



IMPORTANT: The purpose of this form is to supplement the online Uniform Screening Tool when online access is not available or is not desired by a referring agency. The referring agency completing this form is required to provide a copy of this form to the Authorized Entity responsible for entering the information into the online tool. Once the Authorized Entity submits the information into the tool, you may be contacted and asked to supply additional information such as the H&P and FL2.

Refer to the Getting Started page located at <http://www.ncmust.com> for more information on how to prepare and process this paper based form.

Screening Type

Adult Care Home (ACH) PASRR Level I Initial Request Change In Condition

Date

Screener Information

| | | |
|----------------------|------------|-----------------------------|
| Last Name | First Name | Organization Name |
| Organization Address | | Organization City State Zip |
| Telephone | Fax | Email |

Applicant Information

Applicant

| | | | |
|--|------------|-------------|----------|
| Last Name | First Name | Middle Name | |
| Permanent Mailing Address (where does applicant receive their mail?) | | | |
| Street Address | City | State | Zip Code |

Patients Current Location (where does applicant physically reside?)

Specify Location Type : Choose One Same As Screeners Organization Same As Permanent Mailing Address Other(enter below)

| | | | |
|-------------------------------|----------------|----------|---------------------|
| Facility Name (If Applicable) | Street Address | | |
| City | State | Zip Code | County of Residence |

Personal Details

| | | | | |
|------------------------|--------------------|---|------------------------------|----------------|
| Social Security Number | Date of Birth | Applicant's Home or Cell Phone Number | Gender | Marital Status |
| Medicare Number | Medicaid ID Number | Medicaid Status (Select only one) <input type="radio"/> Card Active <input type="radio"/> Medicaid Pending | Medicaid County of Residence | |

Legally Responsible Person

| | | | | |
|------|----------------|-----|--|----------------------------------|
| Name | Street Address | | | |
| City | State | Zip | Home or Cell Phone Number (999-999-9999) | Work Phone Number (999-999-9999) |

Other Contact Person

| | | | |
|----------------|-----------------|---------------------------------|----------------------------------|
| Name | Type of Contact | Home/Cell Number (999-999-9999) | Work Phone Number (999-999-9999) |
| Street Address | City | State | Zip Code |

Attending/ Primary Physician

| | | | |
|----------------|-------|--|---------------------------------|
| Physician Name | | | |
| Street Address | | Mailing Address (if Different from Street Address) | |
| City | State | Zip Code | Telephone Number (999-999-9999) |

| Physical Health Diagnoses | | | |
|---|--|--|---|
| Substance Abuse | | | |
| Has History Of, or Currently has a Substance Abuse Problem <input type="radio"/> Yes <input type="radio"/> No | | Date of Last Use (MM/DD/YYYY) | |
| Terminal Prognosis | | | |
| Is there a Terminal Prognosis? <input type="radio"/> Yes <input type="radio"/> No | Has a Doctor Certified a Terminal Prognosis? <input type="radio"/> Yes <input type="radio"/> No | Name of Physician | Date of Physician Certification |
| Cognitive Impairment | | | |
| Is there a Cognitive Impairment Diagnosis? <input type="radio"/> Yes <input type="radio"/> No | | | |
| Cognitive Impairment Diagnoses (Check all that apply) | | If Other Cognitive Impairment Diagnosis, Specify | Is Dementia the Primary Diagnosis ? <input type="radio"/> Yes <input type="radio"/> No |
| <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Cerebral Atrophy <input type="checkbox"/> Chronic or Organic Brain Syndrome <input type="checkbox"/> Coma/Comatose <input type="checkbox"/> Creutzfeldt-Jakob Disease <input type="checkbox"/> Dementia <input type="checkbox"/> Frontotemporal Dementia <input type="checkbox"/> Huntingtons's Disease <input type="checkbox"/> Lewy Body Dementia <input type="checkbox"/> Multi-infarct Dementia <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Pick's Disease <input type="checkbox"/> Pre-Senile Dementia <input type="checkbox"/> Wernicke-Korsakoff Syndrome (WKS) <input type="checkbox"/> Other | | | |
| Current Psychiatric Medications | | | |
| Medication Name | | Type of Medication <input type="radio"/> Formulary <input type="radio"/> Over the Counter | |
| If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication | | | |
| Medication Name | | Type of Medication <input type="radio"/> Formulary <input type="radio"/> Over the Counter | |
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| Medication Name | | Type of Medication <input type="radio"/> Formulary <input type="radio"/> Over the Counter | |
| If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication | | | |

Mental Health

Is there an MH Diagnosis?
 Yes No

| | |
|--|--------------------------------|
| If MH Diagnosis, specify Disorders/Diagnoses <input type="checkbox"/> Anxiety/panic disorder <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Delusional disorder <input type="checkbox"/> Eating disorder <input type="checkbox"/> Major Depression <input type="checkbox"/> Personality disorder <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Schizoaffective disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Somatoform disorder <input type="checkbox"/> Other | If Other MH Diagnosis, Specify |
|--|--------------------------------|

Intellectual/Developmental Disability (I/DD) Diagnosis

Is there an I/DD Diagnosis or Suspicion of I/DD?
 Yes No

| | | |
|---|----------------------|---|
| If I/DD Diagnosis is Present/Suspected, Indicate the Severity Level <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> Profound <input type="radio"/> Suspected Only | Age at Onset (years) | Are I/DD Services Being Provided? <input type="radio"/> Yes <input type="radio"/> No |
|---|----------------------|---|

Conditions Related to Intellectual/Developmental Disability (I/DD) Diagnoses

Is there a RC Diagnosis?
 Yes No

| | | |
|--|--------------------------------|---|
| Select All RC Diagnoses <input type="checkbox"/> Autism <input type="checkbox"/> Blindness <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Closed Head Injury <input type="checkbox"/> Deafness <input type="checkbox"/> Epilepsy <input type="checkbox"/> Other | If Other RC Diagnoses, Specify | Did the Condition Manifest Prior to Age 22? <input type="radio"/> Yes <input type="radio"/> No |
|--|--------------------------------|---|

Mental Health Behavioral Profile

| | |
|--|--|
| Concentration / Task Limitations within the Past 6 Months <input type="checkbox"/> Serious difficulty completing age related tasks <input type="checkbox"/> Serious loss of interest in things <input type="checkbox"/> Serious difficulty maintaining concentration/attention <input type="checkbox"/> Numerous errors in completing tasks which she/he should be physically capable <input type="checkbox"/> Requires assistance with tasks for which she/he should be physically capable <input type="checkbox"/> Other | Adapting To Changes within the Past 6 Months <input type="checkbox"/> Requires mental health intervention due to increased <input type="checkbox"/> Requires judicial intervention due to symptoms <input type="checkbox"/> Symptoms have increased as a result of adaptation <input type="checkbox"/> Serious agitation or withdrawal due to adaptation <input type="checkbox"/> Other |
| (Other) Concentration / Task Limitations within the Past 6 Months | (Other) Adapting To Changes within the Past 6 Months |

Mental Health Treatments

| | |
|--|---|
| Treatments Received within the Past 2 Years <input type="checkbox"/> None <input type="checkbox"/> Inpatient Psychiatric Hospital <input type="checkbox"/> Partial Hospitalization/day treatment <input type="checkbox"/> Outpatient Treatment | Date Treatment was Received (MM/DD/YYYY) _____ _____ _____ |
|--|---|

Mental Illness Interventions

| | | |
|---|---|-----------------------------------|
| Interventions to Prevent Hospitalization <input type="checkbox"/> None <input type="checkbox"/> Housing intervention <input type="checkbox"/> Supportive Living <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Other | Intervention Treatment Date (MM/DD/YYYY) _____ _____ _____ | If Other MI Intervention, Specify |
|---|---|-----------------------------------|

