NYLAG
New York Legal Assistance Group

2023 Elder Law Forum

NYLAG APPENDIX -- Medicaid Changes 2023

Medicaid increases – Income & Assets

Unwinding of Public Health Emergency – Links and resources

3. DOH presentation Feb. 2023 https://info.nystateofhealth.ny.gov/sites/default/files/NYSDOH%20Presentation%20-%20PHE%20and%20Continuous%20Coverage%20Unwind%20Plan.pdf ..... --
2. NYLAG webpage on Unwinding http://health.wnylc.com/health/news/86/ ..... --
3. DOH webpage for consumers on unwinding https://www.health.ny.gov/health_care/medicaid/changes/ ..... --

New York Independent Assessor

1. NYIA Authorized Representative Form (https://nyia.com/content/dam/digital/united-states/new-york/nymc-ia/language-masters/en/pdf/MM-CF-0822.pdf) 51
2. Excerpt – UAS Reference Community Health Assessment Guide (instructions). 52-159
3. NYIA Sample Outcome Notice 160-162

ONLINE LINKS – with DOH GUIDANCE on NYIA

4. NYLAG webpage on NYIA http://health.wnylc.com/health/news/85/#Independnet%20Assessor%20NEW
5. 22 OHIP/ADM-01 New York Independent Assessor for Personal Care (PCS) and Consumer Directed Personal Care Services (CDPAS) (4/20/22)

   https://www.health.ny.gov/health_care/medicaid/publications/22adm01.htm
6. GIS 22 MA/09 Implementation of Assessments Conducted by the New York Independent Assessor (NYIA) Based on an Immediate Need for PCS/CDPAS (11/16/22) https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/22ma09.pdf
7. MLTC Policy 22.01 New York Independent Assessor for Personal Care (PCS) and Consumer Directed Personal Assistance Services (CDPAS) (4/27/22) https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/docs/2022-04-27_mltc_22-01.pdf
8. Mainstream Managed Care Guidance, May 16, 2022 Implementation of New York Independent Assessor for Personal Care (PCS) and Consumer Directed Personal Assistance Services (CDPAS) (4/28/22)

   https://www.health.ny.gov/health_care/managed_care/plans/docs/mmc_nyia_guidance.pdf
9. Mainstream Managed Care Guidance, Process for Expedited Request for Assessment and the New York Independent Assessor (11/17/22) https://www.health.ny.gov/health_care/managed_care/plans/mmc_guidance.htm

FAIR HEARING DECISIONS on NYIA (online)

OTDA's fair hearing decision archive --https://otda.ny.gov/hearings/search/

1. FH 8480913Z (NYC) (Risk of falling does not render condition unstable) https://otda.ny.gov/fair%20hearing%20images/2022-8/Redacted_8480913Z.pdf
2. FH 8477309M (Albany) (Reversing NYIA no need for 120+ days CBLTC)

   https://otda.ny.gov/fair%20hearing%20images/2022-11/Redacted_8477309M.pdf

3. FH 8483074N (NYC) (Son can't be required to provide "voluntary" care) https://otda.ny.gov/fair%20hearing%20images/2022-8/Redacted_8483074N.pdf

New Immediate Need Forms:

1. DOH Attestation of Immediate Need DOH- 5786 (replaces OHIP 0103)(https://www.health.ny.gov/forms/doh-5786.pdf).....163-165
2. DOH-5779 Practitioner Statement of Need https://www.health.ny.gov/forms/doh-5779.pdf 166-167
3. HCSP 3052 Transmittal Need (NY only) 168 https://www1.nyc.gov/assets/hra/downloads/pdf/services/micsa/HCSP-3052%20Immediate%20Need%20Transmittal.pdf

SEE OUR http://nyhealthaccess.org Health Care Advocacy Webpage

TO:	Local District Commissioners, Medicaid Directors
FROM:	Lisa Sbrana, Director Division of Eligibility and Marketplace Integration
SUBJECT:	2023 Federal Poverty Levels
ATTACHMENT:	2023 FPL Chart
EFFECTIVE DATE:	January 1, 2023
CONTACT PERSON:	Local District Support Unit Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to inform local departments of social services (LDSS) of the revised federal poverty levels (FPLs). The revised FPLs are effective January 1, 2023, as published in the Federal Register.

The new FPLs should be used for all transactions with a Medicaid Budget Logic (MBL) eligibility "From" date of January 1, 2023, or later. The revised figures will be available on MBL on February 13, 2023. For all new and pending applications, income must be compared to the 2023 FPLs. All redeterminations effective January 1, 2023, or later, must be re-budgeted retroactive to January 1, 2023, using the Medically Needy Income Level (MNIL) based on the 2023 FPLs.

Due to the continuous enrollment condition introduced in the Families First Coronavirus Response Act (FFCRA), neither Phase 1 nor Phase 2 of Mass Re-Budgeting (MRB), including the systematic update of the 8.7 percent (%) Cost of Living Adjustment (COLA), was run. Districts will be informed of any additional updates regarding MRB.

Due to the increase in the FPLs, some Specified Low-Income Medicare Beneficiaries (SLMB) may be income eligible for the Qualified Medicare Beneficiary (QMB) benefit. In such cases, staff must complete a 99-change transaction on the eMedNY Buy-in span, with the effective date of January 1, 2023, and change the Medicare Savings Program (MSP) code appropriately. For NYC, the change in MSP level can be transmitted via an undercare case transaction.

Medicare Part B Premium

In 2023, there is a COLA of 8.7% for Social Security benefits. Under a "hold-harmless" provision of federal law, a beneficiary's Medicare Part B premiums in any year cannot rise higher than that year's COLA.

In 2023, most beneficiaries will pay the full Part B premium. In other words, the 8.7% COLA will generate enough increased income for them to pay $164.90 without reducing their net Social Security benefits.

If an individual's Social Security benefit does not increase enough for them to pay the $164.90 without their benefit decreasing, the "hold harmless" provision will limit the Part B premium increase to the amount of their 2023 Social Security benefit increase.

The "hold-harmless" provision does not apply to all beneficiaries. The Medicare Part B premium for individuals in the following categories will increase to $164.90 (or higher) in 2023:

- Individuals whose income is above $91,000, or a married individual when the couple's combined income is over $182,000, will pay the standard premium and an Income Related Monthly Adjustment Amount (IRMAA).

- New Medicare Part B beneficiaries. Since these individuals did not pay the Medicare Part B premium in 2023, the "hold harmless" provision does not apply; and

- Individuals who do not have the Medicare Part B premium deducted from their Social Security benefit. This includes individuals who are enrolled in the Medicare Savings Program. These individuals will not be directly affected; the increased premium will be paid by Medicaid.

If an individual has chosen to pay the Medicare Part B premium to reduce a spenddown obligation, the actual premium that is paid must be used in calculating the individual's budget.

Family Member Allowance

As a result of the increase in the FPLs, the amount used in the Family Member Allowance (FMA) formula increased to $2,465.00. The maximum monthly FMA increased to $822. All spousal impoverishment cases involving a family member entitled to the family member allowance, with a budget effective date of January 1, 2023, or later, and which were budgeted using the 2022 Family Member Allowance, must be re-budgeted using the 2023 Family Member Allowance.

If a district determines that a previously budgeted case with a "From" date of January 1, 2023, or greater, has been negatively affected due to use of 2022 FPL, or a case is brought to the district's attention, the case should be re-budgeted using the revised FPLs. If eligible, covered medical expenses paid by an individual as a result of an improper calculation must be reimbursed pursuant to 10 OHIP/ADM-9, "Reimbursement of Paid Medical Expenses Under 18 NYCRR §360-7.5(a)."

Congregate Care

Medicaid eligibility for SSI-related consumers is determined by comparing income, after appropriate deductions, to the MNIL or the Medicaid Standard (and MBL Living Arrangement Chart as appropriate) – and applying whichever income level is most beneficial. For individuals residing in Congregate Care living arrangements, the Congregate Care income levels, generally, are higher than the MNIL. However, for purposes of determining the most beneficial income level for a single individual residing in a Congregate Care Level 1, Level 2, or Level 3 living arrangement, the increased MNIL for January 2023 is higher than the income levels for Congregate Care Levels 1 - 3 for single individuals. Districts are reminded to apply the most beneficial income level.

Charts with the 2023 FPLs for the various categories of Medicaid eligibility are attached to this GIS.

Please direct any questions to your local district liaison.

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

NEW YORK STATE INCOME AND RESOURCE STANDARDS FOR NON-MAGI POPULATION
EFFECTIVE JANUARY 1, 2023

HOUSE HOLD SIZE	100% FPL		138% FPL MEDICAID INCOME		150% FPL		185% FPL		186% FPL		200% FPL		250% FPL		RESOURCES	
	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY
ONE	14,580	1,215	20,121	1,677	21,870	1,823	26,973	2,248	27,119	2,260	29,160	2,430	36,450	3,038	30,182	1
TWO	19,720	1,644	27,214	2,268	29,580	2,465	36,482	3,041	36,680	3,057	39,440	3,287	49,300	4,109	40,821	2
THREE	24,860	2,072	34,307	2,859	37,290	3,108	45,991	3,833			49,720	4,144				3
FOUR	30,000	2,500	41,400	3,450	45,000	3,750	55,500	4,625			60,000	5,000				4
FIVE	35,140	2,929	48,494	4,042	52,710	4,393	65,009	5,418			70,280	5,857				5
SIX	40,280	3,357	55,587	4,633	60,420	5,035	74,518	6,210			80,560	6,714				6
SEVEN	45,420	3,785	62,680	5,224	68,130	5,678	84,027	7,003			90,840	7,570				7
EIGHT	50,560	4,214	69,773	5,815	75,840	6,320	93,536	7,795			101,120	8,427				8
NINE	55,700	4,642	76,866	6,406	83,550	6,963	103,045	8,588			111,400	9,284				9
TEN	60,840	5,070	83,960	6,997	91,260	7,605	112,554	9,380			121,680	10,140				10
EACH ADD'L PERSON	5,140	429	7,094	592	7,710	643	9,509	793			10,280	857				+

SPOUSAL IMPOVERISHMENT	INCOME	RESOURCES
Community Spouse	$3,715.50	$148,620
Institutionalized Spouse	$50	$30,182
Family Member Allowance	$2,465 (150% of FPL for 2) is used in the FMA formula the maximum allowance is $822	N/A

SPECIAL STANDARDS FOR HOUSING EXPENSES					
REGION	Amount	REGION	Amount	REGION	Amount
Central	$358	Northeastern	$425	Northern Metropolitan	$1,031
Rochester	$367	Long Island	$1,445		
Western	$301	New York City	$1,701		

*In determining the community spouse resource allowance on and after January 1, 2023, the community spouse is permitted to retain resources in an amount equal to the greater of the following $74,820 or the amount of the spousal share up to $148,620. The spousal share is the amount equal to one-half of the total value of the countable resources of the couple as of the beginning of the most recent continuous period of institutionalization of the institutionalized spouse on or after September 30, 1989.

Revised January 19, 2023

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

NON-MAGI POPULATION						
CATEGORY	INCOME COMPARED TO	HOUSEHOLD SIZE		RESOURCE LEVEL		SPECIAL NOTES
		1	2	1	2	
UNDER 21, ADC-RELATED	MEDICAID LEVEL	1,677	2,268	NO RESOURCE TEST		
SSI-RELATED	MEDICAID LEVEL	1,677	2,268	30,182	40,821	Household size is always one or two.
COBRA CONTINUATION COVERAGE	100% FPL	1,215	1,644	4,000	6,000	A/R may be eligible for Medicaid to pay the COBRA premium.
AIDS INSURANCE	185% FPL	2,248	3,041	NO RESOURCE TEST		A/R must be ineligible for Medicaid, including COBRA continuation.
QUALIFIED MEDICARE BENEFICIARY (QMB)	138% FPL	1,677	2,268	NO RESOURCE TEST		If the A/R is determined eligible, Medicaid will pay Part B and/or A premium, coinsurance and deductible.
QUALIFING INDIVIDUAL (QI)	GREATER THAN 138% BUT LESS THAN OR EQUAL TO 186% FPL	1,677	2,268	NO RESOURCE TEST		If the A/R is determined eligible, Medicaid will pay Medicare Part B premium. The A/R must have part A to qualify.
		2,260	3,057			
QUALIFIED DISABLED & WORKING INDIVIDUAL (QDWI)	200% FPL	2,430	3,287	4,000	6,000	If the A/R is determined eligible, Medicaid will pay Medicare Part A premium.
MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD)	250% FPL	3,038	4,109	30,182	40,821	Countable retirement accounts are disregarded as resources effective 10/01/11.

Revised January 19, 2023

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

New York State Income Standards for MAGI Population
Effective January 1, 2023

House Hold	100% FPL		110% FPL		138% FPL LIF LEVEL		154% FPL		155% FPL		223% FPL	
Size	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY
One	14,580	1,215	16,038	1,337	20,121	1,677	22,454	1,872	22,599	1,884	32,514	2,710
Two	19,720	1,644	21,692	1,808	27,214	2,268	30,369	2,531	30,566	2,548	43,976	3,665
Three	24,860	2,072	27,346	2,279	34,307	2,859	38,285	3,191	38,533	3,212	55,438	4,620
Four	30,000	2,500	33,000	2,750	41,400	3,450	46,200	3,850	46,500	3,875	66,900	5,575
Five	35,140	2,929	38,654	3,222	48,494	4,042	54,116	4,510	54,467	4,539	78,363	6,531
Six	40,280	3,357	44,308	3,693	55,587	4,633	62,032	5,170	62,434	5,203	89,825	7,486
Seven	45,420	3,785	49,962	4,164	62,680	5,224	69,947	5,829	70,401	5,867	101,287	8,441
Eight	50,560	4,214	55,616	4,635	69,773	5,815	77,863	6,489	78,368	6,531	112,749	9,396
Nine	55,700	4,642	61,270	5,106	76,866	6,406	85,778	7,149	86,335	7,195	124,211	10,351
Ten	60,840	5,070	66,924	5,577	83,960	6,997	93,694	7,808	94,302	7,859	135,674	11,307
Each Add't Person	5,140	429	5,654	472	7,094	592	7,916	660	7,967	664	11,463	956

Revised January 19, 2023

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

MAGI POPULATION						
CATEGORY	INCOME COMPARED TO	HOUSEHOLD SIZE		RESOURCE LEVEL		SPECIAL NOTES
		1	2	1	2	
PRESUMPTIVE ELIGIBILITY FOR PREGNANT CONSUMERS	223% FPL	N/A	3,665	NO RESOURCE TEST		Qualified provider makes the presumptive eligibility determination. Cannot spenddown to become eligible for presumptive eligibility.
PREGNANT CONSUMERS	223% FPL	N/A	3,665	NO RESOURCE TEST		A woman determined eligible for Medicaid for any time during her pregnancy remains eligible for Medicaid coverage until the last day of the month in which the 60th day from the date the pregnancy ends occurs, regardless of any change in income or household size composition. If the income is above 223% FPL the A/R must spenddown to the Medicaid income level. The baby will have guaranteed eligibility for one year.
CHILDREN UNDER ONE	223% FPL	2,710	3,665	NO RESOURCE TEST		If the income is above 223% FPL the A/R may apply for CHPlus or spenddown to the Medicaid level. One year guaranteed eligibility if mother is in receipt of Medicaid on delivery. Eligibility can be determined in the 3 months retro to obtain the one year extension.
CHILDREN AGE 1 THROUGH 5	154% FPL	1,872	2,531	NO RESOURCE TEST		If income is above 154% FPL the A/R may apply for CHPlus or if chooses to spenddown, must spenddown to the Medicaid level.
CHILDREN AGE 6 THROUGH 18	110% FPL	1,337	1,808	NO RESOURCE TEST		If income is above 154% FPL the A/R may apply for CHPlus or if chooses to spenddown, must spenddown to the Medicaid level.
	154% FPL	1,872	2,531			
PARENTS/CARETAKER RELATIVES	138% FPL	1,677	2,268	NO RESOURCE TEST		If income is above 138% FPL the A/R may apply for Advanced Premium Tax Credit (APTC) or Essential Plan (EP) if chooses to spenddown, must spenddown to the Medicaid Level.
19 AND 20 YEAR OLDS LIVING WITH PARENTS	138% FPL	1,677	2,268	NO RESOURCE TEST		If income is above 155% FPL the A/R can apply for APTC or EP or if chooses to spenddown, must spenddown to Medicaid level.
	155% FPL	1,884	2,548			
SINGLE/CHILDLESS COUPLES AND 19 AND 20 YEARS LIVING ALONE	100% FPL	1,215	1,644	NO RESOURCE TEST		Single/Childless Couples (S/CCs) cannot spenddown, but can apply for APTC or EP; 19 and 20 year olds if income over 138% may apply for APTC or EP if chooses to spenddown, must spenddown to the Medicaid level.
	138% FPL	1,677	2,268			
FAMILY PLANNING PROGRAM	223% FPL	2,710	3,665	NO RESOURCE TEST		Eligibility determined using only applicant's income.

Revised January 19, 2023

Pickle

Section 503 of Public Law 94-566, referred to as the Pickle Amendment, protects Medicaid eligibility for all recipients of Retirement Survivors and Disability Insurance (RSDI) who were previously eligible for SSI benefits concurrently. These recipients are individuals who would be eligible for SSI, if all RSDI Cost of Living Allowances (COLAs) received since they were last eligible for and receiving RSDI and SSI benefits concurrently, were deducted from their countable income. (See 85 ADM-35 for further information). The reduction factors in the chart below, "REDUCTION FACTORS FOR CALCULATING MEDICAID ELIGIBILITY UNDER THE PICKLE AMENDMENT", should be used when determining Medicaid eligibility for individuals who are entitled to a reduction to their countable SSI Income.

If SSI was terminated during this period:	Multiply 2022 Social Security income by:	If SSI was terminated during this period:	Multiply 2022 Social Security income by:	If SSI was terminated during this period:	Multiply 2022 Social Security income by:
May – June 1977	0.214	Jan. 1992 – Dec. 1992	0.502	Jan. 2007 – Dec. 2007	0.741
July 1977 – June 1978	0.226	Jan. 1993 – Dec. 1993	0.517	Jan. 2008 – Dec. 2008	0.758
July 1978 – June 1979	0.241	Jan. 1994 – Dec. 1994	0.531	Jan. 2009 – Dec. 2011	0.802
July 1979 – June 1980	0.265	Jan. 1995 – Dec. 1995	0.545	Jan. 2012 – Dec. 2012	0.831
July 1980 – June 1981	0.303	Jan. 1996 – Dec. 1996	0.560	Jan. 2013 – Dec. 2013	0.845
July 1981 – June 1982	0.337	Jan. 1997 – Dec. 1997	0.576	Jan. 2014 – Dec. 2014	0.858
July 1982 – Dec. 1983	0.362	Jan. 1998 – Dec. 1998	0.588	Jan. 2015 – Dec. 2016	0.872
Jan. 1984 – Dec. 1984	0.374	Jan. 1999 – Dec. 1999	0.596	Jan. 2017 – Dec. 2017	0.875
Jan. 1985 – Dec. 1985	0.388	Jan. 2000 – Dec. 2000	0.610	Jan. 2018 – Dec. 2018	0.892
Jan. 1986 – Dec. 1986	0.400	Jan. 2001 – Dec. 2001	0.632	Jan. 2019 – Dec. 2019	0.917
Jan. 1987 – Dec. 1987	0.405	Jan. 2002 – Dec. 2002	0.648	Jan. 2020 – Dec. 2020	0.932
Jan. 1988 – Dec. 1988	0.422	Jan. 2003 – Dec. 2003	0.657	Jan. 2021 – Dec. 2021	0.944
Jan. 1989 – Dec. 1989	0.439	Jan. 2004 – Dec. 2004	0.671		
Jan. 1990 – Dec. 1990	0.459	Jan. 2005 – Dec. 2005	0.689		
Jan. 1991 – Dec. 1991	0.484	Jan. 2006 – Dec. 2006	0.717		

Note: This updates the Reduction Factors included in the Medicaid Reference Guide (MRG). The MRG table should no longer be used.

