT FOR A MENTAL ILLNESS WITHIN THE LAST TWO YEARS? ☐ YES ☐ NO

IF YES, INDICATE WHEN (I.E., MONTH/YEAR) AND WHERE MENTAL HEALTH TREATMENT WAS RECEIVED: ______

19. DOES THE PERSON HAVE A DIAGNOSIS OF ANY OF THE FOLLOWING AS DEFINED IN DSM-III R, SCHIZOPHRENIA, PARANOIA, MAJOR AFFECTIVE DISORDER, SCHIZOAFFECTIVE DISORDER OR ATYPICAL PSYCHOSIS? ☐ YES ☐ NO
20. IF YES, WAS THE DIAGNOSIS MADE BEFORE THE AGE OF 22? ☐ YES ☐ NO

21. DOES THE PERSON HAVE REGULARLY PRESCRIBED A MAJOR TRANQUILIZER OR OTHER PSYCHOTROPIC MEDICATIONS? ☐ YES ☐ NO
IF YES, LIST: (Please include dosage, frequency and indicate for what conditions) ______

MO 886-2447 (10-89) **DISTRIBUTION:** Physician: Canary Copy; Nursing Facility: If not suspected to be MR or MI, retain all copies. If suspected MR or MI, retain only the Gold copy and send the remaining copies to the Division of Aging along with the DA-124A and DA-124B. DA 124C

PERSON'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DCN NUMBER

22. DOES THIS INDIVIDUAL EXHIBIT BEHAVIORS WHICH WOULD LEAD YOU TO SUSPECT THAT THIS PERSON MAY HAVE A MENTAL ILLNESS? ☐ YES ☐ NO

IF YES, LIST ALL SPECIFIC BEHAVIORS WHICH SUGGEST MENTAL ILLNESS: ____________

D. SCREENING CRITERIA FOR MENTAL RETARDATION/RELATED CONDITION

23. DOES THE PERSON HAVE A DIAGNOSIS OF MENTAL RETARDATION? ☐ YES ☐ NO

24. DOES THE PERSON HAVE A HISTORY OF A DEVELOPMENTAL DISABILITY THAT OCCURRED PRIOR TO 22 YEARS OF AGE? ☐ YES ☐ NO

25. DOES THE PERSON HAVE ANY CONDITION OR BEHAVIOR WHICH MIGHT LEAD YOU TO SUSPECT THAT THIS PERSON HAS A DEVELOPMENTAL DISABILITY OR MENTAL RETARDATION? ☐ YES ☐ NO

IF YES, DESCRIBE: ____________

26. IS THE INDIVIDUAL BEING REFERRED BY AN AGENCY THAT SERVES PERSONS WITH MENTAL RETARDATION OR OTHER DEVELOPMENTAL DISABILITIES? ☐ YES ☐ NO

IF YES, INDICATE THE NAME OF THE AGENCY: ____________

27. WAS THE INDIVIDUAL FOUND ELIGIBLE FOR THAT AGENCY'S SERVICES? ☐ YES ☐ NO

E. GENERAL SCREENING INFORMATION

28. LIST ALL CURRENT MEDICAL AND PSYCHIATRIC RELATED DIAGNOSES FOR THE INDIVIDUAL: ____________

29. LIST ALL MEDICATIONS CURRENTLY PRESCRIBED FOR THE INDIVIDUAL: (Please include dosage and frequency) ____________

30. WHAT IS THE SPECIFIC REASON FOR ADMISSION TO THE NURSING FACILITY? ____________

F. PHYSICIAN'S SIGNATURE

PHYSICIAN'S SIGNATURE	DATE	TELEPHONE NUMBER
▶		

FAILURE TO COMPLETE AND SUBMIT THE REQUIRED INFORMATION OR FALSIFYING INFORMATION ON THIS FORM MAY JEOPARDIZE AN INDIVIDUAL'S ABILITY TO ENTER OR CONTINUE RESIDENCE IN A MEDICAID CERTIFIED BED.

