For OLTC Use Only

Date Keyed: __________ Keyed By: ______________________________ Service Control No.: _________

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
EVALUATION OF MEDICAL NEED CRITERIA

DAAS WAIVER PROGRAMS - **EC** ☐ **AAPD** ☐ **AL** ☐ **Tier** ☐ **1** ☐ **2** ☐ **3** ☐ **4**
FACILITIES - **NH** ☐ **ICF/ID** ☐ **Autism Waiver** ☐ **PACE** ☐ **TEFRA** ☐

PART I ☐ **ASSESSMENT (New Application)** ☐ **REASSESSMENT (UR)** ☐ **TRANSFER** ☐ **CHANGED CONDITION**

Name of Nursing Facility (if applicable) ______________________ **Vendor ID:**

Entered NF From: ☐ Hospital ☐ Nursing Facility ☐ ALF ☐ Other ______________________

Date of Admission: ______________

Client's Last Name First Name Middle initial) | **Social Security Number** | **Medicaid ID Number**

☐ **Male** ☐ **Female** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Married** **Date of Birth** ______________

Lives ☐ Alone ☐ With Spouse ☐ With Adult Child ☐ With Sibling ☐ Other ______________

Client's Current Residence ☐ House/Apt. ☐ NF ☐ RCF ☐ Other ______________ **County (Code)** ________

Has client been in a NF before? ☐ Yes ☐ No If Yes, Date of Discharge if within last 12 months ______________

Name of NF: ____

Has client applied for ARChoices (formerly ElderChoices or AAPD) or Assisted Living before? ☐ Yes ☐ No If Yes, when? ______________

For the purpose of determining my need for licensed nursing home care, I hereby authorize the release of any medical information by a licensed physician to the Arkansas Department of Health and Human Services. (If signed by MARK, must have witness.)

______________________________ ______________________________
Signature of Client or Legal Guardian **Signature of Witness (if required)**

Part II Hospitalized within last 6 months? ☐ Yes ☐ No If Yes, what dates? ______________

Reason for hospitalization ______________________________

Hospice patient? ☐ Yes ☐ No Hospice start date: ____________ Hospice discharge date: ____________

Date of death ______________

TRANSFERRING

☐ Bed to chair without help
☐ Bed to chair with help of another person or persons
☐ Must be lifted into chair by another person or persons
☐ Requires turning in bed by another person or persons
☐ Bedfast
☐ Transfers with assistive devices

If assistance is required, please indicate the frequency and type of assistance:

Needs assistance: ☐ Daily _____ Times per week

AMBULATION

☐ Walks alone
☐ Walks holding to HH objects
☐ Walks with cane, crutches, walker
☐ Walks with help of another person or persons
☐ Wheelchair push by another person
☐ Wheelchair using self-propulsion

If assistance is required, please indicate the frequency and type of assistance:

Needs assistance: ☐ Daily _____ Times per week

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Applicant/Resident Name: ,

CONTINENCE STATUS

	Yes	No	Occasionally	
Incontinent Bladder	☐ Yes	☐ No	☐ Occasionally	
Incontinent Bowel	☐ Yes	☐ No	☐ Occasionally	
Artificial Aids	☐ Yes	☐ No	☐ Occasionally	☐ Bladder/Bowel Training
Assistance Required	☐ Yes	☐ No	☐ Occasionally	

If assistance is required, please indicate the frequency and type of assistance: ☐ Daily ___________ Times per week

NUTRITIONAL STATUS Height: ______ Weight: ______ Therapeutic Diet: ☐ Yes ☐ No

Appetite: ☐ Good ☐ Fair ☐ Poor

EATING ☐ Feeds self ☐ Fed by another person ☐ Some assistance from another person is needed
☐ Fed by other than mouth.

If assistance is needed from another person, please explain the type of assistance, the frequency, and by whom provided. If fed by other than mouth, please explain.