Revised January 21, 2023

TO:	Local District Commissioners, Medicaid Directors
FROM:	Lisa Sbrana, Director Division of Eligibility and Marketplace Integration
SUBJECT:	Changes to Medicare Savings Program (MSP) Income Levels
ATTACHMENT:	Attachment I – Sample One-Time Medicare Savings Plan Letter
EFFECTIVE DATE:	January 1, 2023
CONTACT PERSON:	Local District Support Units Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to advise local departments of social services of an increase in the percent of Federal Poverty Level (FPL) for determining eligibility for payment of Medicare premiums through the Medicare Buy-In process pursuant to Chapter 56 of the Laws of 2022.

This change is effective with new applications and requests for redetermination of Medicare Savings Program (MSP) eligibility received on or after January 1, 2023. Determinations for any period prior to January 1, 2023, must be determined using the 2022 MSP FPL levels.

New FPL levels effective January 1, 2023

Qualified Medicare Beneficiary (QMB) Clients with income less than or equal to 138% of the FPL will be QMB eligible, beginning January 1, 2023. QMB eligible clients may also have active Medicaid coverage. NY Medicaid will pay Medicare Part B premiums, coinsurance, and deductibles for those eligible at the QMB level.

Specified Low Income Medicare Beneficiary (SLMB) This category will no longer be used for new applications or renewals on or after January 1, 2023. Since the SLMB income level is 120% of the FPL, it is being subsumed into the QMB level.

Qualifying Individuals (QI) Clients with income above 138% of the FPL and less than or equal to 186% of the FPL will be QI eligible, beginning January 1, 2023.

Note: Clients cannot be enrolled as QI and enrolled in NY Medicaid at the same time. They must choose which program they prefer. NY Medicaid will pay only Medicare Part B premiums for those eligible at the QI level.

Mass re-budgeting will not occur for those with current MSP coverage. Letters will be sent to these individuals who are MSP eligible, above the 2022 QMB level, advising them that they may be eligible for MSP with benefits not currently available with their current level of coverage.

Instructions on where to obtain and submit both the MSP Only and full Medicaid applications are provided. (See Attachment I). A separate letter with similar information will be sent to those individuals who are eligible for Medicaid with excess income. Should consumers contact local districts in the month of December, staff should wait until January to process any applications or changes when the new rates take effect. Current processes for determining MSP eligibility will not change. MSP determinations must be completed before determining Medicaid eligibility per 00 OMM/ADM 07.

2023 MSP Income limits	
CATEGORY	INCOME/FPL
QMB	0% up to and equal to, 138%
SLMB	*Category is no longer applicable*
QI	Above 138% and up to and equal to, 186%

MSP Redeterminations

When processing a request for a redetermination of MSP outside of the Client's normal renewal period, the coverage and authorization "To" date should not be changed. This will result in the individual keeping the same renewal month as they had prior to the new determination.

Upstate QI Eligible Individuals

All Upstate QI individuals will no longer be renewed in June of each year. Upstate QI eligible applicants will no longer be given a coverage and authorization "To" date of 12/31/49. Applicants newly eligible for QI will be given coverage "From" and "To" dates corresponding to their date of application.

Example: Applications submitted in April of 2023, determined QI eligible, will be provided a coverage and authorization "From" date of 04/01/2023 and a coverage and authorization "To" date of 03/31/2024.

If the district touches a case prior to the annual renewal, for a client who is currently eligible for QI, and has a coverage and authorization "To" date of 12/31/49, they must update the coverage and authorization "To" date to June 30, 2023. This will result in the individual continuing to have the same renewal period but end the practice of using 12/31/49.

The Department is working on a process to address the current population with 12/31/49 authorization "To" dates who do not report a change or request an update to their case, so that these clients will be renewed based on an authorization "To" date of 6/30/23, rather than the 12/31/49 date. This is expected to be resolved during the first quarter of 2023.

Retroactive MSP

The policy for retroactive MSP benefits has not changed. Clients eligible for QMB are not entitled to retroactive benefits. Clients eligible for SLMB and QI may be entitled to retroactive benefits for three months prior. However, retroactive QI benefits may not be provided for a previous calendar year.

As of January 1, 2023, the SLMB category should no longer be utilized in eMedNY unless you are entering retroactive SLMB that will be for all or a part of the period 10/01/2022 to 12/31/2022. Clients may show as being currently enrolled at the SLMB level after January 1, 2023, however they will no longer be able to be determined eligible for SLMB in WMS.

If, after January 1, 2023, there is a need to determine MSP eligibility retroactively for SLMB for any time in the last quarter of 2022, a manual budget will need to be performed and eMedNY

updated. Determination for SLMB eligibility in 2022 will need to use the MSP rates for 2022.

Please direct any questions to your local district liaison.

XL0218 (09/97)

NOTICE NUMBER : U000000000 Page: 1 ***

COUNTY DSS
COUNTY ADDRESS
CITY,STATE ZIP

SE LE ENVIARA UNA COPIA EN ESPANOL DE ESTA NOTIFICACION EN UN SOBRE APARTE

NOTICE NUMBER:	DATE:	CASE NUMBER:
U000000000	December 1, 2022	AB000000

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
OFC ID	UNIT ID	WKER ID	DEFAULT MA	###-###-####

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP ###-###-####

OR Agency Conference ###-###-####

Fair Hearing information and assistance ###-###-####

Record Access ###-###-####

Child/Teen Health Plan ###-###-####

CASE NAME / AND ADDRESS

OFC/UNIT/WKER

CONSUMER NAME
CONSUMER ADDRESS
CITY, STATE ZIP

If you are blind or seriously visually impaired and need notices or other written materials in an alternative format (large print, audio, or data CD, or Braille), contact your local social services district.

MEDICAL ASSISTANCE

Good News, as part of the New York State 2023 Budget, individuals who have been eligible for the Medicare Savings Program only, may now be eligible to enroll in NY Medicaid which covers many health care services not covered by Medicare.

You, or someone in your household, is currently enrolled in the Medicare Savings Program. Some categories of the Medicare Savings Program do not provide any Medicaid benefits. As of January 1, 2023, you may be eligible for Medicaid as well as the Qualified Medicare Beneficiary (QMB) Medicare Savings Program. QMB will cover your Medicare premiums and cost-sharing.

If you, or someone in your household, would like to be considered for Medicaid eligibility, you must submit a fully completed Medicaid application, along with a Supplement A form. The application can be obtained from your local department of social services or downloaded from the internet at https://www.health.ny.gov/forms/doh-4220.pdf. The Supplement A form is also available from your local department of social services or downloaded from the internet at https://www.health.ny.gov/forms/doh-5178a.pdf.

If you, or someone in your household, would like to be considered for only the Medicare Savings Program, please complete the Medicare Savings Program Application. This application can be obtained from your local department of social services or downloaded from the internet at https://www.health.ny.gov/forms/doh-4328.pdf.

Once you complete and submit the application and documentation to your local department of social services, you will receive notification regarding your eligibility for these programs based on the changes that take effect January 1, 2023.

Questions regarding the application, general Medicaid information, or the Medicare Savings Programs may be directed to your social services district at the agency

SAMPLE

telephone number listed above.

SAMPLE

TO:	Local District Commissioners, Medicaid Directors
FROM:	Lisa Sbrana, Director Division of Eligibility and Marketplace Integration
SUBJECT:	Increase of Medicaid Medically Needy Income Level to 138% of the Federal Poverty Level and Related Medically Needy and MBI-WPD Resource Level Changes
ATTACHMENT:	Attachment I - Sample One-Time Excess Income Letter
EFFECTIVE DATE:	January 1, 2023
CONTACT PERSON:	Local District Support Units Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to advise social services districts of a change to the Medicaid Medically Needy income level, and the impact this change has to the resource level for SSI-related consumers and for the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD). Pursuant to Chapter 56 of the Laws of 2022, the Medically Needy income level (MNIL) will be 138% of the federal poverty level (FPL) effective January 1, 2023. Districts are also advised that the Medically Needy income and resource levels are subject to change annually based on changes to the FPL. Since the FPL for 2023 is not available until March 2023, the MNIL for January 2023 is based on the 138% FPL for 2022.

Medically Needy Income Level

For SSI-related consumers, the change in MNIL to 138% FPL results in the income level for an individual increasing from $934.00 for 2022 ($1,367 for a couple) to $1,563 ($2,106 for a couple) effective January 1, 2023. The SSI-related income disregards and deductions continue to apply. Also, although this increase may reduce the number of Medicaid consumers who have excess income, the change does not eliminate the Excess Income (Spenddown) Program. Consumers with income above the MNIL may spenddown to the new MNIL. A one-time letter will be sent in December 2022 to inform current Medicaid consumers who have been identified as having excess income of the increased MNIL, and to provide instructions for contacting their local department of social services (LDSS) to request a recalculation of their income before their next renewal (See Attachment I). For current Medicaid consumers who do not contact the LDSS for a recalculation of their income in response to the December 2022 one-time letter, the LDSS should redetermine the individual's income eligibility based on the new MNIL levels at the next consumer contact or at renewal, whichever comes first.

NOTE: Medicaid eligibility for SSI-related consumers is determined by comparing income, after appropriate deductions, to the MNIL or the Medicaid Standard (and MBL Living Arrangement Chart as appropriate) – and applying whichever income level is most beneficial. For individuals residing in Congregate Care living arrangements, the Congregate Care income levels, generally,

are higher than the MNIL. However, for purposes of determining the most beneficial income level for a single individual residing in a Congregate Care Level 1 or Level 2 living arrangement, the increased MNIL for January 2023 is higher than the income levels for Congregate Care Level 1 and Level 2 for single individuals. Districts are reminded to apply the most beneficial income level.

Medically Needy Resource Level

The Medically Needy resource level for SSI-related individuals is calculated at 150% of the Medicaid MNIL. As a result of the change to the MNIL, the resource level for an SSI-related individual will increase from $16,800 ($24,600 for a couple) for 2022 to $28,133 for an individual ($37,902 for a couple) effective January 1, 2023.

Medicaid Buy-In Program for Working People with Disabilities Resource Levels

The resource levels for the Medicaid Buy-In Program for Working People with Disabilities will also increase effective January 1, 2023. The MBI-WPD resource levels, currently a fixed level of $20,000 for an individual and $30,000 for a couple, will increase to the same amount as the Medically Needy resource levels effective January 1, 2023. The income level for MBI-WPD remains 250% FPL. As referenced above, the Medically Needy resource levels are subject to change annually based on changes to the FPL. MBI-WPD Client Notice System (CNS) notices and manual notices have been updated to reflect the resource level changes.

Effective Date

The new Medically Needy income and resource levels are effective January 1, 2023, and apply to new applications and requests for an increase in coverage received on or after January 1, 2023.

Please direct any questions to your local district liaison.

XL0218 (09/97)

NOTICE NUMBER : U000000000 Page: 1 *****

COUNTY DSS
COUNTY
ADDRESS
CITY,STATE ZIP

SE LE ENVIARA UNA COPIA EN ESPANOL DE ESTA NOTIFICACION EN UN SOBRE APARTE

NOTICE NUMBER:	DATE:	CASE NUMBER:
U000000000	December 1, 2022	AB00000

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
OFC ID	UNIT ID	WKER ID	DEFAULT MA	###-###-####

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP ###-###-####

OR Agency Conference ###-###-####

Fair Hearing information and assistance ###-###-####

Record Access ###-###-####

Child/Teen Health Plan ###-###-####

CASE NAME / AND ADDRESS

OFC/UNIT/WORKER

CONSUMER NAME
CONSUMER ADDRESS
CITY, STATE ZIP

If you are blind or seriously visually impaired and need notices or other written materials in an alternative format (large print, audio, or data CD, or Braille), contact your local social services district.

MEDICAL ASSISTANCE

Dear Medicaid Member,

This letter is being sent to you to let you know that as part of the New York State 2023 Budget, the Medically Needy Income level will increase beginning in January 2023, when it will be based on 138% of the Federal Poverty level. **This is good news!**

What does this change mean?

It means that Medicaid enrollees who have their Medicaid through their local social services district (including the Human Resources Administration (HRA) in New York City) and who have their monthly income compared to the Medically Needy income level **may be able to keep more of their monthly income** under this change beginning in 2023.

Why am I getting this letter?

If you or someone in your household has excess income under current Medicaid rules **and lives in the community** - for example, someone in your household living in the community has a "Spenddown" or a community-based income contribution called "Net Available Monthly Income" contribution (known as a "**NAMI**" contribution) - this change could lower the amount of income you or your household member may have to contribute on a monthly basis in order to get Medicaid coverage.

Do I **need to do anything?**

No, you don't have to do anything - this change will be applied to your case at your Medicaid renewal. BUT if you want to see if you can start contributing less **of your income towards your Medicaid coverage sooner than your next Medicaid renewal**, you can request that your local social services district review your budget after January 1, 2023, to see if you can start contributing less of your income before your next Medicaid renewal.

SAMPLE

How do I ask for a budget review before my next Medicaid renewal if I want one?

After January 1, 2023, you can contact your local social services district at the address or agency telephone number listed above. You will need to have the following information ready to tell your local social services district:

- **your current gross income (before taxes and deductions):$_____**
- **your total allowable deductions (like health insurance premiums, Medicare premiums, etc.):$_____**

You can provide this information to your district via fax, using NYDocSubmit, a mobile application for your Apple iOS or Android device*, mail, or over the phone. If you call, you may have a brief wait while the district helps other callers with questions and budget reviews. But you will get the help you need.

What do I do if I have questions about this letter?

You can contact your local social services district at the address or agency telephone number list above.

Thank you!

New York State Medicaid

*NYDocSubmit" is available through the Apple App Store or Google Play Store, for use with an Apple iOS or Android phone or tablet with a working camera and data or Wi-Fi connectivity.

SAMPLE

Human Resources Administration
Department of Social Services

Medical Assistance Program (MAP)
MEDICAID ALERT

December 27, 2022

Increase of Medicaid Medically Needy Income Level to 138% of the Federal Poverty Level and Related Medically Needy and MBI-WPD Resource Level Changes

This Alert is to inform Providers, Client Representatives, Community Based Organizations, Hospitals, Homecare Agencies, Nursing Homes, Advocates, Managed Care/Managed Long Term Care Plans, and agencies assisting Medicaid consumers of the New York State General Information System(GIS) message advising the district of a substantial increase to the Medically Needy Income level (MNIL) and impacts on the resource level for SSI-related consumers, and for the Medicaid Buy-In Program for Working People with Disabilities. These changes are pursuant to Chapter 56 of the Laws of 2022. The MNIL for January 2023 is based on the 138% FPL for 2022.

Medically Needy Income Level

Effective January 1, 2023, for SSI-related consumers the increase in the Medically Needy Income level to 138% FPL results in the income level for an individual increasing from $934 in 2022 ($1,367 for a couple) to $1,563 ($2,106 for couple). The SSI-related income disregards and deductions continue to apply.

Although this increase may reduce the number of Medicaid consumers who have excess income, the change does not eliminate the Excess Income (Spenddown) Program. Consumers with income above the MNIL in 2023 may spenddown to the new 2023 MNIL.

Medicaid eligibility for SSI-related consumers is determined by comparing income, after appropriate deductions, to the MNIL or the Medicaid Standard (and MBL Living Arrangement Chart as appropriate) and applying whichever income level is most beneficial. For individuals residing in Congregate Care living arrangements, the Congregate Care income levels, generally, are higher than the MNIL. However, for purposes of determining the most beneficial income level for a single individual residing in a Congregate Care Level 1 or Level 2 living arrangement, the increased MNIL for January 2023 is higher than the income levels for Congregate Care Level 1 and Level 2 for single individuals. Districts are reminded to apply the most beneficial income level.

In December 2022, New York State sent a letter to inform current Medicaid consumers who have been identified as having excess income of the increased MNIL, and to provide instructions for contacting the local district Medical Assistance Program/Homecare/Nursing Homes to request a recalculation of their income before their next renewal.

Medical Assistance/ Homecare Programs local District Mailing

In addition, the Medical Assistance Program/ Homecare/ Nursing Home division are also sending a one-time mailing with the attached MAP-3190, *2023 Budget Review Request* and MAP-3190a, *2023 Budget Review Request Cover Lette*r. Consumers can self-attest to their income for 2023. Documentation is not required. The completed form must be returned in the business reply envelope that was sent with the Budget Review Request forms. Consumer who misplace the business return envelope can submit the completed form as follows:

- **Medicaid Surplus cases** can fax the completed form to **917 639-0645** or return it to any community Medicaid Office
- **HCSP/MLTC/CASA consumers:** Mail to HCSP 785 Atlantic Avenue, 7th Floor, Bklyn, 11238 or drop off at window 16 at 785 Atlantic Avenue
- **Nursing Home cases** can fax the completed form to **917 639-0736**.
    - **Note:** the changes to the income and resource levels do not impact Chronic Care Budgeting.

For current Medicaid consumers who do not contact the LDSS for a recalculation of their income in response to their December 2022 one-time letter, the Medical Assistance Program will redetermine the consumer eligibility based on the new MNIL at the next consumer contact or at renewal, whichever comes first.

Medically Needy Resource Level

As a result of the change to the MNIL, the resource level for an SSI-related individual will increase from $16,800 ($24,600 for a couple) in 2022 to $28,133 for an individual and $37,902 for a couple effective January 1, 2023

Medicaid Buy-In program for Working People with Disabilities Resource levels

The resources levels for the Medicaid Buy-In Program for Working People with Disabilities will also increase effective January 2023. The MBI-WPD resource levels, currently at a fixed level of $20,000 for an individual and $30,000 for a couple, will increase to the same amount as the Medically Needy resource levels effective January 1, 2023. The income level for MBI-WPD remains at 250% FPL.

