



**PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
PRIMARY ASSESSMENT FORM**

DATE					
PARTICIPANT (LAST, FIRST, MI)		DCN	DATE OF BIRTH	RACE	SEX
ADDRESS (STREET, CITY, ZIP)			COUNTY	PHONE NUMBER(S)	
NAME OF PERSON MAKING REFERRAL			RELATIONSHIP	PROVPHONE NUMBER	
NAME OF REFERRING AGENCY		REASON FOR REFERRAL <input type="checkbox"/> In-Home Services <input type="checkbox"/> RCF/ALF - PC <input type="checkbox"/> CDS Services <input type="checkbox"/> ADC <input type="checkbox"/> HDM <input type="checkbox"/> MFP			
PRIMARY HEALTH CARE PROVIDERS		ROLE	PHONE		
CURRENT DIAGNOSES/CONCERNS					
RECENT HOSPITALIZATIONS, SURGERIES, OR PROCEDURES:					
MEDICAID STATUS:					
LIVING ARRANGEMENTS/MARITAL STATUS:					
GUARDIAN: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes provide details:					
LEVEL OF CARE DETERMINATION			*Please type points into the appropriate score field for each section. Total points will show at the bottom of the form.		
BEHAVIORAL:					
<ul style="list-style-type: none"> • Determine if the applicant or recipient: <ul style="list-style-type: none"> • Receives monitoring for mental condition • Exhibits one of the following mood or behavior symptoms - wandering, physical abuse, socially inappropriate or disruptive behavior, inappropriate public sexual behavior or public disrobing; resists care • Exhibits one of the following psychiatric conditions - abnormal thoughts, delusions, hallucinations 					
COMMENT:					
0 pts	Stable mental condition AND no mood or behavior symptoms observed AND no reported psychiatric conditions				
3 pts	Stable mental condition monitored by a physician or licensed mental health professional at least monthly OR behavior symptoms exhibited in past, but not currently present OR psychiatric conditions exhibited in past, but not recently present				
6 pts	Unstable mental condition monitored by a physician or licensed mental health professional at least monthly OR behavior symptoms are currently exhibited OR psychiatric conditions are recently exhibited				
9 pts	Unstable mental condition monitored by a physician or licensed mental health professional at least monthly AND behavior symptoms are currently exhibited OR psychiatric conditions are currently exhibited				
COGNITION:					
<ul style="list-style-type: none"> • Determine if the applicant or recipient has an issue in one or more of the following areas: <ul style="list-style-type: none"> • Cognitive skills for daily decision making • Memory or recall ability (short-term, procedural, situational memory) • Disorganized thinking/awareness - mental function varies over the course of the day • Ability to understand others or to be understood 					
COMMENT:					
0 pts	No issues with cognition AND no issues with memory, mental function, or ability to be understood/understand others				
3 pts	Displays difficulty making decisions in new situations or occasionally requires supervision in decision making AND has issues with memory, mental function, or ability to be understood/understand others				
6 pts	Displays consistent unsafe/poor decision making requiring reminders, cues or supervision at all times to plan, organize and conduct daily routines AND has issues with memory, mental function, or ability to be understood/understand others				
9 pts	Rarely or never has the capability to make decisions OR displays consistent unsafe/poor decision making or requires total supervision requiring reminders, cues or supervision at all times to plan, organize and conduct daily routines AND rarely or never understood/able to understand others				
18 pts	TRIGGER: No discernible consciousness, coma				



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MOBILITY:	
<ul style="list-style-type: none"> Determine the applicant or recipient's primary mode of locomotion Determine the amount of assistance the applicant or recipient needs with: <ul style="list-style-type: none"> Locomotion - how moves walking or wheeling, if wheeling how much assistance is needed once in the chair Bed Mobility - transition from lying to sitting, turning, etc. 	
COMMENT:	
0 pts	No assistance needed OR only set up or supervision needed
3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
6 pts	Maximum assistance needed, i.e. applicant or recipient needs two (2) or more individuals or more than 50% weight-bearing assistance OR total dependent for bed mobility
18 pts	TRIGGER: Applicant or recipient is bedbound OR totally dependent on the others for locomotion
EATING:	
<ul style="list-style-type: none"> Determine the amount of assistance the applicant or recipient needs with eating and drinking. Includes intake of nourishment by other means (e.g. tube feeding or total parenteral nutrition (TPN)). Determine if the participant requires a physician ordered therapeutic diet. 	
DIET ORDERED BY PHYSICIAN:	
COMMENT:	
0 pts	No assistance needed AND no physician ordered diet
3 pts	Physician ordered therapeutic diet OR set up, supervision, or limited assistance needed with eating
6 pts	Moderate assistance needed with eating, i.e. applicant or recipient performs more than 50% of the task independently
9 pts	Maximum assistance needed with eating, i.e. applicant or recipient requires an individual to perform more than 50% for assistance
18 pts	TRIGGER: Totally dependent on others
TOILETING:	
<ul style="list-style-type: none"> Determine the amount of assistance the applicant or recipient needs with toileting. Toileting includes: the actual use of the toilet room (or commode, bedpan, or urinal), transferring on/off the toilet, cleansing self, adjusting clothes, managing catheters/ostomies, and managing incontinence episodes. 	
COMMENT:	
0 pts	No assistance needed OR only set up or supervision needed
3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
6 pts	Maximum assistance needed, i.e. applicant or recipient needs two (2) or more individuals, or more than 50% of weight-bearing assistance
9 pts	Total dependence on others
BATHING Bathing includes: taking a full body bath/shower and the transferring in and out of the bath/shower.	
<ul style="list-style-type: none"> Determine the amount of assistance the applicant or recipient needs with bathing. 	
COMMENT:	
0 pts	No assistance needed OR only set up or supervision needed
3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
6 pts	Maximum assistance, i.e. applicant or recipient requires two (2) or more individuals, more than 50% of weight-bearing assistance OR total dependence on others
DRESSING AND GROOMING:	
<ul style="list-style-type: none"> Determine the amount of assistance needed by the applicant or recipient to dress, undress and complete daily grooming tasks 	
COMMENT:	
0 pts	No assistance needed OR only set up or supervision needed
3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks independently
6 pts	Maximum assistance, requires two (2) or more individuals, more than 50% weight-bearing assistance OR total dependence on others