HEARING ☐ No difficulty ☐ Adequate ☐ Limited ☐ Profound loss
☐ Hearing Aid ☐ Unable to determine ☐ Other: ____________________

VISION ☐ No difficulty ☐ Adequate ☐ Limited ☐ Blind
☐ Corrected w/lenses ☐ Unable to determine ☐ Other: ____________________

SPEECH/LANGUAGE ☐ No difficulty ☐ Can understand ☐ Can't understand
☐ Can express self ☐ Can't express self ☐ Difficulty expressing self
☐ Other: ____________________

SKIN ☐ No problem ☐ Clear ☐ Dry ☐ Rash ☐ Bruises ☐ Stasis Ulcers
☐ Tears ☐ Fragile ☐ Jaundiced ☐ Decubitus - Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4

If receiving treatment for decubitus, please describe treatment:

BEHAVIOR/ATTITUDE ☐ Happy ☐ Depressed ☐ Cooperative ☐ Abusive ☐ Forgetful ☐ Sad
☐ Lonely ☐ Withdrawn ☐ Restless ☐ Agitated ☐ Lethargic
☐ Argumentative ☐ Aphasic ☐ Anxious/Apprehensive ☐ Normal
☐ Other ____________________

MENTAL STATUS ☐ Clear ☐ Somewhat confused ☐ Moderately confused ☐ Markedly confused
☐ Alert ☐ Forgetful ☐ Needs supervision for personal safety
☐ Hyperactive ☐ Withdrawn ☐ Needs restraint

If confused or needs supervision for personal safety, please explain:

ORIENTATION LEVEL ☐ Alert ☐ Oriented x 3 ☐ Disoriented x 3 ☐ Oriented person/place
☐ Non-responsive ☐ Oriented person only ☐ Unable to determine

OTHER MED. COND. ☐ Nausea/Vertigo ☐ Pain ☐ Edema ☐ Arrhythmia ☐ Contractures-UE,LE
☐ Dyspnea ☐ Tremors ☐ Paresis/Paralysis ☐ Frail

☐ Seizures/Convulsions Date of last seizure: ______________ Controlled by meds ☐ Yes ☐ No
☐ Other ____________________

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Applicant/Resident Name: ,

PART III **MEDICATION:** ☐ Independent ☐ Dependent/Assisted ☐ Help Available ☐ Help Available 50% ☐ No Help Available

If assisted, please explain the type of assistance, the frequency of the assistance, and by whom the assistance is provided:

MEDICATIONS/TREATMENTS:

If therapies are listed, please include the frequency of the therapies, the provider of the therapies, and the expected duration:

List all durable medical equipment and any specialized equipment currently being used by the applicant:

RN/COUNSELOR COMMENTS (including reported medical history):

Estimated duration of need for nursing home care: ☐ Convalescent ☐ Permanent ☐ Indefinite __________ months

Signature of licensed DHHS RN/NF RN or LPN/COUNSELOR and Date **Recommendation Code (if applicable)**

STATUS OF MAJOR IMPAIRMENT ☐ Improving ☐ Stable ☐ Deteriorating

PROGNOSIS ______________________________

DIAGNOSIS (Please list in the order of significance as related to the need for nursing home care)

Diagnosis A ______________________________

Diagnosis B ______________________________

Waiver Programs only: ***To individual completing DHHS-703* -** If Alzheimer's or dementia is entered above as diagnosis, please explain related behavior:

Is this person's need for nursing home care the result of an accident caused by a third party? ☐ Yes ☐ No
(If yes, please attach any identifying information you may have about the accident, plus the name of any insurance company involved.)

I have examined this patient within the past thirty (30) days and have reviewed this form and certify the accuracy of the information. I am aware of the Utilization Review requirements for the necessity of admission and for continued stay and that this form will be reviewed by the Utilization Review Committee of the Arkansas Department of Health and Human Services.

Signature of Examining Physician **Date**

Incomplete applications cannot be processed. Failure to answer all questions completely may result in a request for missing or additional information and will delay the processing of this application.
This assessment should be completed and signed by a RN or LPN for all Nursing Facility admissions.

For OLTC Use Only		
Date Keyed: ________	Keyed By: ____________________	Service Control No.: ________

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
EVALUATION OF MEDICAL NEED CRITERIA

DAAS WAIVER PROGRAMS -	EC ☐	AAPD ☐	AL ☐	Tier	☐ 1	☐ 2	☐ 3	☐ 4
FACILITIES -	NH ☐	ICF/MR ☐						

The first line, which has date keyed, keyed by, and service control number, is used by OLTC staff only. Leave this line blank.
Put an **X** in the correct box that identifies the program you are applying. For nursing homes, select NH. If you have a master copy, place the **X** by NH on the master copy prior to making the other copies. This form is used for multiple programs. They are the Elders Choice, Alternatives for Adults with Physical Disabilities and Assisted Living, Nursing Homes and Intermediate Care Facilities/Mental Retardation facilities. Please check the correct box that identifies the facility or program you are representing.