Effective Date

The new Medically Needy income and resource levels are effective January 1, 2023 and apply to new applications and requests for an increase in coverage received on or after January 1, 2023.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

Return Address

Human Resources Administration
Department of Social Services

MAP-3190a (E) 12/02/2022

CASE NUMBER: _____

If you have any questions call: HRA Medicaid Helpline **at 888-692-6116.**

2023 Budget Review Request (Cover Letter)

You are receiving this letter because you or someone in your household has excess income under the current Medicaid rules. Beginning in January 2023, a new Medicaid income rule may allow you or someone in your household to keep more of your monthly income. You may have already received a similar letter announcing these changes – the only difference is this letter contains a mail-back form and return envelope to make it even easier for you to request a review of your Medicaid income budget.

You can request to have your income reviewed under this new Medicaid income rule before your next Medicaid renewal by completing the enclosed Budget Review Request form and returning it in the enclosed Postage Paid Business Reply Envelope. You will receive a notice in the mail after your request is reviewed.

Do you have a medical or mental health condition or disability? Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at **888-692-6116**. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

KEEP THIS PAGE FOR YOUR RECORDS

Return Address

Human Resources Administration
Department of Social Services

MAP-3190 (E) 01/10/2023

CASE NUMBER: _____

If you have any questions call: HRA Medicaid Helpline **at 888-692-6116.**

2023 Budget Review Request Form

Current Mailing Address on File

Address _____

_____

If your address has changed, provide your updated information below. **Only complete this section if address is different from the address above.**

Address _____

_____

You must answer both questions and sign and date the form if you would like your budget to be re-evaluated.

Current Gross Income (before taxes and deductions)

- Income may include: wages, salaries, commissions, tips, overtime, self-employment, Social security benefits, disability benefits, unemployment benefits, veterans benefits, workers compensation, child support payments/alimony, pensions, annuities, trust income, rental income, money from relatives or friends to meet living expenses, Temporary cash assistance, Supplemental Security Income (SSI), student grants or loans.

Name	Income Type	Income Amount	Frequency

Total allowable deductions such as current health insurance premiums, Medicare premiums etc.

Name	Deduction	Deduction Amount	Frequency

☐ I attest that the above information is accurate.

Client Signature _____ Date _____

Do you have a medical or mental health condition or disability? Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? We can help you. Call us at 888-692-6116. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

2023 NYS INCOME AND RESOURCE STANDARDS AND FEDERAL POVERTY LEVELS (FPL)

Reference Documents: GIS: 23/MA/02, 22/MA 14, 22/MA 12, 22/MA 10, 2022-00068-01, and NYS Partnership for Long-Term Care

Note: The Figures highlighted in yellow are awaiting the new 2023 levels.

Human Resources Administration
Department of Social Services

MAPDR-01 04/05/2023
(Obsoletes MAPDR-71)

Note: Staff is advised that no consumer who was in receipt of Medicaid coverage on or after March 18, 2020, is to lose their Medicaid coverage during the COVID-19 emergency. The only exceptions for discontinuing coverage are when a consumer voluntarily terminates coverage, is no longer a resident of the State or is deceased.

For additional details regarding Applications and Renewals, staff is directed to, 2020 MAP INF-04 COVID-19 (Coronavirus Easements), GIS 20 MA/04, Coronavirus (COVID-19) – Medicaid Eligibility Processes During Emergency Period, GIS 20 MA/11, Update to GIS 20/MA 04, Coronavirus (COVID-19) - Medicaid Eligibility Processes During Emergency Period .

Financial Levels for Medicaid and Related Program Eligibility

1. Non-MAGI Medicaid Levels (SSI and SSI-Related Consumers With or Without A Surplus)

Family Size	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Monthly Income	$1,677	$2,268	$2,859	$3,450	$4,042	$4,633	$5,224	$5,815	$6,406	$6,997	$592

2. Non-MAGI Resource Levels

Family Size	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Resource Level	$30,182	$40,821	$25,013	$28,275	$31,539	$34,800	$38,064	$41,325	$44,588	$47,850	$3,263

3. Spousal Support and Resource Levels

Income (MMMNA) - $3,715.50 (Inst Spouse) - **$50**	**Resources** – (Minimum) - $74,820 (Maximum) - $148,620 (Inst Spouse) - $30,182	**Family Member Allowance Formula:** Use - $2,465 **$**822 is the maximum monthly family member allowance

4. NYS Partnership for Long Term Care (NYSP-LTC) Qualified Partnership Policy Holder (QPP) Medicaid Extended Coverage (MEC) Asset Disregards for Total Asset Policy Holders/Dollar-for-Dollar Asset Protection Plan Policy Holders		
Nursing Home		
	Resource Allowance	**Income Allowance (Monthly)**
Applicant	*$30,182	$50
Community Spouse	*$148,620 (Maximum)	$3,715.50
Home Care (Community-Based-Long-Term Care Services)		
	Resource Allowance	**Income Allowance (Monthly)**
Applicant	$30,182	$1,677 **Increased to $1,857.75 for QPP's**
Applicant with Spouse	$40,821	$2,268 **Increased to $3,715. 50 for QPP's**
***Note:** The Resource Allowances in this chart **does not** apply to the Total Asset Protection Plan QPP Policy Holders.		

5. MBI-WPD (Persons 16-64)		
Family Size	**1**	**2**
Monthly Income 250% FPL	$3,038	$4,109
Resources	$30,182	$40,821

6. Family Planning Benefit Program Income Levels (No Resource Test)							
Family Size	**1**	**2**	**3**	**4**	**5**	**6**	**Each Additional Person**
FPBP 223% FPL (Childbearing Age)	$2,710	$3,665	$4,620	$5,575	$6,531	$7,486	$956

Note: FPBP eligibility is to be determined using only the applicant's income. The applicant's income is then compared to 223% of the federal poverty level for the appropriate family size. Family size continues to be determined using legal responsibility.

7. Medicare Savings Program (Buy-In)

		Income		
		Family of 1		Family of 2
QMB 138% FPL	Annual		$20,121	$27,214
	Monthly		$1,677	$2,268

			Family of 1	Family of 2
QI-1	Monthly	Greater than 138%FPL But less than or equal to 186% FPL	1,677	2,268
	Monthly		2,260	3,057

NO RESOURCE TEST FOR ANY MSP PROGRAM

8. Other Important Figures

Medicare Part A Premium: $278.00 (30-39 Quarters)

$506.00 (Less than 30 Quarters)

Medicare Part B Premium: (Rates based upon 2022 income tax filings)

- The Cost-of-Living adjustment (COLA) for Social Security will be 8.7% percent for 2023.
- The standard monthly premium for Medicare Part B enrollees is **$164.90** for 2023**,** a decrease of $5.20 from $170.10 in 2022. Most Medicare beneficiaries will pay this amount. Less than **1%** of Medicare beneficiaries will pay less than the Full Part B standard monthly premium amount in 2023. Due to the SSA 8.7% COLA, some beneficiaries who were held harmless against Part B premium increases in 2022, will pay the full monthly premium of **$164.90** in 2023. This is because the increase in their Social Security benefits will be greater than or equal to the increase in their Part B premium**.**

Under federal law commonly known as the "hold harmless" provision, Medicare Part B premiums cannot raise more than the COLA in any year for most consumers. The "hold-harmless" provision does not apply to all beneficiaries. The Medicare Part B premium for individuals in the following categories has increased to $164.90 (or higher) in 2023:

- Individuals whose income is above **$91,000,** or a married individual when the couple's combined income is over **$182,000,** will pay the standard premium and an Income-Related Monthly Adjustment Amount (IRMAA);
- Beneficiaries who do not receive Social Security benefits;
- Individuals who are directly billed for their Part B premium;
- New Medicare Part B beneficiaries; and
- Individuals who have Medicare and Medicaid, and Medicaid pays the premiums.

Standard Allocation: From non-SSI-related parent to non-SSI- related child $591.00

PASS-THROUGH FACTORS: .974 and .128

Note: Budgets with a "From" date of January 1, 2023, or later, that utilize a Federal Poverty Level (FPL) must be calculated with the 2022 Social Security benefit amount and Medicare Part B premium amount until the 2023 FPLs are available on MBL. The 2022 Social Security amounts and Part B premium must be used until further notice. Staff must recalculate income eligibility based on the new levels and current income when contacted by the consumer or during renewal.

Family Size	1	2
COBRA (100% FPL)	$1,215	$1,644
AIDS Health Ins. Program (AHIP) (185% FPL) (No Resource Test)	$2,248	$3,041
QWDI (200% FPL)	$2,430	$3,287
COBRA, QWDI (Resource Level)	$4,000	$6,000
Pickle/DAC/SSI (Resource Level)	$2,000	$3,000

9. Monthly Regional Nursing Home Rates (Use the rate for the region in which the facility is located)	
NEW YORK CITY (All boroughs) - $14,142	**LONG ISLAND - $14,136 Nassau, Suffolk**
NORTHEASTERN - $12,744 Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	**NORTHERN METROPOLITAN - $13,906 Duchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester**
WESTERN - $12,130 Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	**ROCHESTER - $13,421 Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates**
CENTRAL - $11,726 Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	

10. Fair Market Regional Rates (Averages) / Special Standards for Housing Expenses	
NEW YORK CITY (All boroughs) (Shelter = 59) - $**1,701**	**LONG ISLAND (**Shelter = 60) - **$1,445**
NORTHEASTERN (Shelter = 54) - **$425**	**NORTHERN METROPOLITAN** (Shelter = 58) - **$1,031**
WESTERN (Shelter = 57) - **$301**	**ROCHESTER** (Shelter = 56) - **$367**
CENTRAL (Shelter = 55) - **$358**	
CONGREGATE CARE LEVEL III - (42+ Regional Rate for County- Shelter = 63) - **$1,909 - $3,309**	

In determining the community spouse resource allowance on and after January 1, 2023, the community spouse is permitted to retain resources in an amount equal to the greater of the following: $74,820 or the amount of the spousal share up to $148,620. The spousal share is the amount equal to one-half of the total value of the countable resources of the couple as of the beginning of the most recent continuous period of institutionalization of the institutionalized spouse. The look-back period is anchored in the month the A/R is both institutionalized and applying for MA.

(Remainder of page left blank intentionally)

11. MAGI Levels for Medicaid and Related Program Eligibility											
Family Size	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Each Add'l Person**
Pregnant Women and Infants Under Age 1 (223% FPL)	$2,710	$3,665	$4,620	$5,575	$6,531	$7,486	$8,441	$9,396	$10,351	$11,307	$956
Infants Under Age 1 223% FPL	$2,710	$3,665	$4,620	$5,575	$6,531	$7,486	$8,441	$9,396	$10,351	$11,307	$956
Children Age 1-5 154% FPL	$1,872	$2,531	$3,191	$3,850	$4,510	$5,170	$5,829	$6,489	$7,149	$7,808	$660
Children Age 6 -19 110% FPL	$1,337	$1,808	$2,279	$2,750	$3,222	$3,693	$4,164	4,635	$5,106	$5,577	$472
Children Age 6-19 (Expanded - 154% FPL)	$1,872	$2,531	$3,191	$3,850	$4,510	$5,170	$5,829	$6,489	$7,149	$7,808	$660
Parents and Caretaker Relatives 138% FPL	$1,677	$2,268	$2,859	$3,450	$4,042	$4,633	$5,224	$5,815	$6,406	$6,997	$592
19 and 20 Year Olds Living with Parents 138% FPL	$1,677	$2,268	$2,859	$3,450	$4,042	$4,633	$5,224	$5,815	$6,406	$6,997	$592
19 and 20 Year Olds Living with Parents (Expanded - 155% FPL)	$1,884	$2,548	$3,212	$3,875	$4,539	$5,203	$5,867	$6,531	$7,195	$7,859	$664
S/CCs and 19 and 20 Year Olds Living Alone (100% FPL)	$1,215	$1,644	$2,072	$2,500	$2,929	$3,357	$3,785	$4,214	$4,642	$5,070	$429
S/CCs and 19 and 20 Year Olds Living Alone (Expanded 138% FPL)	$1,677	$2,268	$2,859	$3,450	$4,042	$4,633	$5,224	$5,815	$6,406	$6,997	$592

12. Children's Medicaid Income Eligibility Levels									
Family Size	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Each Additional Person**
Children Under 1; Pregnant Adult*	$2,710	$3,665	$4,620	$5,575	$6,531	$7,486	$8,441	$9,396	$956
Children 1-18 Years	$1,872	$2,531	$3,191	$3,850	$4,510	$5,170	$5,829	$6,489	$660
Note: *Pregnant adult household size calculation includes all expected children.									

13. Child Health Plus Premium Levels – Monthly Income by Family Size (Children Under 19 Not Medicaid Eligible)							
Premium Categories	**1**	**2**	**3**	**4**	**5**	**6**	**Each Add'l Person**
Free Insurance	$2,698	$3,649	$4,600	$5,550	$6,501	$7,452	$951
$15 per child per month (Max $45/family) (**223% - 250% FPL)**	$3,038	$4,109	$5,180	$6,250	$7,321	$8,392	$1,071
$30 per child per month (Max. $90 per family) **(251% - 300% FPL)**	$3,645	$4,930	$6,215	$7,500	$8,785	$10,070	$1,285
$45 per child per month (Max. $135 per family) (**301% - 350% FPL)**	$4,253	$5,752	$7,251	$8,750	$10,250	$11,749	$1,500
$60 per child per month (Max. $180 per family) **(351%-400% FPL)**	$4,860	$6,574	$8,287	$10,000	$11,714	$13,427	$1,714
Full Premium per child/month if **over 400%** FPL (Premium amount varies from plan to plan)	Over $4,860	Over $6,574	Over $8,287	Over $10,000	Over $11,714	Over $13,427	Over $1,714
Note: *Pregnant women count as two.							

14. Disabled Adult Children (DAC) Levels		
Living Arrangements	**Shelter Types**	**Amount**
1	15	$1,180.48
1	28	$1,142.48
1	16	$1,349.00
1	29	$1,319.00
1	42	$1,608.00
1 or 5	Other than: 15, 16, 28, 29 or 42	$1,001.00
2	15	$2,360.96
2	28	$2,284.96
2	16	$2,698.00
2	29	$2,638.00
2	42	$3,216.00
2 or 6	Other than: 15, 16, 28, 29 or 42	$1,475.00
3	All	$1,142.48
4	All	$1,180.48

15. Congregate Care Level I, II and III Levels		
Shelter Codes	**PNA**	**Shelter Amount**
15 - (NYC, Nassau, Suffolk, Westchester, Rockland Counties) Level I	$175.00	$1005.48
16 - (NYC, Nassau, Suffolk, Westchester, Rockland Counties) Level II	$202.00	$1,147.00
28 - (Rest of State) Level I	$175.00	$967.48
29 - (Rest of State) Level II	$202.00	$1,117.00
42 - (NYC, Nassau, Suffolk, Westchester, Rockland Counties) Level III	$241.00	$1,367.00
42 - (Rest of State) Level III	$241.00	$1,367.00

16.	SSI Levels			
SSI Consumer	**Amount**			
Allocation Amount (The difference between the regular Medicaid levels for a household of two [$2,268.00] and a household of one [$1,677.00])	$591.00			
Personal Needs Allowance (Certain waiver participants subject to spousal impoverishment budgeting)	$591.00			
Maximum Social Security Benefit at Full Retirement Age	$3,627.00			
State Supplement (living with others)	Individual	$23.00	Couple	$46.00
State Supplement (living alone)	Individual	$87.00	Couple	$104.00
Federal Benefit Rate	Individual	$914.00	Couple	$1,371.00
SSI Resource Levels	Individual	$2,000.00	Couple	$3,000.00
Family Care Level (LA 3 & 4)	NYC and Nassau, Suffolk, Westchester and Rockland	$1,180.48	Upstate	$1,142.48
SSI-related Student Earned Income Disregard	Monthly	$2,220.00	Annual Max.	$8,950.00

17.	Substantial Gainful Activity (SGA) Levels	
Category	**Amount**	**Payment Occurrence**
Non-Blind	$1,470.00	Monthly
Blind	$2,460.00	Monthly
Month Trial Work Period	$1,050.00	Monthly

18.	Home Equity Maximum
Medicaid Coverage Limit (RVI 1 and 2 cases)	$1,033,000.00

Current Gross Income (before taxes and deductions) $ _____

- Income may include: wages, salaries, commissions, tips, overtime, self-employment, Social security benefits, disability benefits, unemployment benefits, veterans benefits, workers compensation, child support payments/alimony, pensions, annuities, trust income, rental income, money from relatives or friends to meet living expenses, Temporary cash assistance, Supplemental Security Income (SSI), student grants or loans.