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REHABILITATIVE SERVICES:		
<ul style="list-style-type: none"> Determine if the applicant or recipient has the following medically <u>ordered</u> rehabilitative services: Physical therapy/Occupational therapy/Speech therapy/Cardiac rehabilitation/Audiology. 		
TYPE OF PHYSICIAN-ORDERED REHABILITATIVE SERVICES AND FREQUENCY:		
COMMENT:		
0 pts	None of the above therapies ordered	
3 pts	Any of the above therapies ordered 1 time per week	
6 pts	Any of the above therapies ordered 2-3 times per week	
9 pts	Any of the above therapies ordered 4 or more times per week	
TREATMENTS:		
<ul style="list-style-type: none"> Determine if the applicant or recipient requires any of the following treatments: <ul style="list-style-type: none"> Catheter/Ostomy care Alternate modes of nutrition (tube feeding, TPN) Suctioning Ventilator/respirator Wound care (skin must be broken) 		
TYPE OF TREATMENT/COMMENT:		
0 pts	None of the above treatments were ordered by the physician	
6 pts	One or more of the above treatments was ordered by the physician requiring daily attention by a license professional	
MEAL PREPARATION:		
<ul style="list-style-type: none"> Determine the amount of assistance the applicant or recipient needs to prepare a meal. This includes planning, assembling ingredients, cooking, and setting out the food and utensils. 		
COMMENT:		
0 pts	No assistance needed OR only set up or supervision needed	
3 pts	Limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks	
6 pts	Maximum assistance, i.e. an individual performs more than 50% of tasks for the applicant or recipient OR total dependence on others	
MEDICATION MANAGEMENT:		
<ul style="list-style-type: none"> Determine the amount of assistance the applicant or recipient needs to safely manage their medications. Assistance may be needed due to a physical or mental disability. 		
COMMENT:		
0 pts	No assistance needed	
3 pts	Set up help needed OR supervision needed OR limited or moderate assistance needed, i.e. applicant or recipient performs more than 50% of tasks	
6 pts	Maximum assistance needed, i.e. an individual performs more than 50% of tasks for the applicant or recipient OR total dependence on others	
SAFETY:		
<ul style="list-style-type: none"> Determine if the individual exhibits any of the following risk factors: <ul style="list-style-type: none"> Vision Impairment Falling Problems with balance. Balance is moving to standing position, turning to face the opposite direction, dizziness, or unsteady gait After determination of preliminary score, history of institutionalization and age will be considered to determine final score. <ul style="list-style-type: none"> Institutionalization in the last 5 years - long-term care facility, mental health residence, psychiatric hospital, inpatient substance abuse, or settings for persons with intellectual disabilities. Aged - 75 years and over. 		
DATE OF LAST FALL:	TYPE OF INSTITUTIONALIZATION:	TIMEFRAME OR DATE ADMITTED TO INSTITUTION:
COMMENT:		



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0 pts	No difficulty or some difficulty with vision AND no falls in last 90 days AND no recent problems with balance
3 pts	Severe difficulty with vision (sees only lights and shapes) OR has fallen in the last 90 days OR has current problems with balance OR preliminary score of 0 AND Age OR Institutionalization
6 pts	No vision OR has fallen in last 90 days AND has current problems with balance OR Preliminary score of 0 AND Age AND Institutionalization OR Preliminary score of 3 AND Age OR Institutionalization
9 pts	Preliminary score of 6 AND Institutionalization
18 pts	TRIGGER: Preliminary score of 6 AND Age OR Preliminary Score of 3 AND Age AND Institutionalization

Describe what assistance is needed and who is currently helping:**Safety/Emergency Plan**

Emergency Back-up Plan:

Priority Risk: 1 High 2 Medium 3 Low**DIRECTIONS TO LOCATE, SAFETY CONCERNS IN THE HOME, OR ADDITIONAL COMMENTS****VETERAN HISTORY**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 NoIf answering Question 1 in the affirmative, would you like to receive information and assistance regarding the agency's veteran services? Yes No**TOTAL POINTS:** 0

If the individual does not meet the level of care for PACE eligibility with the primary assessment, (minimum of 18 points), complete the secondary assessment.

WORKER SIGNATURE

DATE

Once completed, Level of Care assessments (including any supporting documentation) should be submitted to the MO HealthNet Division via the File Transfer Protocol (FTP) site specified for your PACE organization.