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

INITIAL ASSESSMENT - SOCIAL AND MEDICAL

FSD CO. NO.	CASH
LOAD NO.	XIX

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

A. SOCIAL ASSESSMENT

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

5. SEX

6. RACE

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

8. OCCUPATION

9. DATE ADMITTED TO NF

10. CURRENT LOCATION (ADDRESS)

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

12. NAME OF PROPOSED NURSING FACILITY PLACEMENT, PHONE #

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

B. MEDICAL ASSESSMENT

Attach additional sheets of information if necessary.

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

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

7. SPECIAL LAB TESTS AND FREQUENCY

8. PRESCRIPTION DRUGS (DOSAGE AND FREQUENCY, INCLUDING PRNS; SHOULD CORRELATE WITH DIAGNOSES)
1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

9. LIST ALL DIAGNOSES (SHOULD CORRELATE WITH MEDICATIONS) (INCLUDE PSYCH DX)
1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

10. POTENTIAL PROBLEM AREAS AND/OR ADDITIONAL COMMENTS

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

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

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

14. BEHAVIORAL INFORMATION (CHECK ONE BOX FOR EACH)

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☐	☐	☐	☐	WITHDRAWN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

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

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

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

17. POTENTIAL FOR REHAB ☐ GOOD ☐ FAIR ☐ POOR

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

CENTRAL OFFICE USE ONLY

LEVEL OF CARE DETERMINATION BY DIVISION DRL CENTRAL OFFICE

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

NEXT EVALUATION DATE	SIGNATURE DATE

STATE PHYSICAN'S CONSULTANT ▶

GUIDE #1 - ASSESSED NEEDS:

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

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

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

A. NURSING FACILITY ADMISSIONS FROM HOSPITALS–

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

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

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

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

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

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

C. NURSING FACILITY TRANSFERS–

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

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

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

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

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

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

E. PERSON IS DISCHARGED HOME BUT UNABLE TO STAY–

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