Figure 1 - HRA MAP-3190 excerpt = Gross Income

Type of Income	Info	Cite in MARG[i]
INCOME LISTED ON MAP-3090		
Wages, Salaries, tips, overtime	Write in GROSS earned monthly income separately from other unearned income. TIP: To calculate gross monthly income, multiply gross pay by the following to get monthly gross income. If paycheck is Weekly – multiply x 4.33 Semi-monthly – multiply x 2 Bi-Weekly – multiple x 2.17 If certified disabled, subtract first Impairment Related Work Expenses (IRWE), and PASS plan if any.	pp. 110, 223 p. 224.1, 226
Self-employment income, commissions	May deduct expenses incurred to generate income. (use last year's tax return to show net income or, if not filed, DOH-4669)	113-117
Social Security, Disability, Unemployment	Write GROSS amount before Medicare premium deducted	
Veterans Benefits	Gross amount counts, unless consumer is MAGI or is within 12-month continuous coverage period for MAGI -- Then EXCLUDED from income. Veterans – do not count portion for dependent family member if they are not applying. Also portion of payment for *Aid & Attendance* is EXCLUDED from income (can be difficult to document – review Award letter or call VA)	127
Workers Comp		124-25
Child Support payments/	Disregard one third of **child support** received by disabled or blind child from absent parent	p. 221-22
Spousal support/alimony	Disregard first $100 of support payments	p. 139-141
Pensions	Count GROSS amount before any deductions for health insurance, union dues, taxes, etc.	
Annuities	If it's a RETIREMENT annuity, treat like an IRA – exempt if take RMD/distributions. If not a Retirement annuity, depends on actual annuity contract.	p. 135

Trust income	This is NOT income from Pooled Trusts or Supplemental Needs Trusts. This is income from other types of trusts. NYLAG generally is not handling this type of income.	p. 130
Rental income	NET rental income is countable after expenses. Request last year's tax return.	p. 144-146
Money from Relatives or friends to meet living expenses	Cash gifts from non-legally responsible relatives or friends count as **unearned income**. Counsel them that instead, they can pay **directly** for rent, utilities, or other expenses. Such "in-kind" assistance is not counted as income. Alternately, a bona fide loan to the consumer from a non-legally responsible relative is not countable as income. "The loan may be an oral or written agreement, signed by the A/R[1] and the lender. The written agreement must indicate: the A/R's intent to repay the loan within a specific time; and how the loan is to be repaid, by specific real or personal property, held as collateral, or from future income." MRG. p. 221.	p. 142, 150-153 p. 221 (loans)
Temporary cash assistance Supplemental Security Income (SSI)	Excluded from income – write in separately, note who receives it, and that EXCLUDED.	p. 228
Student grants or loans	Student **loan** received by an undergrad or grad student is exempt. EXEMPT: Any portion of a **grant**, scholarship, fellowship or gift used to pay the cost of tuition and other education-related fees at any educational (including technical or vocational) institution. This disregard does not apply to any portion set aside or actually used for food, clothing or shelter." Graduate assistantship – if it is a grant, it is exempt if used to pay for tuition or fees, but not of used for food, clothing or shelter. If it is employment, then treated as earned income.	p. 228 p. 227
INCOME TO ADD THAT IS NOT MENTIONED ON MAP-3190		
IRA distributions	RMD (Required Minimum Distribution) for 2023 usually indicated on 1st financial statement for IRA or other retirement account issued in 2023. Write in full RMD, and indicate 1/12 of that is counted as monthly income. EX. RMD for 2023 is $1200. Monthly income is $100.	135-36
Holocaust restitution	Write in gross monthly amount but also that it is **EXCLUDED**.	225
Interest and dividends	This is **excluded** for people in the community and for Community Budgeting in nursing homes.	132-33

[1] "A/R" is Applicant/Recipient

DEDUCTIONS

Total allowable deductions such as current health insurance premiums, Medicare premiums etc. $ _____

Figure 2 Deductions from Income - MAP-3190

Type of deduction	Info on deduction	
Earned income – wages or self-employment	Earned income disregard applies. Subtract $65 from gross monthly earned income, then subtract half the remainder.	If under 65 and disabled, might have other deductions – IRWEs and PASS plan. Ask a supervisor.
Standard $20 disregard	Deduct $20 from monthly income. For married couples, deduct only $20 per couple.	
Infrequent or irregular income disregard	Disregard the **first $10 of earned income** and the **first $20 of unearned income in a month if it is received infrequently or irregularly**.	***Infrequent*** - received only once in a calendar quarter from a single source. ***Irregular*** -- if could not reasonably expect to receive it or budget for it due to its unpredictability. If the amount of infrequent or irregular income in a month exceed these amounts, the exclusion still applies. MRG p. 224; 18 NYCRR 360-4.6(a)(2)(x); POMS SI 0500810410. Same dollar amount for a couple – each spouse doesn't get a separate exclusion.
Health insurance premium	Medicare Part B	Cannot deduct if seeking or has QMB.
	Medigap premium	
	Part D premium	May deduct only to extent not covered by Extra Help. To see amount – look up the Part D plan in this list (PDF) (Excel). See blue column "Free Premium with Full Low Income Subsidy." If box marked x means ZERO premium. Otherwise, the amount indicated is the premium that can be deducted.
	Medicare Advantage Premium	Premiums include both a Part C and Part D premium. LIS only covers all or part of the Part D component. To see the premium with Extra Help – go to https://q1medicare.com/2023/MedicareAdvantage-2023CHealthPlanMAPDHMOPPONewYork.php 1. Click on client's **county**, then on the link with the number of Medicare Advantage plans in your county. 2. Scroll down to "Choose Your Medicare Advantage Plan preferences" and in **LIS Subsidy Amount** - select **LIS 100%.** 3. Scroll to the end of the preferences & CLICK on the green button to find plans.

		4. Scroll down to find plan - check for exact plan name/ ID number. Look in box labeled **Monthly Premium (Parts C & D) 100% LIS**. 5. **NOTE: Dual-SNP** (Special Needs Plan) always have a -0- premium.
Pooled Trust or individual Supple-mental Needs Trust deposit		Amount being deposited into trust on a month basis as of Jan. 2023 or the month sending form to DSS (Verification of Deposit).
Special Income Standard for Housing Expenses	IF already had approved Income Standard – note this on form that should continue it. If not, screen to see if qualifies --→	Screen to see if newly qualifies. 1. Was discharged from a nursing home or adult home, or is planning for discharge home, and was enrolled in MLTC prior to nursing home admission or will enroll in MLTC upon discharge? 2. Was in NH or adult home for 30 days 3. Medicaid paid at least SOME part of the cost. Even if Medicare paid most of it. 4. Must have a housing expense If meets above criteria, need to request approval for this standard, which allows deducting amounts in http://www.wnylc.com/health/entry/212/ *__NYC deduction 2023 $1701/month__ EXTRA. (each region is different)
Married Couples	If spouse is not receiving Medicaid, consider whether to use:	• Spousal refusal (or if in MLTC plan, TBI or NHTD waiver, or Immediate Need, cite GIS 12 MA/013 that allows using solely applying spouse's income and single income limit) • Spousal impoverishment – may only use if recipient is in an MLTC plan, TBI or NHTD waiver, or Immediate Need, http://www.wnylc.com/health/entry/222/#1%20married Applying spouse may deduct enough income to bring non-applying spouse's income up to **$3,715.50.**
Disabled Adult Child (DAC)	NOTE that consumer is "DAC" on form and that assets under $2000	• Over age 18 and was disabled before age 22, and • receives SSD benefits based on earnings record of a parent who died or retired • Received SSI before – and lost it because of increased income from Social Security. • Assets must be under $2000

[i] NYS DOH Medicaid Reference Guide, available at https://www.health.ny.gov/health_care/medicaid/reference/mrg/mrg.pdf (posted on https://www.health.ny.gov/health_care/medicaid/reference/mrg/)

CONSUMER/PROVIDER REQUEST TO CHANGE INFORMATION ON FILE

(No Documentation Required)

Human Resources Administration
Department of Social Services

MAP-751k (E) 03/15/2021
Replaces MAP-751, MAP-751a, and MAP-3069b

Case Name: _____

Case Number: _____ CIN: _____

Change is for: _____

A. CORRECT/ADD THE FOLLOWING INFORMATION (CHECK ALL THAT APPLY)

☐ **Change Name**

From: _____

To: _____

☐ **Add/Correct Social Security Number (SSN)**

From: _____

To: _____

☐ **Correct Date of Birth**

From: _____

To: _____

☐ **Add/Change Phone Number**

From: _____

To: _____

☐ **Correct Gender Information**

From: _____

To: _____

☐ **Change Residency Address**

From: _____

To: _____

☐ **Change Mailing Address**

From: _____

To: _____

☐ **Add/Change Secondary Mailing Address**

From: _____

To: _____

CORRECT/ADD THE FOLLOWING INFORMATION (CHECK ALL THAT APPLY)

Language Spoken

☐ **Language Spoken** From: _____ To: _____

Language Read

We have notices available in the following languages:

- English
- Spanish
- Arabic
- Bengali
- French
- Haitian Creole
- Korean
- Polish
- Russian
- Simplified Chinese
- Traditional Chinese
- Urdu

Tell us what language you want your notices sent to you.

☐ **Language Read** From: _____ To: _____

Alternative Format/Visual Impairment

Do you have a visual disability that makes reading notices difficult? We can give you notices in the following formats. Tell us how you want your notices sent to you:

☐ **Large Print** ☐ **Audio CD** ☐ **Data CD** ☐ **Braille**

B. PROVIDER INFORMATION (TO BE COMPLETED BY PROVIDERS ONLY)

Note: This section is not to be used for Home Care Services Program Providers submissions.

Provider Name: _____

Provider Address: _____

Provider Code: _____ Original Determination Date: _____

Admission Date: _____ Admission Number: _____ Discharge Date: _____

Phone Number: _____ Fax Number: _____

NAME (PRINT)	SIGNATURE	DATE

Do you have a medical or mental health condition or disability? Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at **888-692-6116**. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

DEPARTMENT OF HUMAN SERVICES

Monroe County, New York

Adam J. Bello
County Executive

Thalia Wright
Commissioner

REQUEST FOR MEDICAID BUDGET REVIEW FORM

Name				Case Number	
Address				Team/Wker #	
City		State		Zip code	

Dear Medicaid Member,

You recently contacted the Monroe County Department of Human Services Medicaid Unit to request a review of your Medicaid budget after 1/1/23 as you or a someone of your household currently has excess income under current Medicaid rules and lives in the community (for example has a “Spenddown” or a community-based income contribution called a “NAMI”). Effective 1/1/23 the Medicaid income levels increase which may result in Medicaid enrollees being able to keep more of their monthly income.

In order to have your Medicaid budget reviewed, please complete the information below and return this form to us. There is no need to send proof or documentation at this time.

Income Information:

Who	Source of Income		Gross Amount before taxes		Frequency of Income
	_____		_____		_____
	_____		_____		_____
	_____		_____		_____

Allowable Deductions: (for example, health insurance premiums, Medicare premiums, etc.)

Who	Type of Deduction		Dollar Amount (the cost)		Frequency
	_____		_____		_____
	_____		_____		_____
	_____		_____		_____

If you have any questions regarding this letter please contact the Medicaid Customer Service Phoneline at (585)753-2760.

Please return this form to:
Monroe County Dept. of Human Services
111 Westfall Rd. Room
Rochester, NY 14620

Attention: Team/Wker #

Scenario 1 – Pat (Single with Earned and Unearned Income)

- Pat, age 67, gets Social Security of $1,060/mo. and babysits, earning $1000/mo. Pat will be eligible for Medicaid with no spend-down *and QMB* so does not deduct Part B premium.

(See Budget Attached)

Scenario 2 – Morgan and Chris (Married Couple)

- Morgan (M for Medicaid) and Chris (C for Community Spouse) are married.
- Morgan receives Social Security Disability (SSD) in the amount of $2,000 & Chris, age 66, gets SS Retirement in the amount of $1500. Both receive Medicare.
- Morgan needs Home Care Services (MLTC). Since he receives SSD and Medicare and has no children, uses "Disabled, Aged, Blind" (DAB or "SSI-related") budgeting
- See Budget Options Attached
    - Budget as a household size of 2
    - Budget with Spousal Refusal
    - Budget with Spousal Impoverishment

Scenario 3 – Morgan (Sullivan County Resident Discharged Home from Medicaid Paid NH with MLTC Home Care Services)

Scenario 1

Pat's Budget with Earned and Unearned Income

Income	**Amount**	**Calculation**
Social Security	$ 1,060.00	
IRA RMD Required Minimum Distribution	$ -	
Other unearned income	$ -	
Wages - gross (if consumer < 65 use MBI-WPD tab)		$ 1,000.00
subtract $65		*$ 65.00*
		$ 935.00
Net countable earned income	*$ 467.50*	
Total Countable Income before deductions	$ 1,527.50	

Deductions	
Medicare Part B Premium ($164.90 -2023)	$ -
Part D or Medicare Advantage premium not subsidized with Extra Help	*3.00*
Medigap premium	-
Other health insurance premiums (long term care, dental, vision, etc.)	-
Medicaid Disregard	$ 20.00
Total Monthly Deductions	$ 23.00

Net Medicaid Countable Income	$ 1,504.50
Income Guideline for 1 (2023)	$ 1,677.00
Spend-down/Excess Income	**$ -**
Pooled Trust/SNT Deposit	**$ -**
Only if deducting Part B premium in Line 14 - shows amount of Part B premium that may be reimbursed if do not enroll in MSP. **If** exceeds $164.90 then enroll in MSP. (Leave Line 14 blank).	$ 172.50

Scenario 2

Morgan & Chris Budget as a Household Size of 2

Income	**Amount**	**Calculation**
Social Security/pension - applicant	$ 2,000.00	
Social Security/pension - spouse	$ 1,500.00	
IRA RMD Required Minimum Distribution applicant	$ -	
IRA RMD - Spouse	$ -	
Other Unearned Income	$ -	
Wages - gross (spouse and applicant)		$ -
		$ 65.00
		0.00
Net countable earned income	0.00	
Total Countable Income before deductions	$ 3,500.00	

Deductions

Medicare Part B Premium applicant	$ 164.90
Medicare Part B Premium spouse	$ 164.90
Medigap premium applicant	
Medigap premium spouse	
Part D or Medicare Advantage premium not subsidized with Extra Help - applicant	*$* -
Part D or Medicare Advantage premium not subsidized with Extra Help - spouse	*$* -
Other insurance premium (dental, LTC, etc)	*$* -
Medicaid Disregard	$ 20.00
Total Monthly Deductions	$ 349.80

Net Medicaid Countable Income	$ 3,150.20
Income Guideline for 2	$ 2,268.00
Spend-down/Excess Income	**882.20**
Deposited in SNT	
Only if deduct Part B premium in Line 16 and/or 17, shows amount of Part B premium that may be reimbursed.	$ -

Scenario 2
Morgan as a Household Size of 1 with Spousal Refusal

Incom of Applying Spouse ONLY	**Amount**	**Calculation**
Social Security	$ 2,000.00	
IRA RMD Required Minimum Distribution		$ -
Other unearned income		*$ 65.00*
Wages - gross		*$ -*

Net countable earned income	*$ -*
Total Countable Income before deductions	$ 2,000.00

Deductions (Applicant's premiums only)	
Medicare Part B Premium ($164.90 -2023)	$ 164.90
Part D or Medicare Advantage premium not subsidized with Extra Help	
Medigap premium	
Other health insurance premiums (dental, LTC, etc)	
Medicaid Disregard	$ 20.00
Total Monthly Deductions	$ 184.90

Net Medicaid Countable Income	$ 1,815.10
Income Guideline for 1 (2023)	$ 1,677.00
Spend-down/Excess Income	**$ 138.10**
OPTION: Add Part B premium if want MSP (don't enter premium in Line 14)	
Money to be deposited in SNT	**$ 138.10**
ONLY IF deduct Part B premium in Line 14, shows amount of Part B premium that may be reimbursed if do not enroll in MSP. If exceeds $164.90 then enroll in MSP. (Leave Line 14 blank).	$ -

Budgeting for Spousal Impoverishment

ASSET		
Community Spouse -	$0	**2023 CS Resource Allowance -- $74,820 or 1/2 combined assets up to $148,620**
MLTC/NHTD, or Immediate Need Spouse	$0	**2023 limit -$28,133**

INCOME		
Step 1 - Community Spouse Income		
Unearned Income		
Social Security	$1,500.00	
Pension	$0.00	
IRA Required Minimum Distribution	$0.00	
Earned Income - gross monthly	***$0.00***	Note: Earned income disregards used in community budgeting do not apply in this budgeting.
Subtotal Gross Income	***$1,500.00***	
Deductions		
Medicare Part B Premium 2023 ($164.90)	$164.90	
Medigap premium	0	
Other health insurance premium (LTC, vision, dental)	0	
Part D or Medicare Advantage premium not subsidized with Extra Help	$ -	For Part D plans, look up plan on Part D tab in this worksheet and enter amount from Column D. See note below for more info.* For Medicare Advantage plans - see note below**
Total Monthly Deductions	***$164.90***	

Otherwise Available Income of Community Spouse	$1,335.10	***(Total Gross Income - Monthly Deductions)***
Maximum Monthly Maintenance Needs Allowance (MMMNA)	$3,715.90	***Total Amount CS is able to have (MMMNA)($3715.90 2023)***
Community Spouse Monthly Income Allowance	**$2,380.80**	***Amount CS is able to receive from Applicant's income***

Step 2 - Institutional/MLTC Spouse		
Income- Monthly		
Unearned Income		
Social Security	$2,000.00	
Pension	$0.00	
IRA Required Minimum Distribution/Other income	$0.00	
Earned Income		
Wages - Gross	$ -	
Total unearned + Earned income	***$2,000.00***	
Deductions		
Personal Needs Allowance (2023 - $591)	$591.00	***$ Applicant gets to keep (difference between income limit for 1 and 2)***
Medicare Part B Premium 2023 $164.90	$164.90	
Medigap premium	$ -	
Other health insurance premium (LTC, vision, dental)	$ -	
Part D or Medicare Advantage premium not subsidized with Extra Help	-	**For Part D plans, look up plan on Part D tab in this worksheet and enter amount from Column D. See note below for more info.* For Medicare Advantage plans - see note below****
Total Deductions	$755.90	
Net income after deductions	$1,244.10	
Contribution to Spouse	$1,244.10	***Use B26 if under B45***
Excess Income/ Spend-down - May deposit into Pooled Trust	*0.00*	**Strategy Tip**: Try using SINGLE budgeting for applicant. If excess income is less with that budgeting, request use of SINGLE budgeting. Spousal refusal not necessary if qualify for spousal impoverishment budgeting. See GIS 12 MA/013 and GIS 14 MA/025.# If cell shows NEGATIVE number, and Part B premium is deducted in Cell B18, you may request reimbursement of Part B in amount shown. See GIS 02-MA-019: *Reimbursement of Health Insurance Premiums* # and article here**** (this is 5th group listed as eligible for MIPP).

Must Request Budgeting from LDSS

2023

Scenario 3

Medicaid Budgeting -Single (Special Housing Allowance - http://www.wnylc.com/health/entry/212/)

Income	**Amount**	**Calculation**	
Social Security	$ 2,000.00		
IRA RMD (Required Minimum Distribution)	$ -		*Pro-Rate RMD for 2023 divide annual RMD by 12*
Other Unearned Income (Pension, etc)	$ -		
Wages - gross		$ -	*Gross earnings/mo. (TYPE IN ACTUAL EARNINGS)*
		$ 65.00	*Disregard*
		$ -	*Subtract earned income disregard*
Net countable earned income	*$ -*		*Divide cell D7 by 2*
Total Countable Income before deductions	$ 2,000.00		
Deductions			
Medicare Part B Premium	$ 164.90		*Should be -0- if have Medicare Savings Program*
Medicare Advantage Plan Premium	$ -		*Only amount not covered by Extra Help*
Medicare/Medigap Premium	$ -		
Part D premium gross		*$ -*	
		$ 38.90	*Extra Help subsidy up to $38.90 (2023)*
Part D premium - net	$ -		
Medicaid Disregard	$ 20.00		
Housing Allowance (Attachment I to GIS 22 MA/14)	$1,031		*Enter applicable regional allowance -2023 are below*
Total Monthly Deductions	$ 1,215.90		*also posted at http://www.wnylc.com/health/entry/212/*
Net Medicaid Countable Income	$ 784.10		*Gross Income minus Deductions*
Income Guideline for 1	$ 1,677.00		***2023 Guideline***
Spend-down/Excess Income	**$ -**		***Money to be deposited in SNT***

TIPS ON REDUCING POOLED TRUST DEPOSITS – OR CLOSING TRUST

2023 Medicaid Income Limits Increases

NYLAG
New York Legal Assistance Group

New Income Limits may allow Client to Reduce or STOP Deposits into Pooled Trusts

- Some people will no longer need to use a Pooled Income Trust (PIT) if their income is under the new limits. Others can reduce their trust deposit.
- They can reduce or even stop their trust deposit now -- without burdening the LDSS with a request to rebudget. They can wait til renewal for LDSS to rebudget their income.
- Screen them for QMB since anyone eligible for Medicaid with no spend-down is eligible for QMB.