| Orientation | | | |
|--|--|---|--|
| Oriented to Time <input type="radio"/> Yes <input type="radio"/> No | Oriented to Person <input type="radio"/> Yes <input type="radio"/> No | Oriented to Place <input type="radio"/> Yes <input type="radio"/> No | |
| Mood and Behavior | | | |
| <input type="checkbox"/> Socially Inappropriate/Disruptive Behavioral | <input type="checkbox"/> Wandering | <input type="checkbox"/> Physically Abusive | <input type="checkbox"/> Unrealistic Fears |
| <input type="checkbox"/> Resists Care | <input type="checkbox"/> Verbal Expressions of Distress | <input type="checkbox"/> Self Deprecation | <input type="checkbox"/> Negative Statements |
| <input type="checkbox"/> Anxious Non-Health Complaints Concerns | <input type="checkbox"/> Persistent Anger | <input type="checkbox"/> Repetitive Verbalizations | <input type="checkbox"/> Insomnia Disturbed Sleep Patterns |
| <input type="checkbox"/> Sad, Pained, Worried, Facial Expressions | <input type="checkbox"/> Crying/Tearfulness | <input type="checkbox"/> Unpleasant Mood In Morning | |
| <input type="checkbox"/> Reduced Social Interaction/Isolation | <input type="checkbox"/> Repetitive Physical Movements | <input type="checkbox"/> Withdrawal From Activities Of Interest | |
| Interpersonal Functioning | | | |
| <input type="checkbox"/> Combative | <input type="checkbox"/> Dangerous to Self,Others or Property | <input type="checkbox"/> Altercations | <input type="checkbox"/> Homicidal |
| <input type="checkbox"/> Evictions Due To Socially Inappropriate Behavior | <input type="checkbox"/> Fear of Strangers | <input type="checkbox"/> Illogical Comments | <input type="checkbox"/> Paranoid Ideation |
| <input type="checkbox"/> Suicide Attempts/Ideation | <input type="checkbox"/> Social Isolation | <input type="checkbox"/> Excessive Irritability | <input type="checkbox"/> Hallucinations |
| Other Conditions | | | |
| Categoricals | | | |
| Is this a Request for a Short Term Nursing Facility Stay? <input type="radio"/> Yes <input type="radio"/> No | | If Yes Then Indicate the Duration of the Nursing Facility Stay | |
| Communication | | | |
| Makes Self Understood (Choose Only One) <input type="radio"/> Understood <input type="radio"/> Usually Understood <input type="radio"/> Sometimes Understood <input type="radio"/> Rarely/Never Understood | | Understand/Use Of Language (Select all that apply) <input type="checkbox"/> Uses Language/Speaks With No Difficulty <input type="checkbox"/> Incomprehensible sounds <input type="checkbox"/> Gestures <input type="checkbox"/> Writing <input type="checkbox"/> Assistive Devices <input type="checkbox"/> Sign Language <input type="checkbox"/> Does Not Understand/Use Language <input type="checkbox"/> Understands Language But Does Not Use <input type="checkbox"/> Speaks with Difficulty | |
| Functional Limitations | | | |
| Does the applicant have any functional limitations? <input type="radio"/> Yes <input type="radio"/> No | | Select All That Apply <input type="checkbox"/> Incapable of Self-Care <input type="checkbox"/> Incapable of Self-Direction <input type="checkbox"/> Immobile <input type="checkbox"/> Incapable of Independent Living <input type="checkbox"/> Incapable of Learning | |
| Screener Certification | | | |
| Who Supplied the Information? <input type="checkbox"/> Applicant <input type="checkbox"/> Family Member <input type="checkbox"/> Friend of Family or Applicant <input type="checkbox"/> Medical Record <input type="checkbox"/> Doctor <input type="checkbox"/> Nurse <input type="checkbox"/> Case Manager <input type="checkbox"/> Social Worker <input type="checkbox"/> Other | | By signing this form below, I certify that I have completed the above screening of the applicant to the best of my knowledge. I understand falsification as: an individual who certifies a material and false statement in this screening will be subject to investigation for Medicaid fraud and will be referred to the appropriate state agency for investigation. | |
| Screener Name and Signature (Required) _____ Date _____ | | Physicians Name and Signature (If filled out at a physicians office) _____ Date _____ | |