PART I ☐ ASSESSMENT (New Application) ☐ REASSESSMENT (UR) ☐ TRANSFER ☐ CHANGED CONDITION

Name of Nursing Facility (if applicable)

Entered NF From: ☐ Hospital ☐ Nursing Facility ☐ ALF ☐ Other

Date of Admission:

Client's Name (Last, First, Middle Initial)	Social Security Number	Medicaid ID Number

☐ Male ☐ Female ☐ Single ☐ Divorced ☐ Widowed ☐ Married Date of Birth

Lives ☐ Alone ☐ With Spouse ☐ With Adult Child ☐ With Sibling ☐ Other

Client's Current Residence ☐ House/Apt. ☐ NF ☐ RCF ☐ Other **County (Code)**

Has client been in a NF before? ☐ Yes ☐ No If Yes, Date of Discharge if within last 12 months

Name of NF:

Has client applied for ElderChoices, Alternatives or Assisted Living before? ☐ Yes ☐ No If Yes, when?

For the purpose of determining my need for licensed nursing home care, I hereby authorize the release of any medical information by a licensed physician to the Arkansas Department of Health and Human Services. (If signed by MARK, must have witness.)

Signature of Client or Legal Guardian	Signature of Witness (if required)

Part I
Indicate the type of application you are applying for. Select new assessment if this is a new application. Select reassessment if the Office of Long Term Care has sent you a

704 requesting a Utilization Review. (hospice, convalescent or medical review). Select Transfer if the resident transferred from another nursing home, or from a nursing home to hospital, now to your nursing home, without going to any other facility or resident's home. Select change of condition if you are sending in the application because the resident has a significant improvement or decline in his condition.

Enter the **full name** of your nursing facility. Please do not use initials. Multiple facilities have the same initials. If your facility has the same name as another facility, then list the name of your facility and the city. i. e. Same Name Nursing Facility – Hope, or Same Name Nursing Facility – Little Rock. If you have a master copy, enter the name of your nursing facility on the master copy prior to making the other copies.

If you are a hospital and are completing the forms for a nursing home admission, you can put the name of the nursing facility you think they are going to, but put pending in the slot for date of admission.

Indicate where the resident entered the NF from: Hospital, Nursing Facility, Assisted Living Facility or Other (indicate if from home or other place)

Enter the date resident entered the nursing facility. If the resident has not entered the nursing facility, enter "PENDING".

Enter the resident's last name, then the first name followed by the middle initial. Enter the **resident's** social security number. **Do not** enter the social security number of the person they are claiming benefits from.

Insert the Medicaid number. If unknown, leave this line blank.

Select Male or Female. Select the correct answer between Single, Divorced, Widowed or Married.

Enter the resident's date of birth.

Check the correct box for the person resident lives with and enter additional information by "Other" if none applies

Select between the options for resident's current residence between House, NF, or RCF, and enter additional information by Other if none applies.

If resident has been in a NF before, select yes, and if not select no. If resident discharged from a nursing facility within the last 12 months, enter the date of discharge. Enter the name of any NF resident has resided in previously.

If resident has applied for ElderChoices, Alternatives or Assisted Living programs before, select yes. If not, select no.

In order for this application to be processed, **the resident or legal guardian must sign this form.** DHS must have permission to review the medical records of the resident. If the resident makes a mark, one witness signature is required.

Part II	Hospitalized within last 6 months?	☐ Yes	☐ No	If Yes, what dates?
	Reason for hospitalization			
	Hospice patient? ☐ Yes ☐ No	Hospice start date:		Hospice discharge date:

TRANSFERRING	**AMBULATION**
☐ Bed to chair without help	☐ Walks alone
☐ Bed to chair with help of another person or persons	☐ Walks holding to HH objects
☐ Must be lifted into chair by another person or persons	☐ Walks with cane, crutches, walker
☐ Requires turning in bed by another person or persons	☐ Walks with help of another person or persons
☐ Bedfast	☐ Wheelchair push by another person
☐ Transfers with assistive devices	☐ Wheelchair using self-propulsion
If assistance is required, please indicate the frequency and type of assistance:	**If assistance is required, please indicate the frequency and type of assistance:**
Needs assistance: ☐ Daily ____ Times per week	Needs assistance: ☐ Daily ____ Times per week

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Part II

If the resident has been hospitalized in the past 6 months, select yes and enter the dates for each hospitalization in the past 6 months including the current hospitalization if applicable. Brief entries for the reason are acceptable.

Is the resident on hospice? Select yes and enter the hospice start date. If no, select no. If the resident is discharging from hospice, enter the hospice discharge date. If you need a hospice 704 and a non-hospice 704, make a note in this area of the form. If the resident is no longer on hospice due to death, please indicate that the resident has expired in this area of the form.