IF ALL QUESTIONS IN SECTIONS C AND D WERE ANSWERED "NO" AND THERE IS NO PSYCHIATRIC RELATED DIAGNOSIS, THE INDIVIDUAL MAY BE ADMITTED/CONTINUE RESIDENCE WITH NO FURTHER EVALUATION. THIS FORM IS TO BE RETAINED IN THE INDIVIDUAL'S MEDICAL RECORDS.

IF ANY QUESTIONS IN SECTIONS C OR D WERE ANSWERED "YES" OR THERE IS A PSYCHIATRIC RELATED DIAGNOSIS, COMPLETE THE DA-124A AND DA-124B AND SUBMIT ALL THREE COMPLETED FORMS TOGETHER TO THE DIVISION OF AGING, COMRU, 1440 AARON CT., JEFFERSON CITY, MO 65102. THE INDIVIDUAL MAY NOT BE ADMITTED TO A NURSING FACILITY UNTIL THE REQUIRED EVALUATION AND ELIGIBILITY DETERMINATIONS HAVE BEEN COMPLETED, UNLESS AN EXEMPTION WAS INDICATED IN SECTION B.

G. PERMISSION TO CONDUCT SCREENING/REVIEW

I, ____________, GIVE CONSENT FOR THE MISSOURI DEPARTMENT OF SOCIAL SERVICES, THE MISSOURI DEPARTMENT OF MENTAL HEALTH AND THEIR LEGALLY AUTHORIZED REPRESENTATIVES TO OBTAIN INFORMATION FROM PHYSICIANS, HOSPITALS, PSYCHOLOGISTS, AND OTHER SERVICE PROVIDERS WHO HAVE INFORMATION RELEVANT TO THE DETERMINATION OF ELIGIBILITY FOR CARE IN A NURSING FACILITY. I ALSO UNDERSTAND THAT FURTHER EVALUATION MAY BE REQUIRED AND I AUTHORIZE THE DEPARTMENT OF MENTAL HEALTH TO RELEASE NECESSARY INFORMATION TO THE EVALUATION AGENCY.

SIGNATURE OF PERSON OR LEGAL GUARDIAN	DATE
▶	

MO 886-2447 (10-89) DA 124C

DFS COUNTY USE ONLY

DFS CERTIFICATION DATE

DFS C'WKR: ______

CO # ______ LD # ______

Department of Social Services – MISSOURI DIVISION OF AGING

DA-124 A (Rev. 4/84)

INITIAL ASSESSMENT—SOCIAL ASSESSMENT

To be Completed by Facility or Referral Source.

1 SNC 2 XIX

A. GENERAL INFORMATION

1. ______ PATIENT.S NAME (LAST, FIRST, MIDDLE) 2. ______ CASE #: ALPHA/PAY CO./DCN 3. ______ D.O.B. 4. ______ SOCIAL SECURITY NO.

5. ______ SEX 6. ______ GUARDIAN NAME/PHONE 7. ______ CURRENT LOCATION (FULL ADDRESS) 8. ______ DATE ADMITTED

B. PRE-ADMISSION SCREENING INFORMATION:

1. ______ PROPOSED PLACEMENT (FAC. NAME)

2. ______ PROPOSED DATE OF PLACEMENT 3. ______ DATE FACILITY CONTACTED 4. ______ DATE REFERRED TO DA 5. ______ CRU/PAS #

6. ______ REASON APPLICANT WAS NOT REFERRED FOR PREADMISSION SCREENING

C. PATIENT'S BACKGROUND AND SOCIAL HISTORY

9. Ethnic Origin:
   1 ☐ American Indian
   2 ☐ Asian
   3 ☐ Black
   4 ☐ Hispanic
   5 ☐ White
   6 ☐ Other: ______

10. Marital Status:
    1 ☐ Never Married
    2 ☐ Married
    3 ☐ Widowed
    4 ☐ Separated
    5 ☐ Divorced

11. Education Level:
    1 ☐ Grade School
    2 ☐ High School
    3 ☐ College
    4 ☐ Technical Training
    5 ☐ Other: ______

