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

DATE

PERSON BEING REFERRED (LAST, FIRST, MI)	DOB	DCN	RACE	SEX

ADDRESS (STREET, CITY, ZIP)	COUNTY	PHONE NUMBER(S)

NAME OF PERSON MAKING REFERRAL	RELATIONSHIP	PHONE NUMBER(S)

NAME OF REFERRING AGENCY	REASON FOR REFERRAL
	☐ In-home Services ☐ RCF/ALF-Personal Care ☐ Consumer-Directed Services ☐ ADC ☐ HDM

IS THE INDIVIDUAL RECEIVING HOME AND COMMUNITY BASED SERVICES ☐YES ☐ NO IF YES EXPLAIN

MEDICAID STATUS	☐ Active ☐ Applied ☐ Spenddown ☐Not Eligible ☐ Potentially HCB Eligible
VISION/HEARING	☐ Glasses ☐ Visually Impaired ☐ Blind ☐ Hearing Aid ☐ Hearing Impaired ☐ Deaf

LIVING ARRANGEMENTS AND MARITAL STATUS

OTHER PERSONS INVOLVED	ROLE	ADDRESS	PHONE
	Physician		
	Physician		
	Contact		
	Other (identify)		

LIST ALL DIAGNOSES (should correlate with meds., indicate if unstable, include name and date of physician verification)	**LIST (OR ATTACH A LIST OF) MEDICATION (RX and OTC) FOR DIAGNOSES** (should correlate with diagnoses, include dosage and frequency)

ASSESSED NEEDS	**REQUIRED EXPLANATION –** include how need is/was being met, who is/was meeting the need, and why help is now needed. Attach additional pages if needed.	**LOC**
MONITORING ☐ **0** (PRN medical check) ☐ **3** (medical check 1 x mo; stable) ☐ **6** (verified unstable medical condition) ☐ **9** (intensive, continuous monitoring) ☐ Sees physician? ☐ Receives home health or hospice?	Include medical condition and frequency	
MEDICATION ☐ **0** (No Rx Meds) ☐ **3** (Rx Meds for stable condition) ☐ **6** (Set-ups/supervision required) ☐ **9** (Complex/ total assistance) ☐ Medication management needs to be supervised? ☐ Complex drug regime (i.e., multiple prescriptions with various dosages/time of administration or 9 or more prescribed meds.)	Indicate type of supervision needed and how often	
TREATMENT ☐ **0** (none) ☐ **3** (simple dressings, suppositories, ☐ **6** (daily dressings – ulcers, cath. or ostomy care, PRN oxygen i.e., used within last 30 days) ☐ **9** (dressing changes – more than 1 x dy., new/unregulated ostomy, cont. oxygen) ☐ Bowel Program ☐ Catheter ☐ Ostomy ☐ Oxygen	Include type of and frequency of treatment	
RESTORATIVE ☐ **0** (No services) ☐ **3** (maintain current level) ☐ **6** (restore higher funct. level) ☐ **9** (intense teaching/training services to restore to higher level) ☐ Receives restorative (teaching/training) services?	Are services to maintain a current function, or restore the participant to a higher level of functioning	

PERSON BEING REFERRED (LAST, FIRST, MI)	REFERRAL NUMBER (HCS USE ONLY)	LOC
REHABILITATION ☐ **0** (none) ☐ **3** (1 x wk) ☐ **6** (2-3 x wk) ☐ **9** (4 or more x wk) Receives physician-ordered therapy? ☐ PT ☐ OT ☐ ST ☐ Audiology	Indicate where services are provided and frequency	
PERSONAL CARE ☐ **0** (none) ☐ **3** (min. assist need, infrequent incont. – 1 x wk or less) ☐ **6** (moderate assist needed, frequent incont. – 2 to 3 x wk) ☐ **9** (max. assist needed; continuous incont.) ☐ Grooming ☐ Bathing/Equipment ☐ Toileting	Indicate the amount and degree of human assistance required	
DIETARY ☐ **0** (no assist) ☐ **3** (minimal assist w/ cooking/eating, special diet) ☐ **6** (mod assist by others) ☐ **9** (max assist/tube feeding) ☐ Prescribed Calculated Diet ☐ Meal Preparation Needed ☐ Assist w/eating ☐ Tube Feeding	Indicate type of prescribed diet and amount of assistance needed	
MOBILITY ☐ **0** (no human assist) ☐ **3** (periodic human assist) ☐ **6** (direct human assist for ambulation) ☐ **9** (immobile) ☐ Human Assistance ☐ Turning/Positioning ☐ Assistive Device	Indicate type and duration of human assistance needed and any assistive device needed, architectural barriers	
BEHAVIORAL INFORMATION & MENTAL STATUS ☐ **0** (no assistance needed) ☐ **3** (periodic human assist) ☐ **6** (moderate human assist) ☐ **9** (maximum human assist) ☐ Wanders ☐ MI/MR/DD ☐ Combative ☐ Withdrawn ☐ Depression ☐ Disoriented ☐ Alert / Oriented ☐ Thinks clearly ☐ Dementia ☐ Lethargic ☐ Memory deficits ☐ Suspicious / Paranoid ☐ Supervised for safety ☐ Able to make appropriate independent decisions ☐ Guardian ☐ Conservator ☐ Power of Attorney ☐ Payee	Indicate type and amount of human assistance needed	**LOC TOTAL**

Needs assistance with the following: (indicate what help is needed and who is currently helping)

☐ Laundry	☐ Gather/Take out trash
☐ Vacuum/Dust	☐ Shopping Assistance
☐ Clean Bathroom	☐ Transportation
☐ Clean Kitchen	☐ Assist w/ Handling Money
☐ Make/Change bed	☐ Assist w/Telephone

Safety/Emergency Plan

☐ History of violent behavior	Priority Risk: ☐ 1 High ☐ 2 Medium ☐ 3 Low
☐ Weapons in the home	☐ Emergency Back-up Plan:
☐ Vicious dogs	
☐ Others available in the home for support	

DIRECTIONS TO LOCATE – COMMENTS:

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.