*42 U.S.C. § 1396p(d)(4)(c); N.Y. Estates, Powers and Trusts Law § 7-1.12.
More information: http://www.wnylc.com/health/entry/2/

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How to Help Consumers Reduce their Deposit into a Pooled Trust or SNT

- Calculate their 2023 Medicaid spend-down.
- Evaluate budget with and without enrollment in the QMB Medicare Savings Program.
- If their 2023 spend-down is lower than it was in 2022, counsel on options:
  1. ***Keep*** making monthly trust deposits in the same amount.
  2. ***Reduce*** monthly trust deposits or
  3. ***Stop*** monthly trust deposits – if income is now under the 2023 income limits.

NYLAG
New York Legal Assistance Group

Paula: 2022 budget with Pooled Trust Deposit but no MSP

Gross SSR monthly income		$1,712.00
Health insurance premiums	(Medicare Part B)	- $170.10
	(Medigap)	- $187.90
*Pooled Trust Deposit**		- $400.00
Unearned income disregard		- $20.00
Net countable income		*$934.00*
Income limit for single		- $934
Excess income (Spend-down)		0

If Paula added $170.10 to the $400/month deposit = $570.10, she'd have QMB and a $ZERO spend-down!

NYLAG
New York Legal Assistance Group

Paula: 2023 budget No Pooled Trust Deposit & MSP

Gross SSR monthly income		**$1,862.00**
Health insurance premiums	**(Medicare Part B)**	**- ZERO**
	(Medigap)	**- $187.90**
Pooled Trust Deposit		**- ZERO**
Unearned income disregard		**- $20.00**
Net countable income		***$1,654.10***
Income limit for single		**- $1,677.00**
Excess income (Spend-down)		**0**

If income is higher, or no Medigap deduction, then decide whether to continue with Pooled Trust to eliminate the spend-down.

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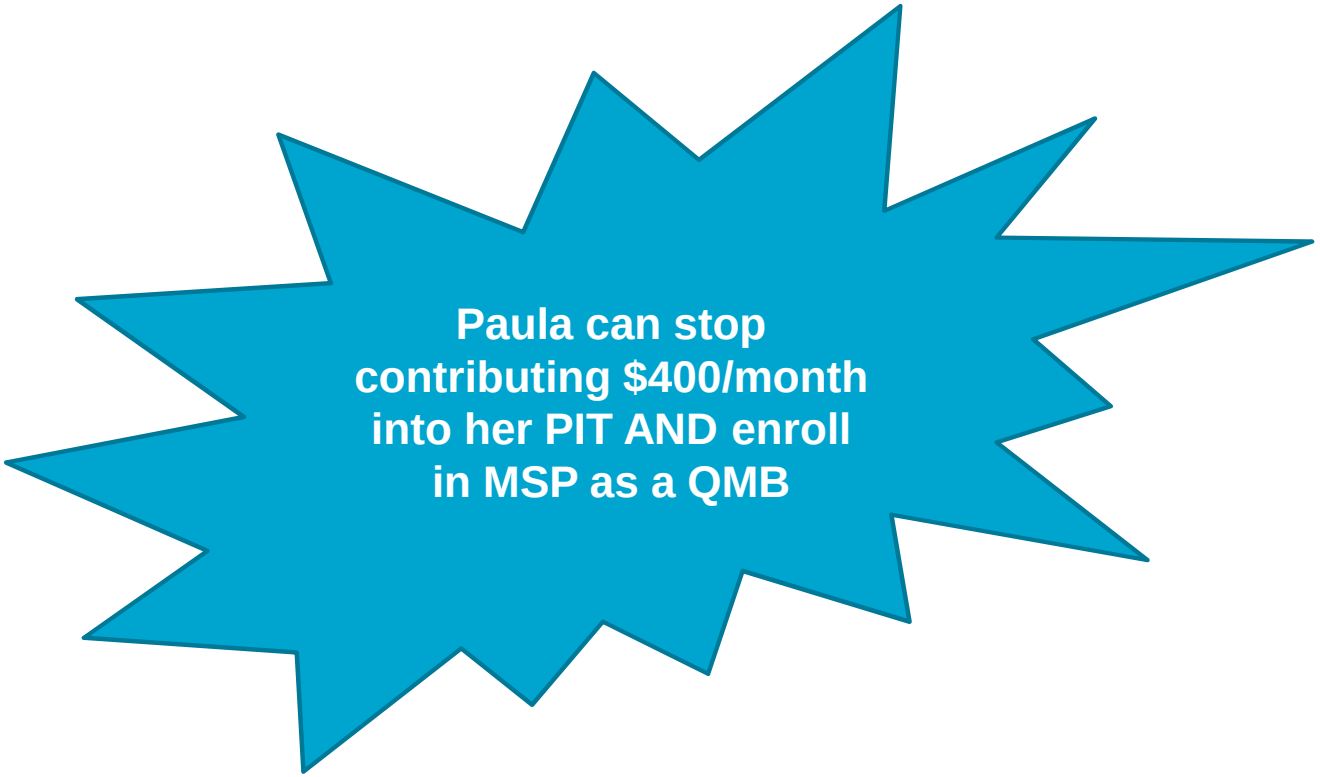

She has no spend-down because of deducting $187.90 for Medigap premium. If she decides to drop Medigap, she'll have a spend-down and then may want to keep PIT.

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New York Legal Assistance Group

Closing a PIT Account – if NO Spend-down

- Consumers can close their trust account by:
  1. **Stop** depositing income into the trust now.
  2. **Submit** expense requests to spend the balance in the trust.
  3. **Contact** trust to close account.
  4. **Trust fee** - If the trust is kept open, most trusts still charge a monthly fee. If the fee is based on a sliding scale based on the amount deposited, the fee should be reduced to the minimum amount until trust is closed, since no income is being deposited.
  5. **Be conservative** – keep trust open even just depositing monthly fee if income is close to the limit. In 2024 may have a spend-down!
- Each pooled trust has different rules and forms for closing a trust. Contact the trust. See list at http://www.wnylc.com/health/entry/4/.

I Assistance Group

In Next Renewal – LDSS will Rebudget case What Happens after You Reduce or Stop deposits into PIT/ SNT?

- Client will receive a Medicaid renewal at some point over the 12-month period starting March/April 2023.
- If still using trust, with the renewal include a *Verification of Deposits* to the trust made in 2023.
- If your estimate of the 2023 spend-down was correct, the trust deposits should offset their new spend-down, and spend-down will remain at ZERO and Medicaid & QMB will be renewed or approved.
- **TIP:** Estimate the 2023 spend-down conservatively - better to put too much than too little into the pooled trust or individual SNT. Consider increasing the deposit by $164.90/mo. to enroll client in QMB and still have a -0- Spend-down!

al Assistance Group

The Return of Annual Renewals for Public Health Insurance Coverage

Medicaid Matters New York

What to Know

- Anyone in New York covered by Medicaid, Child Health Plus or the Essential Plan any time beginning March 2020 has stayed covered through continuous coverage until March 31, 2023.
- The federal government has directed states to resume renewals for public insurance coverage. Some New Yorkers began receiving renewal packets in March 2023, and everyone will receive them over the next year. The first date enrollees can lose coverage if they do not renew or if they no longer qualify is July 1, 2023.

New York has laid out a timeline for resuming annual renewals as follows:

Enrolled through NYC **Human Resources Administration (HRA)**	Enrolled through **local social services district** (outside NYC)	Enrolled through **New York State of Health Insurance Marketplace**
Receive renewal packets beginning March 2023	Receive renewal packets beginning April 2023	Receive renewal packets beginning May 2023

What to Do

1

Make sure your address is up to date.

- If you have moved since March 2020, make sure your new mailing address is provided to either the applicable agency or the New York State of Health Marketplace.

2

Watch your mail for your renewal packet and any additional notices regarding your insurance coverage.

3

Complete your renewal form and return it right away with any required documents. Keep a copy. Watch your mail for a notice that might tell you your coverage will stop. If so, request a hearing to avoid losing coverage.

The Community Health Advocates program is available to assist anyone with the renewal process, as well as hearings. An advocate can be reached at (888) 614-5400 or www.communityhealthadvocates.org.

NEW YORK INDEPENDENT ASSESSOR

and

IMMEDIATE NEED

New York Independent Assessor

New Immediate Need Forms:

See Table of Contents for list of online resources

AUTHORIZED REPRESENTATIVE DESIGNATION FORM

New York Medicaid Choice
1-800-505-5678 (TTY users: 1-888-329-1541)

0000000000CF

Complete and sign this form to name a person as your Authorized Representative with New York Medicaid Choice. You can submit the completed form by fax to (917) 228-8601 or by mail to New York Medicaid Choice, PO Box 5009, New York, NY 10274.

SECTION 1: PERSON DESIGNATING A REPRESENTIVE. *Please print*

Individual's Name: (First name, Last name) _____

Medicaid ID: ___ ___ ___ ___ ___ ___ ___ ___ SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address: _____ City: _____

State: _____ Zip code: _____ Date of Birth: ___ ___ - ___ ___ - ___ ___ ___ ___

Phone # (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Cell # (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

SECTION 2: AUTHORIZED REPRESENTATIVE. *Please print*

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone # (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Date: ___ ___ / ___ ___ / ___ ___ ___ ___

Representative's language preference for written materials:
☐ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Haitian Creole ☐ Korean ☐ Italian

Representative's Signature: _____

* If the signature is of the legal representative, describe the authority to act in that capacity (e.g., guardianship, committee for an incompetent, power of attorney, health care proxy, etc.), in the space below, or if necessary, attach additional pages.

_____

SECTION 3: SIGNATURE

- By signing below I give New York Medicaid Choice permission to release information, in connection with managed care enrollment/disenrollment decisions to the person named in **Section 2** as checked below:
  Please check all that apply. ☐ Medicaid ☐ Medicaid-Medicare ☐ Protected Health/Information
- I would like my mail from New York Medicaid Choice to be sent to:
  ☐ Me only ☐ Me and my Representative ☐ My Representative only
- The time period during which release of information is authorized is:
  From: ___ ___ / ___ ___ / ___ ___ ___ ___ to: ___ ___ / ___ ___ / ___ ___ ___ ___
- I understand that this approval is voluntary. I may withdraw this approval at any time before the "To Date" noted above, by advising New York Medicaid Choice in writing or calling **1-800-505-5678.** Withdrawing consent given to a legal representative will be verified.

I understand that if the person approved to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I also understand that the Authorized Representative Designation Form is used in connection with managed care options.

Individual's Signature: _____ Date: ___ ___ / ___ ___ / ___ ___ ___ ___

MM-CF-0822

Community Health Assessment
Functional Supplement
Mental Health Supplement

Reference Manual
August 2022 Edition
Software Version 1.13

New York State Department of Health
Office of Health Insurance Programs
Division of Long-Term Care

Acknowledgements and Regulations

The Uniform Assessment System for New York (UAS-NY) Community Health Assessment (CHA) is based on research and development conducted by interRAI. interRAI is a collaborative network of researchers in more than **30 countries** committed to improving health care for persons who are elderly, frail, or disabled. Their goal is to promote **evidence-based clinical practice and policy decisions** through the collection and interpretation of high-quality data about the characteristics and outcomes of persons served across a variety of health and social services settings. For information about interRAI, visit www.interRAI.org.

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This reference manual, in conjunction with the UAS-NY Training Environment and related NYS DOH official communication, is the only guidance sanctioned by the NYS DOH for the Community Health Assessment, Functional Supplement, and Mental Health Supplement located in the UAS-NY. In order to maintain the integrity of the data for quality assurance and uniformity of quality measures, use of alternative reference manuals or guidance on assessment response option coding must align with DOH and interRAI guidance.

Use of the UAS-NY does not alter or mitigate an organization's or user's obligation to adhere to all Federal, State, and local laws, policies, and regulations.

interRAI

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Disclaimer

Neither interRAI, nor the publisher, nor the authors intend that this book should be used in lieu of comprehensive, appropriate care. Every reasonable effort has been made to ensure that the information provided is accurate and up-to-date. However, the person's physician or other authorized practitioner should validate information about drugs and therapies for appropriateness before prescribing.

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UAS-NY Community Health Assessment Reference Manual

Table of Contents

INTRODUCTION TO THE UAS-NY

The Uniform Assessment System for New York (UAS-NY) is a web application that allows qualified assessors to securely conduct standardized health assessments which generate outcomes that are used to determine eligibility and service level authorization, as well as guide care planning for New York State residents.

Mission Statement

The UAS-NY's mission is to maintain and advance the leading repository for health information and assessment instruments while providing exceptional communication, training, and support to our 10,000 users and 1,800 organizations. We make the first step in developing individualized service plans efficient and easy to ensure New York State residents receive the right care, within the right setting, at the right time.

The UAS-NY Application

The UAS-NY is housed in the New York State (NYS) Department of Health's (DOH) Health Commerce System (HCS). The UAS-NY contains electronic adult and pediatric assessment instruments for individuals being served in a number of New York State programs under the oversight of various NYS Agencies including: the Department of Health, the Office for People With Developmental Disabilities, the Office of Mental Health, the Office of Addiction Services and Supports, and the Office of Children and Family Services.

The UAS-NY includes the following long-term care assessment instruments:

- The UAS-NY Community Health Assessment (CHA), and related Functional and Mental Health Supplements (where applicable) constitute a comprehensive assessment used for adults, age 18 and over, in home and community-based long-term care programs
- The UAS-NY Pediatric 4-17 Assessment
- The UAS-NY Pediatric 0-3 Assessment

The overall goal of the UAS-NY is to utilize a comprehensive assessment system within all community-based long-term care services and programs which:

- Evaluates individuals' health status, strengths, care needs, and preferences and guides the development of individualized long-term care service plans
- Assists with program eligibility determinations
- Improves care coordination and facilitates service delivery
- Ensures that individuals with long-term care needs receive the right care, within the right setting, and at the right time

In one location, health care providers have access to an individual's demographic information, residential and service delivery addresses, assessment information, and assessment outcome information. The availability of information to the appropriate providers supports care planning and service delivery for an individual.

The UAS-NY contains reporting functionality for information on individuals assessed, as well as aggregate or organization-wide data, which is immediately available to users during and upon completion of the assessment. The UAS-NY also includes an ad hoc reporting function that enables users to create customized reports and to download information from the UAS-NY. This data can then be uploaded to an organization's local management system.

Organizations and users who utilize the UAS-NY and corresponding assessment instruments are required to follow current Federal, State, and local laws, regulations, policies, and guidance.

UAS-NY Support Desk

For questions regarding the contents of this manual, please contact the UAS-NY Support Desk:

Via E-mail: uasny@health.ny.gov

Telephone: 518-408-1021 (option 1)

Support Desk Availability

Staff is available Monday through Friday 8:30 AM – 4:00 PM except during holidays, other prescheduled closures, exceptional inclement weather, and during any building safety drill or emergency situation. Notification of unanticipated closures will typically be sent via a system message which will appear upon logging in to the UAS-NY.

ABOUT THIS REFERENCE MANUAL

The purpose of this Reference Manual is to provide users with the information necessary to conduct the UAS-NY Community Health Assessment. As with any assessment, the underlying goal is to ensure a consistent interpretation and approach for conducting the assessment. This consistency is critical for the individuals being assessed, and for assessors.

To support a standardized and uniform approach, the following information is provided for **most** of the items included in the UAS-NY Community Health Assessment.

Intent	Reason(s) for including the item (or set of items) in the UAS-NY Community Health Assessment, including discussions of how the information will be used by clinical staff to identify problems and develop a plan of care.
Definition	Explanation of key terms.
Process	Sources of information and methods for determining the correct response for an item. Depending upon the item and the individual being assessed, sources include: • Interview and observation of the person • Discussion with the person's family, other caregivers, and the person's physician

- Review of any clinical records or other administrative documentation

Coding — Proper method of recording the response for each item, with explanations of the individual response options.

Some of the items included in the UAS-NY Community Health Assessment are self-explanatory. In these cases, only additional relevant material is presented.

Future Use of This Reference Manual

In addition to being available in the UAS-NY Training Environment, the information presented in this Reference Manual is available to users in the UAS-NY. When conducting the assessment, assessors may select the blue help icon  to access the UAS-NY Community Health Assessment Reference Manual. Using this feature, as well as having the Reference Manual readily available, will support and promote the integrity and consistency of the UAS-NY Community Health Assessment data.

Additional DOH Authorized Reference Manuals and User Guides

To support the understanding and use of the UAS-NY, additional reference manuals and user guides have been developed by the Department of Health. These resources include:

- UAS-NY Pediatric 4-17 Assessment Reference Manual
- UAS-NY Pediatric 0-3 Assessment Reference Manual
- UAS-NY User Guide
- UAS-NY Recording Demographic and Program Information

UAS-NY COMMUNITY HEALTH ASSESSMENT

The UAS-NY Community Health Assessment (CHA), and related Functional and Mental Health Supplements (where applicable) constitute a comprehensive assessment that is conducted by a licensed registered nurse (RN) and utilized by health care professionals.

The UAS-NY Community Health Assessment is comprised of the:

- Community Health Assessment, which enables an assessor to review multiple domains of function, health, social support, and service use, as well as medications, diseases, and other health-related information for an individual
- Functional Supplement, which provides assessors with additional data related to health, function, and support
- Mental Health Supplement, which captures additional information related to mental health service history, mental state, and social relations

The Community Health Assessment, Functional Supplement, and Mental Health Supplement will be hereafter referred to collectively as either the "Community Health Assessment" or as the "assessment(s)."

The responses to the UAS-NY Community Health Assessment measure an individual's objective performance and capacity in a variety of areas. Once completed, the UAS-NY Community Health Assessment is used to generate assessment outcomes for the individual. Together, the UAS-NY Community Health Assessment and the generated outcomes enable assessors to view the whole person at *a given point in time*. The UAS-NY Community Health Assessment is not intended to serve as an open-ended electronic health record, subject to ongoing updates.

The comprehensive nature of the UAS-NY Community Health Assessment supports the development of an individualized plan of care that builds on the strengths of an individual. The result is that individuals receive the right care, at the right time, and in the right setting.

The Community Health Assessment, Functional Supplement, and the Mental Health Supplement

Following the applicable laws, regulations, policy, and guidance for a program or plan, an assessor will conduct the UAS-NY Community Health Assessment by administering the Community Health Assessment and compiling information on medications and disease diagnoses. Many of the "items" included in the Community Health Assessment serve as "triggers" for the two supplements. Depending upon the response to an item, one or both of the supplements may be triggered for completion.

If triggered, the assessor is required to complete the Functional Supplement and/or the Mental Health Supplement. These supplements enable the assessor to capture additional, relevant information about an individual to more fully understand and document the goals and needs of the individual. It is important to note that not all individuals will trigger one or both of the supplements. Assessors may opt to conduct one or both of the supplements if not triggered.