12. Religious Preference:
    1 ☐ Catholic
    2 ☐ Jewish
    3 ☐ Protestant: ______
    4 ☐ Other: ______

13. Occupation(s):
    1. ______
    2. ______
    3. ______
    4. ______

14. Most Recent Living Situation:
    1 ☐ Alone
    2 ☐ With Spouse
    3 ☐ With Relatives
    4 ☐ With Friends
    5 ☐ Other: ______

15. Patients Attitude Toward Placement:

16. Family's Attitude Toward Placement:

17. Social Communications & Interactions Level:

18. Orientation & Memory Level:

19. Hobbies & Interests:

20. Patient's Family Background – Medical:

21. Patient's Family Background – Social:

22. In Case of Emergency Contact:
    NAME ______ RELATIONSHIP ______
    ADDRESS ______
    PHONE ______

23. Significant Family & Friends:

NAME	RELATIONSHIP	PHONE

24. Potential Problem Areas & General Comments:

DO NOT WRITE IN THIS SPACE
CENTRAL OFFICE USE ONLY

LEVEL OF CARE DETERMINATION BY DIVISION OF AGING CENTRAL OFFICE

1 ☐ SNF 4 ☐ MH
2 ☐ ICF 5 ☐ None
3 ☐ IMR 6 ☐ SNC

Next Evaluation Date ______

DATE ______ STATE PHYSICIAN'S SIGNATURE ______

D. REFERRAL INFORMATION

25. Patient Referred By:
    NAME OF INDIVIDUAL OR AGENCY
    ADDRESS
    PHONE

26. Form Completed By:
    SIGNATURE OF INDIVIDUAL
    RELATIONSHIP TO PATIENT
    PHONE ______ DATE ______

REFERRAL DISTRIBUTION:
WHITE ORIGINAL, CANARY and PINK COPY – DFS Co. Office
GOLDENROD COPY – Facility or Physician

DFS DISTRIBUTION:
WHITE ORIGINAL and CANARY COPY – DA Central Office
PINK COPY – DFS Co. Office File

DA DISTRIBUTION:
WHITE ORIGINAL – DA Central Office
CANARY COPY – DFS Co. Office

To be completed by Attending Physician

Department of Social Services – MISSOURI DIVISION OF AGING

INITIAL ASSESSMENT – MEDICAL SUMMARY

DA-124 B (Rev. 4/84)

PATIENT'S NAME (LAST, FIRST, MIDDLE) ____ D. O. B. ____ CASE #: ALPHA / PAY CO. / DCN ____

E. MEDICAL INFORMATION — Date of last medical examination ____

27. Physical Information:
 1) Height ____
 2) Weight ____
 3) B/P ____
 4) Pulse ____

28. Medical Incidents: Dates Types
 1 ☐ Recent CVA ____
 2 ☐ Recent Surgery ____ ____
 3 ☐ Recent Fracture ____ ____
 4 ☐ Other: ____ ____

29. Residual Effects: ____

30. Special Lab Tests:
 1) ____
 2) ____
 3) ____

31. Stability:
 1 ☐ Improving
 2 ☐ Stable
 3 ☐ Deteriorating
 4 ☐ Unstable

32. Prescription Drugs:
 1) ____ 5) ____
 2) ____ 6) ____
 3) ____ 7) ____
 4) ____ 8) ____

33. Medical Status – Current Diagnoses:
 1) ____
 2) ____
 3) ____
 Other: ____

34. Other Comments: ____

F. FUNCTIONAL LEVELS (Check only those which apply.)

35. Functional Impairment:

	Min	Mod	Max	
1	☐	☐	☐	Vision
2	☐	☐	☐	Hearing
3	☐	☐	☐	Speech
4	☐	☐	☐	Ambulation
5	☐	☐	☐	Manual Dexterity

