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. CURRENT LOCATION (ADDRESS)

10. NAME OF PROPOSED NURSING FACILITY PLACEMENT, PHONE #

11. DATE ADMITTED TO NF

12. 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☐	☐	☐	☐	WITHDRAWN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 HSL CENTRAL OFFICE

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

NEXT EVALUATION DATE	SIGNATURE DATE
STATE PHYSICIAN'S SIGNATURE ►	

Reset

GUIDE #1 - ASSESSED NEEDS:

1. MOBILITY - Is resident up ad-lib? Is resident bedfast? Does resident need assist in transfer process (i.e., bed to wheelchair; if so, assist of how many staff needed)? Non-weight bearing?
2. DIETARY - Type of diet? Does resident need assist in opening cartons, cutting meat? Does resident need to be fed (i.e., on a daily basis, on occasion)? Does resident need encouragement to eat?
3. RESTORATIVE SERVICES - Does resident receive daily ROM exercises? Does resident use water or gel mattress? Is resident on B/B training program?
4. MONITORING - Is resident on limited fluid intake? Is resident having lab work on a regular basis? On safety precautions?
5. MEDICATION - Is there a current diagnosis related to drugs listed in B #8? How is medication administered; by whom?
6. BEHAVIORAL/MENTAL CONDITION - Does resident have occasional periods of forgetfulness? Is resident disoriented and/or combative? Is resident responsive to verbal and/or painful stimuli? Does resident have a diagnosis of MR?
7. TREATMENTS - Is resident receiving treatments? What type of treatment? What area is being treated? If resident has decubitus list stage, size and location. Does resident require oxygen; if so, is it continuous or prn?
8. PERSONAL CARE - Is resident capable of self-care? If resident is assisted, what type of assistance is needed and how many staff are required to perform? Is resident continent of B/B? Does resident have Foley catheter?
9. REHAB SERVICES - Give type of rehab – PT, OT, ST, etc. Is rehab given by registered therapist? How often does resident receive therapy – 5 x week, etc.?

NOTE: Refer to 2002 State of Missouri *Long-Term Care Facility Licensure Law and Rules Book,* 19 CSR 30-81.030(5) 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). Submit both forms to: DIV. OF REGULATION AND LICENSURE, COMRU, P.O. BOX 570, JEFFERSON CITY, MO 65102. NOTE: The hospital must take immediate action since the Level II Screening process takes 7-9 working days to complete. The person or their legal guardian must sign & date the DA-124C form whenever a Level II Screening is indicated. If the person does not have a legal guardian but is unable to sign, make notation 'PT UNABLE TO SIGN' and have 2 witnesses sign and date. 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). The hospital may contact the COMRU nurse for prior authorization at 573-526-8609. NOTE: COMRU nurse may require copy of History & Physical.

B. NURSING FACILITY ADMISSIONS FROM HOME OR RCF–

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–If the person is a danger to himself or others, or if protective oversight is necessary, call the Elderly 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 (573-526-8609). If the emergency occurs at night or on a weekend, do the same and contact COMRU at open of next business day before mailing 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.

c. If the person had a Level II Screening prior to placement at the sending facility, and this hospitalization involves a change in the person's mental status, the hospital completes a new DA-124C form, and writes CHANGE IN MENTAL STATUS at the top of the form prior to transferring the person back to (or on to the next) skilled/intermediate nursing facility (if the person stays less than 60 days). That nursing facility sends the new form to COMRU, as in section A, #1. NOTE: If the person stays more than 60 days, the HOSPITAL completes new set of DA-124A/B & C forms (as in section A, #1) and waits for completion of the Level II Screening.

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.