When conducting the UAS-NY Community Health Assessment, assessors must remember that this instrument is not a questionnaire. The UAS-NY Community Health Assessment is not designed for the assessors to read the questions and potential responses and have the individual being assessed chose the most appropriate answer. Rather, this instrument should be used as a guide to structure a clinical and social assessment in planning for community-based care and services. Note that additional information not captured in the UAS-NY Community Health Assessment may be needed to support care planning.

Critical Assessor Skills

Assessors should engage the individual, as well as family members or caregivers, in a conversation about the goals and needs of the individual. Conducting the UAS-NY Community Health Assessment requires assessors to draw upon their communication, interpersonal, analytical, clinical, and reasoning skills.

- Assessors require **strong speaking and listening skills** to promote communication with the individual being assessed, as well as with the primary caregiver or family member if available. The individual being assessed is the primary source of information, and strong communication skills enable the assessor to present the items in an appropriate, understandable, and meaningful way.
- Assessors require **strong inter-personal skills** to keep an individual engaged throughout the assessment process. Equally important is for assessors to be aware of potentially

sensitive items or issues and how to address those items in a respectful and sensitive manner.

- Assessors require **strong analytical skills** to balance what is stated with what is observed, and what is included in a review of secondary documents. Not all information gathered will be consistent, which requires an assessor have further discussions in an attempt to resolve any discrepancies. Ultimately, an assessor will need to determine the appropriate response.
- Assessors require **strong clinical skills** to determine the presence and extent of health-related issues that will affect the services and care for an individual.
- The UAS-NY Community Health Assessment includes a number of items, each with a different intent, set of definitions, procedures, and coding options. Assessors are required to draw on **strong reasoning skills** to understand the assessment, as well as to become both fluent and proficient in its use. This goes a long way in supporting the consistency and accuracy of the assessments.

Basic Principles of the UAS-NY Community Health Assessment

When conducting an assessment, assessors are a guest in the individual's home, with the express purpose of completing a comprehensive assessment. The goal of the assessment is to:

- Maximize the individual's functional capacity and quality of life
- Identify and address health problems and care needs
- Ensure that the individual remains in his or her home for as long as possible

To accomplish this goal, assessors should:

- Identify the purpose of the visit
- Identify functional, medical, and social issues that are presently limiting or likely will become limiting
- Identify the individual's strengths and assets
- Integrate what is observed and heard in order to accurately code each of the UAS-NY Community Health Assessment items

Information collected using the UAS-NY Community Health Assessment can serve to:

- Determine the individual's appropriate level of care and program options
- Facilitate care coordination and an individual's admission to, discharge from, and transition between long-term care services
- Provide a basis for further evaluation of unrecognized or unmet needs
- Inform care planning and ensure that each limiting or potentially limiting factor is viewed in the context of the life circumstances unique to that individual and managed so as to maximize that individual's quality of life and function

Do not expect that all functional, medical, and social matters identified will be fully and comprehensively addressed during the visit. It is more important that all major functional, medical, and social circumstances that limit the individual's quality of life be identified in order to develop a plan for further evaluation or management.

Any acute medical matter should be brought to the attention of the individual immediately, and the individual should be vigorously counseled to seek appropriate medical care, whether or not that can be provided in the home setting.

In accordance with the laws of New York State, if there is evidence of abuse or neglect, referral to an appropriate agency/authority and immediate intervention may be warranted.

Conducting the UAS-NY Community Health Assessment

The initial UAS-NY Community Health Assessment should be completed after the person is referred for service by an agency.

The items on the UAS-NY Community Health Assessment flow in a logical sequence and can be completed in the order in which they appear. However, the assessor is not bound by this sequence. Items may be reviewed in any order that works for the assessor and the individual being assessed.

When conducting an assessment in an individual's home, the assessor needs to consider the order in which the items in the assessment will be addressed. It is generally helpful to assess the individual's cognitive status and ability to communicate early on. This will help gauge the reliability of the information that is gathered from the individual. There is also a need to be sensitive to the individual's reaction to the assessment process and particular issues. There is no one correct order in which the sections of the UAS-NY Community Health Assessment should be addressed. Assessors should take cues from the individual's responses to the "icebreaker" questions for prioritizing areas for assessment.

Remember, the UAS-NY Community Health Assessment is not a questionnaire. Although assessors must gather all the information to complete the UAS-NY Community Health Assessment, the needs of the individual should set the pace and priorities for the assessment process. More than one interview with the individual, or follow-up contacts with family members, other caregivers, or the individual's physician, may be necessary.

Whenever possible, the assessment should be performed in the person's home. Parts of the assessment can be completed in settings other than the person's home, such as a hospital, day care center, or outpatient clinic, with no loss in information quality. However, certain critical items, such as environmental factors, can best be assessed in the home. In any circumstance, the Community Health Assessment must be completed in person, face-to-face. Telephonic, Skype, Face Time, or any other alternative method are not permitted. (Please see UAS-NY Policy 19.1, *Conducting the UAS-NY Community and Pediatric Assessments* for complete information.)

Assessments must be completed according to New York State guidelines. It is expected that the UAS-NY Community Health Assessment be completed in its entirety. An assessment is only considered valid when the RN who conducted the assessment has entered their responses into the UAS-NY Online or Offline Application and has signed and finalized the assessment in the UAS-NY Online Application. Unsigned/unfinalized assessments are not recognized as valid and cannot be used for any purpose, including, but not limited to, eligibility determination, level of service need, care planning, authorization of services, or billing.

Assessors are encouraged to use the "Comments" field at the end of each domain. These open text fields are designed for the assessor to record additional information or observations.

Initiating the UAS-NY Community Health Assessment Process

When introducing the UAS-NY Community Health Assessment to a person, emphasize that the assessment is an integral part of the overall service program of the district or provider agency. If service options are limited, be realistic in channeling the conversation.

Address the person directly whenever possible. When talking with others, it is not necessary to use the word "person," which is used on the UAS-NY Community Health Assessment. Assessors may substitute words such as "older adult," "patient," or "client," or use phrases such as "Mrs. X" or "your mother."

Initially, some assessors may not be fully comfortable conducting the assessment. If this is the case, be sure to let the individual being assessed know that you just started using the assessment and would appreciate their patience.

Ice Breaker Questions

You can begin the assessment process with a series of optional "icebreaker" questions designed to begin a dialogue with the person and family. This may elicit much of the information required to complete the assessment. These questions are not included in the electronic assessment and may vary as appropriate. Some examples:

- How are you (is the person) doing?
- How do you (does he/she) get around in the house?
- How do you perceive your (his/her) present health as compared to a year ago (or when last seen)?
- Do you (does he/she) feel well enough to do what you want (he/she wants) to do?
- Can you (he/she) do the things that you want (he/she wants) to do?
- What type of assistance or services do you (does he/she) need?

COMMUNITY HEALTH ASSESSMENT

Section A. Intake and History

Community Health Assessment Reference Date

Intent — To establish a common period of observation as a reference point for each completed assessment.

Definition — The designated end point of the common observation period for items on the Community Health Assessment. Except where otherwise noted, all information gathered about the person pertains to the 3-day period prior to and including the Community Health Assessment Reference Date for items pertaining to the person's status or performance.

Home-based assessments are usually completed using information gathered during a single visit. However, when an assessment carries over to a second visit, information for the remaining items must be for the time period established by the original Community Health Assessment Reference Date.

Others Present at Assessment

Intent — To identify other individuals who were present at the time of the assessment.

Coding — Enter the names of each individual present. This does not include the assessor.

Reason for Assessment

Intent — To document the reason for completing the assessment.

Coding — Select the appropriate reason for assessment.

First assessment – This is the first assessment that is done at the time of first contact or entry into the home or program, or when initially determining eligibility for home care/home health services. This indicates it is the first assessment ***this organization*** is conducting for the individual. It is not necessarily the first assessment for the individual.

Routine reassessment – A regularly scheduled follow-up assessment to ensure that the care/service plan is appropriate and current.

Return assessment — An assessment conducted when the person returns from the hospital or otherwise re-enters the same organization after a discharge or disenrollment.

Significant change in status reassessment – A comprehensive reassessment conducted at any time during the uninterrupted course of care because the person's status or condition has significantly changed. If the change in status is accompanied by a hospital stay, select "Return assessment" instead.

Discharge assessment, covers last 3 days of service – Use this response only if the program or plan is required to complete a comprehensive assessment upon discharge.

Other – An assessment conducted outside of the established assessment schedule for any reason other than the selections above (e.g., confirmation of the appropriateness of the current plan [not the routine "follow-up" reassessment]). When "Other" is selected, please specify the reason.

Immediate need assessment

Intent — To document that the individual to be assessed has a Statement of Need indicating they are in immediate need of services. Cases of Immediate Need must be referred from a Local Social Services District. This designation allows for the individual's process of enrollment in services to be handled expeditiously. This is only applicable to Initial Assessments.

Definition — An individual is in immediate need of either Personal Care or Consumer Directed Personal Assistance Program services per a medical statement and has attested that they are eligible for Medicaid or are currently enrolled in Medicaid. This is only applicable to Initial Assessments.

Coding — Select the most appropriate response.

- No Selection
- No
- Yes

Referral Source (First Assessment Only)

Intent — To determine how an individual was referred to an organization. This is only recorded for individuals if the "Reason for Assessment" selected above is "first assessment."

Coding — Select the appropriate response.

- Hospital
- Nursing Home
- Out-of-state Nursing Home
- Certified Home Health Agency
- Licensed home care services agency
- Other home and community-based service provider
- Assisted living or adult care facility
- Social or adult day health care program
- Local District or Agency
- Area agency on aging
- Physician or clinic
- Self
- Family or Friend
- Other - When "Other" is selected, please specify.

Caregiver assistance during assessment

Intent — To document assistance provided by any caregiver during the course of the assessment process.

Definition — For this assessment item, a caregiver is anyone present who is assisting the individual during the course of the assessment process. Assistance may include facilitation of the assessment via interactive video teleconference.

Coding — Select the appropriate response.

- No selection
- No
- Yes

Person's Expressed Goals of Care

Intent — The person being assessed is an important member of the health care team. It is essential to ask him/her to identify what his/her goals of care might be. By doing so, the person is encouraged to be an active member of the team. This can also be a starting point to develop a person-centered plan of care or services.

Process — Use this box to document outcomes that the person hopes to achieve as a result of receiving services. These outcomes may relate to almost anything, including improved functional performance, a return to health, increased independence, an ability to maintain community residence, improved social relations, etc.

Talk to the person and phrase your questions about goals of care in the most general way possible. For example, ask, "How can we help you?" "Why are you getting (or applying for) services?" "What benefits do you expect to get?" "What changes in yourself do you hope will occur?" Encourage the person to express personal goals in his or her own words.

Some persons will be unable to articulate a goal, an expected outcome, or even a reason for seeking services. They may say they do not know or that they are getting service at the request of a relative. All of these are reasonable responses. Do not make inferences based on what you or other clinicians believe **should** be goals of care. If the person asks you for clarification on what he or she might expect from services, follow your usual agency policy.

Coding — Record the person's verbatim response in the text box. Abbreviate if necessary. Enter "NONE" if the person is unable to articulate a goal of care.

One or More Care Goals Met in the Last 90 Days (or Since Last Assessment if Less Than 90 Days Ago)

Intent — To identify if any of the person's treatment goals, established by the person or members of the care team (e.g., by nurses, social workers, therapists, or medical doctors), have been achieved in the last 90 days (or since the last assessment, if that was less than 90 days ago).

Process — Confer with the person and clinical professionals, and review any clinical documentation. Question the person to determine his or her perception regarding

an improvement in function or return to health. Keep in mind that discussions with professionals may be biased by payment category (e.g., fee for service) or the nature of the care (e.g., open-ended maintenance program).

Residential/Living Status at Time of Assessment

Intent — To document the person's living arrangement at the time of the current assessment. The person's living arrangement may be long-standing or temporary.

Process — Ask the person or family if you are unsure of where the person is currently living, or consult the person's administrative records.

Coding — Select the one most appropriate response.

Private home/apartment/rented room – Any house, condominium, apartment, or room in the community, whether owned or rented by the person or another party. Also included in this category are retirement communities and independent housing for older adults or the disabled.

Adult care facility **–** An entity established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care, and supervision to five or more adults unrelated to the operator.

Adult care facility with assisted living services –An adult care facility that is also approved to provide or arrange for home health services.

Adult housing offered by the Office of Mental Health – For example, psychiatric group home. A residential setting for adults with mental health problems who need supervision and limited services (meals, housekeeping).

Housing offered through the Office for People with Developmental Disabilities – A setting that provides services to persons with physical disabilities. Typically, persons live in a group setting with 24-hour staff presence. Individuals are encouraged to be as independent and active as possible.

Psychiatric hospital or unit – A psychiatric hospital that focuses on the diagnosis and treatment of psychiatric disorders and which is separate from other inpatient facilities, such as an acute care, rehabilitation, or chronic care hospital. A psychiatric unit is a single unit, located in a general hospital, which is dedicated to the diagnosis and treatment of psychiatric disorders.

Nursing Home – A licensed health-care facility that provides 24-hour skilled or intermediate-level nursing care.

Rehabilitation hospital/unit – A licensed rehabilitation hospital that focuses on the physical and occupational rehabilitation of individuals who have experienced disease or injury with a subsequent decline in physical function. A rehabilitation unit is located within an acute care hospital and focuses on the acute rehabilitation of individuals who have experienced disease or injury with a subsequent decline in physical function.

Hospice facility/palliative care unit – A hospice facility (or unit within a facility providing care that is more general) provides care to persons who have a terminal

illness with a prognosis of less than 6 months to live, as certified by a physician. The goal of hospice care is to provide comfort and quality of life while assisting the person and family. Palliative care is the care of persons whose diseases are not responsive to curative treatments. It targets pain and symptom relief, without precluding use of life-prolonging treatments. Palliative care is often provided from the time a person is diagnosed with a life-threatening illness.

Acute care hospital – A facility licensed as an acute care hospital that focuses primarily on the diagnosis and treatment of acute medical disorders.

Correctional facility – A jail, penitentiary, or halfway house operated by a local, state, or federal government to care for and house persons who have been sentenced to incarceration by a criminal court.

Homeless (with or without shelter) – A homeless person does not have a fixed residence (a house, apartment, room, or other place to stay on a regular basis). The person may live on the streets, or outside in wooded or open areas. The person may sleep in cars, in abandoned buildings, under bridges, etc. Persons who are homeless may or may not take advantage of existing homeless shelters.

Other – Any other type of setting not listed above.

When "Other" is selected, please specify.

Living Arrangement

Intent — To record with whom the person lives and the duration of this arrangement. These items will help determine the need for more, fewer, or different services.

Process — Ask the person or family member.

Coding — Select the one most appropriate response that reflects with whom the person is presently living. Note that this excludes any temporary living arrangements made while services are being set up.

- Alone – Includes person who lives only with a pet, lives on the streets, or is homeless (whether or not the person uses shelters).
- With spouse/partner only – Includes spouse/partner, girlfriend or boyfriend, common-law marriage, or long-term same-sex relationship.
- With spouse/partner and other(s) – Lives with spouse or partner and any other individual(s), whether family or unrelated.
- With child (not spouse/partner) – Lives with child(ren) only, or with child(ren) and other individual(s), but not with spouse or partner.
- With parent(s) or guardian(s) – Lives with parent(s) or guardian(s) only, or with parent(s) or guardian(s) and other individual(s), but not with spouse or partner, or child(ren).
- With sibling(s) – Lives with sibling(s) only, or with sibling(s) and other individual(s), but not with spouse or partner, child(ren), or parent(s) or guardian(s).
- With other relative(s) – Lives with a relative (such as aunt or uncle) other than spouse or partner, child(ren), parent(s), or sibling(s).

- With non-relative(s) – Lives in a group setting (e.g., a boarding home, long-term care facility, group home, or jail) or in shared accommodation with non-relative(s) (e.g., roommate). Excludes single overnight stays, such as in a homeless shelter.

Residential History During Last Five (5) Years

Intent	To determine the individual's five-year history and involvement with residential, clinical care.
Process	Ask the person and caregivers. Review any available documentation.
Definitions	Refer to definitions presented for "Residential/Living Status at time of assessment."
Coding	Select **all** settings the person lived in during the five **(5) years** prior to the date the case was opened.

Education - Highest Level Completed

Intent	To determine the individual's level of education at time of entry.
Process	Ask the person and caregivers. Review any available documentation.

Definitions No schooling – Individual did not attend or participate in any formal education.

Eighth grade or less – Individual was enrolled in a formal education program and completed no more than eighth grade, junior high school, or middle school.

Some high school– Individual was enrolled in high school (ninth grade or higher), but did not earn a high school diploma or its equivalent.

Completed high school – Individual earned a high school diploma or its equivalent.

Technical/trade school – Individual completed or earned a certification from an accredited vocational school.

Some college/university – Individual attended a post-secondary institution but did not earn a degree.

Diploma/bachelor's degree –Individual attended a post-secondary institution and earned a bachelor's degree.

Graduate degree – Individual attended a post-secondary institution and earned a master's degree or higher.

Unknown

Coding Select the one most appropriate response.

History of Attendance at a Special Education Program or Setting

Intent To determine if the individual has attended a special education program.

Process Ask the person and caregivers. Review any available documentation.

Definitions Special Education Program or Setting – the educational program is designed to focus on and address the specific educational needs of individuals with developmental disabilities.

Coding Select the one most appropriate response.

Employment Status

Intent To determine the person's present employment status, as it may have an impact on support planning, specifically around vocational issues.

Definitions Employed – Individual receives payment for full- or part-time work.

Unemployed, seeking employment – Individual is not employed and is actively seeking full- or part-time work.

Unemployed, not seeking employment – Individuals that are unemployed and not actively seeking employment. This includes a student who is not looking for employment while attending school, a retiree, or a parent who has chosen to stay at home to care for the family.

Process Ask the person or family members about the person's employment status.

Coding Select the appropriate code for present employment status. If the individual is employed, enter the name of the employer.

Employment Arrangements – Excluding Volunteering

Intent To document the person's employment arrangement.

Definitions Competitive employment – The person works in a workplace where he/she receives adequate pay for work (i.e., minimum wage or better) and does not receive any special support or supervision.

Supported employment – The person receives special support, monitoring or supervision while at work (e.g., a job coach).

Vocational Rehabilitation – The person works in a protected work environment that often provides a stipend for work performed (e.g., sheltered workshop).

Other - When "Other" is selected, please specify.

Not Applicable

Process Ask the person, family, or others about the person's present employment arrangement.

Coding Select the present employment arrangement. If other is selected, specify the employment arrangement.

Involvement in structured activities

Intent To document the person's involvement in structured activities

Definitions Formal education program – Includes enrollment in any formally recognized education program (e.g., elementary or high school, college, university, private vocational/technology/business school, retraining program).

Volunteerism (e.g., for community services) – The person currently provides services without compensation (e.g., with a community service, program, or group). Note: the person may be employed *and* serve as a volunteer. "Currently provides" implies holding an ongoing volunteer position, regardless of whether the person actively fulfilled his/her duties as a volunteer in the last 3 days.