36. Behavioral Information:

	Min	Mod	Max	
1	☐	☐	☐	Confused
2	☐	☐	☐	Withdrawn
3	☐	☐	☐	Hyperactive
4	☐	☐	☐	Wanders
5	☐	☐	☐	Suspicious
6	☐	☐	☐	Combative
7	☐	☐	☐	Supervised For Safety
8	☐	☐	☐	Causes Mgt. Problems
9	☐	☐	☐	Controlled with Medications(s)

37. Mental Status:

	Yes	No	
1	☐	☐	Lucid
2	☐	☐	Labile
3	☐	☐	Comatose
4	☐	☐	Semi-Comatose
5	☐	☐	Mentally Retarded

____ IQ ____ LEVEL OF FUNCTIONING

G. PATIENT CARE ASSESSMENT

38. Ordered Rehabilitative Services: (Enter frequency per week.)
 1 ____ Physical Therapy
 2 ____ Speech Therapy
 3 ____ Occupational Therapy
 4 ____ Other: ____

39. Specialized Nursing Procedures Required: (Check those which apply.)
 1 ☐ Bowel & Bladder
 2 ☐ Catherization Care
 3 ☐ Colostomy Care (Ileostomy Care)
 4 ☐ Decubitus Care
 5 ☐ Diabetic Urine Test
 6 ☐ Fracture Care
 7 ☐ Gastrostomy
 8 ☐ Inhalation Therapy
 9 ☐ Intake & Output
 10 ☐ I.V. Fluid
 11 ☐ Oral Suction
 12 ☐ Oxygen
 13 ☐ Prosthesis Care
 14 ☐ Restraints
 15 ☐ Special Skin Care
 16 ☐ Sterile Dressings
 17 ☐ Therapeutic Diets
 18 ☐ TPR/BP
 19 ☐ Tracheostomy Care
 20 ☐ Tube Feedings
 21 ☐ Other: ____

40. ASSESSED NEEDS: (Check only those which apply and give rationale for assessment)

	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 ____

41. DA State Office Use ONLY

H. PHYSICIAN'S EVALUATION AND RECOMMENDATION:

	Yes	No	
42.	☐	☐	Does medical regimen of patient need to be under the supervision of an MD/DO?
43.	☐	☐	Will a nursing facility be capable of providing the needed care?
44.	☐	☐	If placed in a nursing facility, would you have plans for evantual discharge?

45. What is this patient's prognosis?
 1 ☐ Improvement
 2 ☐ Stabilization
 3 ☐ Deterioration
 4 ☐ Instability

46. Current condition has existed since ____

47. Level of Care Determination — In my opinion this patient's medical condition and/or functioning capabilities qualify for the following level of care:
 1 ☐ Acute Care Hospital
 2 ☐ Skilled Nursing Facility
 3 ☐ Intermediate Care Facility
 4 ☐ Intermediate Care Facility – Mentally Retarded
 5 ☐ Mental Hospital
 6 ☐ Residential Care Facility
 7 ☐ Adult Boarding Facility

48. Alternative Determination — Although this patient's condition qualifies for care in at least an intermediate care facility, in my opinion, institutionalization may be avoided at this time by the provision of the following services within the patient's home.
 1 ☐ Home-Health
 2 ☐ Personal Care
 3 ☐ Homemaker/Chore
 4 ☐ Day Care/Treatment
 5 ☐ Adult Family Care
 6 ☐ Respite
 7 ☐ Other: ____

____ ATTENDING PHYSICIAN'S SIGNATURE ____ ADDRESS

____ DATE ____ TELEPHONE ____ CITY ____ COUNTY

REFERRAL DISTRIBUTION:
WHITE ORIGINAL, CANARY and PINK COPY — DFS Co. Office
GOLDENROD COPY — Facility or Physician

DFS DISTRIBUTION:
WHITE ORIGINAL and CANARY COPY — DA Central Office
PINK COPY — DFS Co. Office File

DA DISTRIBUTION:
WHITE ORIGINAL — DA Central Office
CANARY COPY — DFS Co. Office