Under Transferring, check the proper response. More than one selection may be appropriate. If assistance is required for transferring, indicate the frequency and type of assistance i.e. supervision, stand by assist, extensive assistance of two, limited assistance of one, uses Hoyer lift, etc. Describe the care staff provides. If assistance is provided at least once a day select daily or enter the number of times per week assistance is provided.

Under Ambulation, check the proper response or responses. If assistance is required in the area of ambulation, enter the frequency and type of assistance i.e. supervision, stand by assist, extensive assistance of two, limited assistance of one, etc. Describe the care staff provides. If assistance is provided at least once a day select daily or enter the number of times per week assistance is provided.

Applicant/Resident Name:

Make sure the resident's name is on each page submitted.

CONTINENCE STATUS	Incontinent Bladder	☐ Yes	☐ No	☐ Occasionally	
	Incontinent Bowel	☐ Yes	☐ No	☐ Occasionally	
	Artificial Aids	☐ Yes	☐ No	☐ Occasionally	☐ Bladder/Bowel Training
	Assistance Required	☐ Yes	☐ No	☐ Occasionally	
If assistance is required, please indicate the frequency and type of assistance:				☐ Daily	Times per week

NUTRITIONAL STATUS	Height:	Weight:	Therapeutic Diet:	☐ Yes	☐ No
Appetite:	☐ Good	☐ Fair	☐ Poor		
EATING	☐ Feeds self	☐ Fed by another person	☐ Some assistance from another person is needed		
	☐ Fed by other than mouth.				

If assistance is needed from another person, please explain the type of assistance, the frequency, and by whom provided. If fed by other than mouth, please explain.

Is the resident incontinent of bowel and bladder all of the time or occasionally? Select the correct continence status. Does the resident have any artificial aids? Catheter, colostomy? Mark an X if the resident participated in the bladder and bowel training program. Indicate the frequency and type of assistance required. Select daily if assistance required every day or list the number of times per week. Type of assistance may be peri care, assistance of 1 or 2 to transfer to the toilet, emptying the bedside commode, emptying the urinal, etc. Please indicate the amount of assistance staff is providing.

Provide the height and weight of the resident. If the resident is on a therapeutic diet, select yes and write in the name of the diet her or in nurses comments on the last page of the 703. If no, select no.

Select the best appetite choice.

Select the correct method by which the patient eats. If fed by other than mouth, please explain. If assistance is provided by another person, explain the type of assistance provided, the frequency and by whom. i.e. set up help, cutting up food, opening packages, spoon feeding, cueing, administering the tube feedings.

HEARING	☐ No difficulty	☐ Adequate	☐ Limited	☐ Profound loss			
	☐ Hearing Aid	☐ Unable to determine	☐ Other:				
VISION	☐ No difficulty	☐ Adequate	☐ Limited	☐ Blind			
	☐ Corrected w/lenses	☐ Unable to determine	☐ Other:				
SPEECH/LANGUAGE	☐ No difficulty	☐ Can understand	☐ Can't understand				
	☐ Can express self	☐ Can't express self	☐ Difficulty expressing self				
	☐ Other:						
SKIN	☐ No problem	☐ Clear	☐ Dry	☐ Rash	☐ Bruises	☐ Stasis Ulcers	
	☐ Tears	☐ Fragile	☐ Jaundiced	☐ Decubitus - Stage:	☐ 1	☐ 2	☐ 3 ☐ 4

If receiving treatment for decubitus, please describe treatment:

Select the best responses for Hearing, Vision, Speech/Language. These areas provide a picture of the resident's needs and abilities.

Select the best response for the condition of the skin and describe any treatments the resident is receiving. i.e. dressing changes twice a day, goes to wound clinic, whirlpool tx by PT. Supply any information that may be helpful in describing the wound and the assistance provided by staff.

BEHAVIOR/ATTITUDE	☐ Happy	☐ Depressed	☐ Cooperative	☐ Abusive	☐ Forgetful	☐ Sad
	☐ Lonely	☐ Withdrawn	☐ Restless	☐ Agitated	☐ Lethargic	
	☐ Argumentative	☐ Aphasic	☐ Anxious/Apprehensive		☐ Normal	
	☐ Other					

MENTAL STATUS	☐ Clear	☐ Somewhat confused	☐ Moderately confused	☐ Markedly confused
	☐ Alert	☐ Forgetful	☐ Needs supervision for personal safety	
	☐ Hyperactive	☐ Withdrawn	☐ Needs restraint	

If confused or needs supervision for personal safety, please explain:

ORIENTATION LEVEL	☐ Alert	☐ Oriented x 3	☐ Disoriented x 3	☐ Oriented person/place
	☐ Non-responsive	☐ Oriented person only	☐ Unable to determine	

For Behavior/Attitude and Mental Status, select the responses that apply. If the resident is confused or needs supervision for personal safety, please explain. i.e. wandering, cannot find his room, forgets his name, have to orient to surroundings multiple times a day.