Day program – Any program (outside the home) where the person receives social, recreational, medial, or functional support (e.g., teaching of self-care, instrumental activities of daily living [IADL] or social skills).

Other – If **other**, please specify.

Process Ask the person, family, or others about the person's involvement in any structured activities.

Coding Select the most appropriate response to indicate the person's involvement in structured activities. If other is selected, specify as appropriate.

Section B. Cognition

It is important to determine the person's actual performance in remembering, making decisions, and organizing daily self-care activities. These items are crucial factors in many care-planning decisions, in part because of their impact upon the person's ability to follow instructions and treatment regimens, and to make independent decisions in the community. Documentation should be entered in the comments section to support response options. For example, when there is difficulty only with new tasks or situations.

Cognitive Skills for Daily Decision Making

Intent

To record the person's actual performance in making everyday decisions about the tasks or activities of daily living. These items are especially important for further assessment and care planning in that they can alert the assessor to a mismatch between a person's abilities and his or her current level of performance, as the family may inadvertently be fostering the person's dependence.

Definition

Here are some examples of decision-making tasks:

- Choosing items of clothing
- Knowing when to eat meals
- Knowing and using space in the home appropriately
- Using environmental cues (e.g., clocks or calendars) to organize and plan the day
- In the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from family in order to plan the day
- Using awareness of one's own strengths and limitations in regulating the day's events (e.g., asking for help when necessary)
- Making prudent decisions concerning how and when to go out of the house; where applicable, acknowledging the need to use a walker or other assistive device and using it faithfully

Process

Interview and observe the person, then consult with a family member or other caregiver. Review the events of each day. **The inquiry should focus on whether the person is actively making decisions about how to manage tasks of daily living, not whether the caregiver believes the person might be capable of doing so. Remember that the intent of this item is to record what the person is doing (actual performance).** When a family member takes decision-making responsibility away from the person regarding tasks of everyday living, or when the person chooses not to participate in decision making (whatever his or her level of capability may be), the person should be considered as having impaired performance in decision making.

Coding

Select the one most appropriate response.

- Independent – The person's decisions in organizing daily routines and making decisions were consistent, reasonable, and safe (reflecting lifestyle, culture, values).

- Modified independence – The person organized daily routines and made safe decisions in familiar situations but experienced some difficulty in decision making when faced with new tasks or situations.
- Minimally impaired – In specific recurring situations, decisions were poor or unsafe, with cues/supervision necessary at those times.
- Moderately impaired – The person's decisions were consistently poor or unsafe; the person required reminders, cues, or supervision at all times to plan, organize, and conduct daily routines.
- Severely impaired – The person never (or rarely) made decisions.
- No discernible consciousness, coma – The person is nonresponsive.

Memory/Recall Ability

Intent — To determine a person's ability to remember past events (short-term memory) and to perform sequential activities (procedural memory).

Process — Short-term Memory – Conduct a structured test of short-term memory. If this is not possible, ask the person to describe a recent event that you should both have knowledge of (e.g., the election of a new political leader, a major holiday) or that you can validate with a family member (e.g., what the person had for breakfast). **If there is no positive indication of memory ability, code the item "Memory problem."**

Procedural memory OK –This item refers to the cognitive ability needed to perform sequential activities. Dressing is an example of such an activity, as multiple steps are required to complete the task. The person must be able to perform or remember to perform all or most of the steps in order to be coded "Yes, memory OK." If the person demonstrates difficulty in two or more steps, code as "Memory problem." Remember that persons in need of care in the home often have physical limitations that impede their independent performance of activities. Do not confuse such physical limitations with the cognitive ability (or inability) to perform sequential activities.

Coding — Code for recall of what was learned or known.

Change in Decision Making as Compared to 90 Days Ago (or Since Last Assessment)

Intent — To compare the person's current decision-making ability to that of 90 days ago, or since the last assessment if that was less than 90 days ago. The changes may be permanent or temporary, and the cause may be known (e.g., psychotropic medication or new pain) or unknown. If the person is newly admitted to the program, include changes since admission **and** changes during the period prior to admission.

Process — Talk to the person and family members. Ask them to compare the person's decision-making status now versus 90 days ago (or since the last assessment if less than 90 days ago). To help identify the 90-day time period, ask the person or others to pinpoint an event that occurred 3 months ago, and then to relate the person's functioning to that event. For example, if the person visited a family

member 3 months ago, ask how able he or she was in making decisions during that trip.

Section C. Communication and Vision

Making Self Understood (Expression)

Intent — To document the person's ability to express or communicate requests, needs, opinions, and urgent problems, and to engage in social conversation. Such communication may take the form of speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

Process — Interact with the person. Observe and listen to the person's efforts to communicate with you. If possible, observe his/her interactions with family. If he/she has communication devices, encourage their use during the assessment. Observe the person's interactions with others in different settings (e.g., one-on-one, in groups, with family members) and different circumstances (e.g., when calm, when agitated). Note that this item is not intended to address differences in language understanding, such as only speaking in a language not familiar to the assessor.

Coding — Select the most appropriate response:

- Understood – The person expresses ideas clearly without difficulty.
- Usually understood – The person has difficulty finding the right words or finishing thoughts (resulting in delayed responses), **but** if given time, requires little or no prompting.
- Often understood – The person has difficulty finding words or finishing thoughts, **and** prompting is usually required.
- Sometimes understood – The person has limited ability, but is able to express **concrete** requests regarding at least basic needs, such as food, drink, sleep, and toilet.
- Rarely or never understood **–** At best, understanding is limited to interpretation of highly individual, person-specific sounds or body language. For example, caregiver has learned to interpret person signaling the presence of pain or need to toilet.

Ability to Understand Others (Comprehension)

Intent — To describe the person's ability to comprehend verbal information, whether communicated to the person orally, in writing, or through sign language or Braille. This item measures the person's ability not only to hear messages but also to process and understand language.

Process — Interact with the person. Consult with family.

Coding — Select the most appropriate response.

- Understands – Clearly comprehends the speaker's message(s) and demonstrates comprehension by words or actions/behaviors.

- Usually understands – With little or no prompting, person misses some part or intent of the message but comprehends most of it. The person may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.
- Often understands – The person misses some part or intent of the message. However, with prompting (repetition or more detailed explanation), the person often comprehends the conversation.
- Sometimes understands – The person demonstrates frequent difficulties integrating information and responds adequately only to simple and direct questions or directions. When the message is rephrased or simplified, or gestures are used, the person's comprehension is enhanced.
- Rarely or never understands – The person demonstrates very limited ability to understand communication, or the assessor cannot determine whether the person comprehends messages, based on his or her verbal and nonverbal responses. Includes situations where the person can hear sounds but does not understand messages.

Hearing

Intent — To evaluate the person's ability to hear with environmental adjustments, if necessary.

Process — Evaluate hearing ability after the person has a hearing appliance in place (if the person uses an appliance). Be sure to ask if the battery works and if the hearing aid is turned on. Interview and observe the person, and ask about hearing function. Consult the person's family. Test the accuracy of your findings by observing the person during your verbal interactions.

Ask the person about hearing function, and observe hearing function during your verbal interactions. Use a variety of observations to make your assessment (e.g., one-on-one vs. in group situations). If possible, observe the person interacting with others, such as family members. Always be mindful of environmental factors (nearby conversations, outside noises, etc.) that could influence your assessment. If necessary, consult with the family, primary support people, or speech or hearing specialists to clarify the person's exact hearing level.

Be alert to what you have to do to communicate with the person. Clues that there is a hearing problem include having to speak more clearly or slowly, or use a louder tone or more gestures. Persons with hearing problems may also need to see your face to know what you are saying, or you may have to take the person to a more quiet area to conduct the interview.

Coding — Select the most appropriate response.

- Adequate – No difficulty in normal conversation, social interaction, listening to TV.
- Minimal difficulty – Difficulty in some environments (e.g., when the other person speaks softly or is more than 6 feet [2 meters] away).
- Moderate difficulty – Problem hearing normal conversation, requires quiet setting to hear well.

- Severe difficulty – Difficulty in all situations (e.g., speaker has to talk loudly or very slowly, or person reports that all speech is mumbled).
- No hearing.

Vision

Intent — To evaluate the person's ability to see close objects in adequate light, using the person's customary visual appliances for close vision (such as glasses or a magnifying glass).

Definition — Adequate light – Light that is sufficient or comfortable for a person with normal vision.

Process — Ask person, family member, or staff if the person has manifested any change in usual vision patterns – for example, is the person still able to read newsprint, greeting cards, and the like?

Ask the person about his or her visual abilities. Test the accuracy of your findings by asking the person to look at regular-sized print in a book or newspaper with whatever visual appliance he or she customarily uses for close vision (such as glasses or a magnifying glass). Then ask the person to read aloud, starting with larger headlines and ending with the finest, smallest print.

Be sensitive to the fact that some persons are not literate or are unable to read English. In such cases, ask the person to read aloud individual letters or numbers (such as dates or page numbers), or to name items in small pictures.

If the person is unable to communicate or follow your directions for testing vision, observe the person's eye movements to see if his or her eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether the person has any visual ability.

Coding — Select the most appropriate response.

- Adequate – The person sees fine detail, including regular print in newspapers/books.
- Minimal difficulty – The person sees large print, but not regular print in newspapers/books.
- Moderate difficulty – The person has limited vision; is not able to see newspaper headlines, but can identify objects in his or her environment.
- Severe difficulty – The person's ability to identify objects in his or her environment is in question, but the person's eye movements appear to be following objects (especially people walking by). Also includes the ability to see only light, colors, or shapes.
- No vision – The person has no vision; eyes do not appear to be following objects (especially people walking by).

NOTE: Many persons with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such persons appear to "track" or follow moving objects in their environment

with their eyes. For persons who appear to do this, select "Severe difficulty." This is often the best assessment you can do with the limited technology available.

Section D. Mood and Behavior

Mood distress is a serious condition and is associated with significant morbidity. Associated factors include poor adjustment to one's living situation, functional impairment, resistance to daily care, inability to participate in activities, social isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain. It is particularly important to identify signs and symptoms of mood distress, because they are treatable.

It would be very unusual for family members to have received specific training in how to evaluate persons who have distressed mood. Therefore, although family may sense that something is wrong, mood distress is often underdiagnosed and undertreated in community settings. Thus, this assessment may serve as a crucial first opportunity to identify whether such problems are present.

Indicators of Possible Depressed, Anxious, or Sad Mood

Intent — To record the presence of indicators observed in the last 3 days, irrespective of the assumed cause of the indicator/behavior.

Definitions — The mental state indicators may be expressed verbally through direct statements or through nonverbal indicators or behaviors that can be monitored by observing the person during usual daily routines.

Made negative statements – For example, "Nothing matters;" "Would rather be dead than live this way;" "What's the use;" "Regret having lived so long;" "Let me die."

Persistent anger with self or others – For example, easily annoyed, anger at care received.

Expressions, including nonverbal, of what appear to be unrealistic fears – For example, fear of being abandoned, being left alone, or being with others; intense fear of specific objects or situations.

Repetitive health complaints – For example, persistently seeks medical attention, incessant concern with body functions.

Repetitive anxious complaints/concerns (non-health-related) – For example, persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, and relationships.

Sad, pained, or worried facial expressions – For example, furrowed brows, constant frowning.

Crying, tearfulness – Distress may also be expressed through such nonverbal indications.

Withdrawal from activities of interest – Including long-standing activities, being with family/friends.

Reduced social interactions – Avoids social interactions; lack of responsiveness to others.

Process

Feelings of psychic distress may be expressed directly by the person who is depressed, anxious, or sad. Distress can also be expressed through nonverbal indicators. Initiate a conversation with the person, being cognizant of earlier statements by (or observations of) the person. Some persons are more verbal about their feelings than others and will either tell someone about their distress, or will at least tell someone when asked directly how they feel. For persons who verbalize their feelings, ask how long these conditions have been present. Other persons may be unable to articulate their feelings (perhaps because they cannot find the words to describe how they feel, or lack insight or cognitive capacity). Observe the person carefully for any indicator, both at the time of the planned assessment and in any direct contacts you may have with the person during the 3 days covered by this assessment. Consult with family members who have direct knowledge of the person's typical and current behavior, and any other clinicians working with the person (such as the primary care provider, if available).

Remember to be aware of cultural differences in how these indicators may be manifested. Some persons may be more or less expressive of mental health concerns, emotions, or feelings because of their cultural norms. Be cautious not to minimize your interpretation of an indicator based on your expectations about the person's cultural background. On the other hand, it is important to be especially sensitive to these indicators when assessing a person whose culture may make him or her more stoic in his/her expressions.

Coding

Based on your interaction with and observation of the person, select the appropriate response based on the person's behavior over the last 3 days.

- Not present
- Present but not exhibited in last 3 days – indicates that while the assessor knows the condition is present and active, it was not physically manifested over the last 3 days
- Exhibited on 1–2 of last 3 days
- Exhibited daily in last 3 days

Remember, select the response for each item based on what you see or what is reported to you, regardless of what you believe the cause to be. Whenever possible, ask the person.

Behavior Symptoms

Intent

To identify the frequency, during the last 3 days, of behavioral symptoms that cause distress to the person, or are distressing or disruptive to others with whom the person lives. Such behaviors include those that are potentially harmful to the person or disruptive to others. These items are designed to pick up problem behaviors exhibited by the person that may be considered as "combative or agitated" by some health professionals.

Acknowledging and documenting behavioral symptoms provides a basis for further evaluation, care planning, and delivery of consistent, appropriate care toward ameliorating the behavioral symptoms.

Definitions

Wandering – Moved with no rational purpose, seemingly oblivious to needs or safety.

Verbal abuse – For example, others were threatened, screamed at, cursed at.

Physical abuse – For example, others were hit, shoved, scratched, sexually abused. This item identifies physically aggressive behavior without making the distinction between intentional and unintentional behaviors.

Socially inappropriate or disruptive behavior – For example, made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through others' belongings.

Inappropriate public sexual behavior or public disrobing – Sexual behavior should only be considered inappropriate when it contravenes usual social norms (e.g., deliberately exposing self, masturbating in public or in a room while others are present, and unacceptable sexual gestures, touching, pinching). Sexual activity in private (either alone or between consenting adults) is not considered here. Public disrobing refers to behavior that contravenes local laws. In the case of disrobing, remember to code for the absence or presence of the behavior but not the intent. For example, select "Present but not exhibited in last 3 days," or higher if a person reports undressing in public because there were no private places available.

Resists care – For example, taking medications/injections, activities of daily living (ADL) assistance, eating.

Process

Ask the family member or caregiver if each specified problem behavior occurred. Take an objective view of the person's behavioral symptoms, and focus on the person's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. The fact that some family members have become used to the behavior or minimize the person's presumed intent ("He doesn't really mean to hurt anyone — he's just frightened") should not be considered in coding items. Rather, code each item based on whether the person manifested the behavioral symptom.

Observe the person and the way he or she responds to attempts by family members or others to deliver care. Ask caregivers if they know what occurred throughout the day and night for the past 3 days. If possible, try to do this when the person is not in the room. Recognize that responses given with the person present may need to be validated later and that the presence of multiple caregivers during the assessment may discourage individuals from answering accurately.

A review of information in the record may also be helpful.

Coding

Select the appropriate response for the presence of each behavior symptom over the last 3 days, regardless of what you believe to be the underlying cause of the behavior. Remember to select the response for both the presence of the behavior

and the number of days in which it was exhibited, no matter how often it was exhibited per day.

Select one of the following options:

- Not present
- Present but not exhibited in last 3 days – indicates that while the assessor knows the condition is **present** and **active**, it was not physically manifested over the last 3 days
- Exhibited on 1–2 of last 3 days
- Exhibited daily in last 3 days

Self-Reported Mood

Intent — To record the person's self-reported mood over the last 3 days. In some cases, the person may deny feeling a particular way in the last 3 days but reports that the issue continues to be "present" and active.

Definitions — These items involve verbal reports of the person's subjective evaluation of three dimensions of mood state (anhedonia, anxiety, dysphoria) over the last 3 days.

Process — Once you have completed your own rating of the person's mood state using the other items in the Mood section of the assessment, ask the person the following questions directly:

"In the last 3 days, how often have you felt…?

- Little interest or pleasure in things you normally enjoy?
- Anxious, restless, or uneasy?
- Sad, depressed, or hopeless?"

Only the person's responses should be used to determine the appropriate selection response. Do not select a response based on your own inferences about the person's mood state and do not select ratings given by family, friends, or other informants. These items should be treated strictly as self-report measures. Do not dwell on these items and do not input responses for the person. Select "Person could not (would not) respond if the person is unable (due to cognitive impairment, for example) or refuses to respond.

Coding — For each item, use the **person's response as to whether/how often he or she experienced the feelings referenced in the items** over the last 3 days, regardless of what the person believes to be the underlying cause of those feelings. Remember to select the response for both the presence of the indicator and the number of days in which it was felt, no matter how often it was felt per day. Select "Person could not (would not) respond" for persons unable or unwilling to respond.

Use the following selection options:

- Not in last 3 days

- Not in last 3 days, but often feels that way – use only if the person indicates the feeling is frequently **present** and **active**, but was not experienced in the last 3 days
- In 1 –2 of last 3 days
- Daily in the last 3 days
- Person could not (would not) respond

Section E. Psychosocial Well-Being

Social Relationships

Intent — To document and describe the person's interaction patterns and adaptation to his or her social environment. To assess the degree to which the person is involved in social activities, meaningful roles, and daily pursuits.

Definitions — Participation in social activities of long-standing interest — The person engaged in social activities that have been of long-standing interest to him or her. The activities may be quite varied and should be counted as long as they involve interaction with at least one other person. Examples include attending meetings of informal clubs or religious services, playing bridge or bingo, volunteering at the local clothing bank, or gossiping with the neighbors on their front porches in the evening.

Visit with a long-standing social relation or family member – The person was visited by (or made a visit to) any family member, friend, or social acquaintance with a long-standing relationship with the person (e.g., a neighbor or fellow member of a community organization or religious group). The focus here is on well-established, informal ties rather than visits with paid staff, volunteers, or new acquaintances.

Other interaction with long-standing social relation or family member – For example, telephone or e-mail. The person interacted through a means other than a face-to-face visit with a family member, friend, or social acquaintance with a long-standing relationship with the person (e.g., a neighbor or fellow member of a community organization or religious group). The focus is on well-established, informal ties rather than contacts by paid staff, volunteers, or new acquaintances.

Openly expressing conflict or anger with family or friends – The person expresses feelings such as abandonment, ingratitude on part of the family, lack of understanding by close friends, or hostility regarding relationships with family or friends.

Fearful of a family member or close acquaintance – The person expresses (verbally or through behavior) fear of a family member or close acquaintance. Such fear can be expressed in many ways. A person may state that he or she is afraid of a caregiver or may appear to withdraw whenever the caregiver is around. This may include fear of physical or emotional abuse or mistreatment. It is not necessary to establish the reason for the fear, only to determine whether it is present.