For Orientation Level, select the best response.

OTHER MED. COND.	☐ Nausea/Vertigo	☐ Pain	☐ Edema	☐ Arrhythmia	☐ Contractures-UE,LE
	☐ Dyspnea	☐ Tremors	☐ Paresis/Paralysis	☐ Frail	
	☐ Seizures/Convulsions	Date of last seizure:		Controlled by meds	☐ Yes ☐ No
	☐ Other				

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List any of the above medical conditions the resident may have. This will give an accurate picture of the resident's needs. Write in any conditions not listed.

Applicant/Resident Name:

Make sure the resident's name is on each page submitted.

PART III	MEDICATION:	☐ Independent	☐ Dependent/Assisted	☐ Help Available
		☐ Help Available 50%	☐ No Help Available	

If assisted, please explain the type of assistance, the frequency of the assistance, and by whom the assistance is provided:

MEDICATIONS/TREATMENTS:

If therapies are listed, please include the frequency of the therapies, the provider of the therapies, and the expected duration:

List all durable medical equipment and any specialized equipment currently being used by the applicant:

Part III

Indicate whether or not the resident can self administer his medications or if assistance is required. If assistance is required, indicate the type of assistance. Is assistance given based on facility policy or is resident unable to administer own meds? Did the resident have problems with medication administration prior to this admission? Use this space to describe the medication needs. List as many medications as you can in the

space provided. In addition, you may attach the Physician's Orders or the Medication Administration Record if resident is on multiple medications that cannot be entered in the space provided.
List the names of any treatments the resident is receiving.
List any therapies the resident is receiving, the frequency, the provider, and the expected duration. i. e. P.T. , O. T. 3 x week x 6 weeks.
List all durable medical equipment or special equipment used by the applicant.

RN/COUNSELOR COMMENTS (including reported medical history):

Estimated duration of need for nursing home care: ☐ Convalescent ☐ Permanent ☐ Indefinite ____ months

Signature of licensed DHHS RN/NF RN or LPN/COUNSELOR and Date | **Recommendation Code (if applicable)**

An RN or LPN must fill out this section for nursing home admissions. It should include a brief medical history and the need for nursing home care. It should be a brief summary of the resident's condition and needs. This is an area to mention additional information not included elsewhere on the form.
Please indicate if the resident is being admitted for a short term convalescent care, determined to need nursing home care forever, or an indefinite period such as 6 months. The RN or LPN signature must be present for this form to be processed. The date the nurse signed must also be entered here.
The recommendation code is for staff use only. Leave this line blank.

STATUS OF MAJOR IMPAIRMENT ☐ Improving ☐ Stable ☐ Deteriorating

PROGNOSIS

DIAGNOSIS (Please list in the order of significance as related to the need for nursing home care)

Diagnosis A

Diagnosis B

Indicate the status of the major impairment. Is it improving, stable, or deteriorating?
List the prognosis. i.e. good, fair, grave, etc.
Enter the diagnosis in the order of significance as related to the need for nursing home care.

Waiver Programs only: ***To individual completing DHHS-703*** - If Alzheimer's or dementia is entered above as diagnosis, please explain related behavior:

This section is only completed for waiver applications.

Is this person's need for nursing home care the result of an accident caused by a third party? ☐ Yes ☐ No
(If yes, please attach any identifying information you may have about the accident, plus the name of any insurance company involved.)

I have examined this patient within the past thirty (30) days and have reviewed this form and certify the accuracy of the information. I am aware of the Utilization Review requirements for the necessity of admission and for continued stay and that this form will be reviewed by the Utilization Review Committee of the Arkansas Department of Health and Human Services.

Signature of Examining Physician	**Date**

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Indicate if nursing home care is the result of an accident caused by a third party. Select yes or no.
The examining physician or advanced practice nurse must sign all new assessments or transfer applications, certifying the accuracy of the information. The administrator, examining physician or advanced practice nurse can sign reassessment or change of condition applications. The date the application is signed must be entered here. This date is used for the effective date in many instances.
Fax completed application to: Medical Need Determination, 501-682-8052 or 501-683-5306.