Neglected, abused, or mistreated – The person experienced a serious or life-threatening situation or condition that went untreated or was not appropriately acknowledged. The situation may have put the person at risk of death or of complications that impinge on physical or mental health.

Process — Ask the person for his or her point of view. In what activities does he or she enjoy participating? When was the last time he or she was able to participate? Who tends to come visit, and when was the last time that individual visited? Are there other ways the person contacts family or friends (e.g., by telephone or e-mail)? Is the person generally content or unhappy in relationships with family and friends? If the person is unhappy, about what specifically is he or she unhappy?

If possible, also talk with family members and friends who visit or have frequent telephone contact with the person. The primary caregiver may have a good sense of who visits or contacts the person. He or she can also describe the most common social activities the person was involved in recently.

Coding — Select the most appropriate response:

- Never
- More than 30 days ago
- 8 to 30 days ago
- 4 to 7 days ago
- In last 3 days
- Unable to determine

Lonely

Definition — The person states or otherwise indicates that he or she feels lonely. The person may feel that others do not visit enough or desires more social interaction, even if visited regularly. Others may also report that the person sometimes comments on feeling lonely.

Process — Talk with the person to determine whether he or she feels lonely. If possible, speak with the person's family or other informal contacts, such as neighbors, to get their perception of the person's feelings of loneliness.

Change in Social Activities in Last 90 Days (Or Since Last Assessment if Less Than 90 Days Ago)

Intent — To identify a recent change (as compared to 90 days ago — or since the last assessment if fewer than 90 days have passed) in the person's level of participation in social, religious, occupational, or other preferred activities. If the level of participation has declined, determine whether the person is distressed by it.

Definition — The level of participation refers to the quantity (how many) of different types of social activities; the intensity (how frequently contact occurs); and the quality of the activity (how deeply the person is involved). Remote participation is equally important and significant for the person's role fulfillment and self-esteem (e.g., a person who cannot move outside his or her home may still participate or be

associated with some kind of religious, political, or social activity). Distress occurs when the person's mood is adversely affected by a recent change in the level of participation (e.g., as evidenced by sadness, loss of motivation or self-esteem, anxiety, or depression).

Process — Talk with the person to determine whether a change has occurred and to determine his or her subjective response to any changes. If possible, speak with the family or other informal contacts (such as neighbors) to get their opinions on whether the person's activity levels have changed and, if so, how he or she responded to those changes.

Coding — Select the most appropriate response:

- No decline – There was no change, or there was an increase in the person's level of participation in social activities.
- Decline, not distressed – The person experienced a decline in his or her level of participation in social activities, without a corresponding increase in his or her distress.
- Decline, distressed – Both decline and distress are observed or reported.

Length of Time Alone during the Day (Morning and Afternoon)

Intent — To identify the actual amount of time the person is alone in the morning and afternoon.

Definition — The amount of time the person is literally alone, without any other person in the home. If the person is residing in a board-and-care facility, adult-care facility, or other situation where there are other persons in their own rooms, count the amount of time the person spends by him- or herself in the person's own room as time alone.

Process — First ask the person how much time he or she spends alone. Be clear about how "being alone" is defined. Confirm with caregivers the amount of time the person spends alone.

Coding — Select the most appropriate response:

- Less than 1 hour
- 1–2 hours
- More than 2 hours but less than 8 hours
- 8 hours or more

Major Life Stressors in Last 90 Days

Intent — To identify any life events that the person considers to have had a major impact on his or her life in the last 90 days.

Definition — Life stressors – Experiences that either disrupted or threatened to disrupt the person's daily routine and that imposed some degree of readjustment.

Process — Ask the person if any stressful events have occurred in the last 90 days. Examples may include an episode of severe personal illness, the death or severe illness of a close family member or friend, the loss of the person's home, a major loss of

income or assets, being the victim of a crime such as robbery or assault, the loss of the person's driving license or car.

Section F. Functional Status

IADL Self-Performance and Capacity

Intent — To examine the areas of function that are most commonly associated with independent living (instrumental activities of daily living, or IADLs).

Definitions — Meal preparation – How meals are prepared (planning meals, assembling ingredients, cooking, setting out food and utensils). This item should be assessed in terms of the person's ability to put meals together, regardless of the quality or nutritional value of the meal. For example, if the person is able to make cold cereal for breakfast, or put together a cold sandwich and drink coffee at lunch, or make toast for dinner without assistance, the person would be scored as independent in meal preparation capacity.

Ordinary housework – How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry).

Managing finances – How bills are paid, checkbook is balanced, household expenses are budgeted, and credit card account is monitored.

Managing medications – How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments).

Phone use – How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed).

Stairs – How a **full** flight of stairs is managed (i.e., 12–14 stairs). If the person is able to go up and down only a half flight (2–6 stairs), do not score as independent.

Shopping – How shopping is performed for food and household items (selecting items, paying money). **This item does not include transportation.**

Transportation – How person travels by public transportation (navigating system, paying fare) or drives self (including getting out of the house, into and out of vehicles).

Equipment Management (includes only oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment or supplies) – The **ability** (NOT compliance or willingness) to set up, monitor, and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. Note: If person is in nursing home at time of assessment, this should not be answered. **Answer for all other settings if the listed equipment is being used by the person.**

Process — Question the person about his or her performance of normal activities around the home or in the community in the last 3 days. You may also talk to family

members if they are available. Use your own observations as you are gathering information for other Community Health Assessment items.

Coding

For each item, select the most appropriate response in the following two categories:

Performance – Measures what the person actually did within each IADL category in the last 3 days. Do not base your selection on what the person might be capable of doing (see the Capacity category).

Capacity – Select the response based on the person's presumed ability to carry out the activity. This requires speculation by the assessor.

Because of a lack of skills or experience, a person may not perform some activities but would be capable of doing so with the proper training or opportunity. Therefore, it is important to distinguish between nonperformance that is due to impairment of capability (caused by health problems) and nonperformance that is due to other factors (not related to the person's health). For example, some males may never have learned to cook, and some females may never have handled financial matters. For some activities, the person may perform the activity independently at times but receive/require assistance at other times. First, determine whether the person actually performed the activity. If not, evaluate whether the person is capable of performing the activity.

- Independent – No help, setup, or supervision needed.
- Setup help only – Article or device provided or placed within reach, no physical assistance or supervision in any episode.
- Supervision – Oversight/cuing required.
- Limited assistance – Help required on some occasions.
- Extensive assistance – Help required throughout task, but performs 50% or more of task on own.
- Maximal assistance – Help required throughout task, but performs less than 50% of task on own.
- Total dependence – Full performance of activity during entire period by others.
- Activity did not occur – During entire period. **NOTE: You may select this response for the Performance category, but do not select it to for the Capacity category.**

ADL Performance

Intent

To record what the person did for him- or herself and how others assisted in the performance of self-care activities of daily living (ADLs) during the last 3 days.

Definitions

ADL self-performance – Measures based on all episodes of the activity over the last 3 days.

Bathing – How the person takes a full-body bath or shower. Includes how person transfers in and out of tub or shower **and** how each part of body is bathed: arms, upper and lower legs, chest, abdomen, and perineal area. **Exclude washing of back and hair.**

Personal hygiene – How the person manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands. **Exclude baths and showers.**

Dressing upper body – How the person dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.

Dressing lower body – How the person dresses and undresses (street clothes, underwear) from the waist down, including prostheses, orthotics, belts, pants, skirt, shoes, fasteners, etc.

Walking – How the person walks between locations on the same floor indoors.

Locomotion – How the person moves between locations on the same floor (walking or wheeling). If the person uses a wheelchair, this measures self-sufficiency once he or she is in the chair.

Transfer toilet – How the person moves onto and off of the toilet or commode.

Toilet use – How the person uses the toilet room (or commode, bedpan, urinal), cleanses him- or herself after toilet use or incontinent episode(s), changes bed pad, manages ostomy or catheter, adjusts clothes. **This item does not include transfer on and off the toilet.**

Bed mobility – How the person moves to and from a lying position, turns from side to side, and positions his or her body while in bed.

Eating – How the person eats and drinks (regardless of skill). Includes intake of nourishment by other means (such as tube feeding or total parenteral nutrition).

Setup help – Assistance characterized by the provision of articles, devices, or preparation necessary for the person's self-performance of an activity. This includes giving or holding out an item the person takes from the helper, if the helper then leaves the person alone to complete the activity. If someone remains nearby to watch over the person, the person is receiving oversight, thus the response would be "Supervision." Following are a few examples of setup help. For the "Personal hygiene" item, setup help might mean providing a washbasin or grooming articles. For "Walking," it might take the form of handing the person a walker or cane.

Weight bearing – Persons require varying degrees of physical assistance to complete ADL tasks. A key concept in scoring the degree of assistance is the degree of weight-bearing support provided. When relating to non-upright positions, such support might take the form of a helper holding the full weight of an arm while assisting the person with putting on a shirt. When relating to standing or walking, such support might mean taking the person's weight by holding him or her under the armpit, or allowing the person to lean on the helper's arm. Guiding movements with minimal physical contact and contact guarding with intermittent physical assistance are **not** considered weight bearing.

Process

To describe functioning, the assessor should first get a sense of the episodes in each ADL area over the last 3 days. Determine what the person does for him- or herself and the nature of assistance provided (if any).

When ADL self-performance in an area varies over the last 3 days, identify the 3 most dependent episodes — that is, the episodes when the person received the greatest care or assistance from others. The summarization that is done to develop the ADL scores (as described below) focuses on the most dependent episodes, providing a picture of the person's need for help from others in managing the ADLs.

In order to summarize ADL self-performance, gather information as noted below.

- Gather information from multiple sources. For example, talk with the person, family, staff, and others.
- Ask questions pertaining to all aspects of the ADL definitions. For example, when discussing "Personal hygiene," inquire how the person manages washing in the morning, combing hair, brushing teeth, and shaving. A person can be independent in one aspect of personal hygiene yet require extensive assistance in another aspect.
- Observe how the person is performing the physical tasks.
- Talk with the person to ascertain what he or she does for him- or herself in each ADL, as well as the type and level of assistance provided by others.
- If possible, talk with immediate caregivers or family members.
- Finally, weigh all responses to come up with a consistent picture of the person's ADL performance for each episode assessed in each area.

Coding

The following are the ADL Self-Performance scoring rules.

If **all** episodes in the last 3 days were performed at the same support level, score the ADL at that level.

- Note that regarding the scores "Independent", "Total dependence", and "Activity did not occur", this is the only situation in which such a score would apply. In other words, to receive one of these scores, all performance episodes must be at the same level.
- Also note that this rule applies when there was only one performance episode during the 3-day period. For example, if over the course of the 3 days the person moved once between locations on the same floor but was bed-bound for the remainder of the time, then the score for "Locomotion" should be based on the single episode when the person moved.

If **any** episodes were at level "Total dependence" and other episodes were less dependent, the item should be scored "Maximal assistance".

Otherwise, focus on the three most dependent episodes (or the two most dependent episodes if the ADL was only performed twice). If the most dependent of these episodes would be scored "Independent, setup help only", score the item "Independent, setup help only". If the most dependent of these episodes would receive a higher score, however, the item should receive the score to match the

least dependent of those episodes in the range between "Supervision" and "Maximal Assistance".

In accordance with these rules and the guidelines, select the most appropriate response.

- Independent – No physical assistance, setup, or supervision in any episode.
- Independent, setup help only – Article or device provided or placed within reach, no physical assistance or supervision in any episode.
- Supervision – Oversight/cuing.
- Limited assistance – Guided maneuvering of limbs, physical guidance without taking weight.
- Extensive assistance – Weight-bearing support (including lifting limbs) by one helper where person still performs 50% or more of subtasks.
- Maximal assistance – Weight-bearing support (including lifting limbs) by two or more helpers; **or**, weight-bearing support for more than 50% of subtasks.
- Total dependence – Full performance by others during all episodes.
- Activity did not occur during entire period – Do not confuse a person's total dependence in an ADL activity with nonoccurrence of the activity itself. For example, even a person who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment) and must be evaluated under the eating category for his or her level of assistance in the process. A person who is highly involved in giving him- or herself a tube feeding should not be assessed as "Totally Dependent." Instead, the person should be assessed at an appropriate level based on the nature of the help received from others.

Here are general guidelines for recording accurate ADL Self-Performance:

- The coding scale for ADLs records the person's actual level of involvement in self-care and the type and amount of support actually received during the last 3 days.
- Do not base your assessment on the person's capacity for involvement in self-care — that is, what you believe the person **could** do for him- or herself.
- Do not record the type and level of assistance you think the person "should" be receiving (e.g., based on a written plan of care or expectations the family may have). The type and level of assistance actually provided might be quite different from what is indicated in a care plan. Record what is actually happening.
- Engage family (or, when possible, staff who have helped the person over the last 3 days) in discussions regarding the person's ADL functions. Remind these persons that the focus is on the last 3 days only. To clarify your own understanding and observations about each ADL activity (bed mobility, walking, transfer to toilet, etc.), ask probing questions, beginning with the general and proceeding to the more specific.

Primary Mode of Locomotion Indoors

Intent — To record the primary mode of locomotion and type of appliances, aids, or assistive devices the person used indoors over the last 3 days.

Definitions — Cane – A slender stick held in the hand and used for support when walking.

Crutch – A device for aiding a person with walking. Usually it is a long staff with a padded crescent-shaped portion at the top that is placed under the armpit.

Scooter – Motorized vehicle operated by a person for use in getting from one location to another.

Walker – A mobile device used to assist a person with walking. Usually consists of a stable platform made of metal tubing that the person grasps while taking a step. The person then moves the walker forward and takes another step.

Coding — Select the appropriate response for the primary mode of locomotion used by the person indoors within the last 3 days. For persons who walk by pushing a wheelchair in front of them for support, or by using a walker-type device such as a Merry Walker, select "Walking, uses assistive device."

- Walking, no assistive device
- Walking, uses assistive device – For example, a cane, walker, crutch, or pushing wheelchair
- Wheelchair, scooter
- Bed-bound

Activity Level

Intent — Moderate physical activity in connection with activities of everyday life or chosen activities can help to keep persons fit in many ways. Below a certain threshold of activity, functional decline may be accelerated.

It is necessary to understand whether the person is motivated to undertake physical activity, what the person's needs may be, what barriers need to be overcome, and whether health education is needed.

Many persons are interested in maintaining health. They usually know that lifestyle practices may be important, but they often need concrete information about how important their own lifestyle is for health maintenance. For example, the person may understand the general importance of exercise and good nutrition, but may not be willing or readily able to make changes in his or her lifestyle without some type of support or assistance.

Definition — Exercise or physical activity – Any exercise that involves at least moderate physical activity, such as walking outdoors, swimming, yoga, class, exercise with machines.

Went out of the house or building – This means the person went outdoors, no matter how short the period of time he or she spent outdoors. This could mean going into the yard, standing on an open porch, or walking down the street.

Process For "Exercise of physical activity," ask the person and family to describe the person's involvement in physical activity in the last 3 days (e.g., walking).

For "Went out of the house or building," ask the person or family if the person went outside in the last 3 days.

Coding For "Exercise of physical activity," if the accumulated time is between 2 hours and 3 hours, select "1–2 Hours.**"** Hours of exercise do not have to occur all at once on a given day; they may be accumulated over the course of several instances.

For "Went out of the house or building," if illness or weather did not permit (e.g., if it snowed or there was a "tropical" downpour) and the person did not leave the house but normally would have during a 3-day period, select "Did not go out in last 3 days, but usually goes out over a 3-day period."

Change in ADL Status as Compared to 90 Days Ago (Or Since Last Assessment if Less Than 90 Days Ago)

Intent To determine whether the person's current ADL status differs from the status of 90 days ago (or since the last assessment, if that was less than 90 days ago).

Process Talk to the person. Ask the person to think about how well he or she was able to perform ADLs 90 days ago. How does the person's current ADL status compare to 90 days ago? If indicated, talk to a family member or caregiver.

Coding If there is a change in multiple domains, select the response for the overall direction of change. Select the most appropriate response:

- Improved
- Declined
- No Change
- Uncertain

Overall Self-Sufficiency Has Changed Significantly as Compared to Status of 90 Days Ago (Or Since Last Assessment if Less Than 90 Days Ago)

Intent To monitor the person's overall self-sufficiency in the community over time. If this is the person's first assessment, include changes during the period prior to admission to the service agency.

Definition Overall self-sufficiency – Includes self-care performance and support, continence patterns, involvement patterns, use of treatments, etc.

Process Discuss with the person. If available, review clinical records, transmittal records (if new admission or readmission), previous assessments (if this is a reassessment), and any care plan notes if available. If necessary, discuss with a family member or caregiver.

Coding — Select the most appropriate response:

- Improved
- No Change
- Deteriorated

Driving

Intent — To evaluate one aspect of community independence and determine whether the person's driving is a concern.

Definitions — Drove car (vehicle) in the LAST 90 DAYS – For example, the person drove to a store, to visit, to a medical appointment.

If drove in LAST 90 DAYS, assessor is aware of whether someone has suggested that person limits OR stops driving.

Process — Ask the person about his or her driving and whether the person plans to continue driving. Be aware that driving may be a sensitive issue. Certain conditions may impair driving ability temporarily or on a more permanent basis. Ask whether the person thinks he or she is able to drive currently. If the person is unsure, recommend that before returning to driving, he or she talk to a physician, take a practice-driving test, or consult an occupational therapist or other appropriate professional(s) to assess driving capacity.

Transportation

Intent — To determine whether individual can physically tolerate, without substantial discomfort, transportation to access community-based programs and medical services outside the home.

Definition — Transportation includes automobile, taxi, van, etc. used to transport persons with disabilities. Inability to tolerate transportation, including the amount of time spent in transport, may necessitate that all services be provided in the home. Medical appointments may require special medical transportation.

Process — Ask the individual or family members, if they are available.

Section G. Continence

Bladder Continence

Intent — To determine and record the person's pattern of bladder continence (control) over the last 3 days.

Definition — This item describes the person's bladder continence pattern, taking into account any control plans or devices, such as scheduled toileting plans, continence training programs, or urinary appliances. It does not refer to the person's ability to toilet him- or herself — for example, a person may require extensive assistance in toileting and still be continent. Bladder incontinence includes any level of dribbling or wetting of urine.

Process

Review the person's urinary elimination pattern with him or her. Make sure that your discussions are held in private. Control of bladder function is a sensitive subject, particularly for persons who are struggling to maintain control. Many persons with poor control will try to hide their problems out of embarrassment or fear of retribution or institutionalization. Others will not report problems because they mistakenly believe that incontinence is a natural part of aging and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many persons are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive, straightforward manner.

Validate continence patterns with people who know the person well (such as family caregivers).

Remember to consider continence patterns over the last 3-day period, 24 hours a day, including weekends.

Coding

A six-level scale is used to describe continence patterns. Select the one response to indicate the person's level of urinary continence over the last 3 days.

- Continent – Complete control, including control achieved by cuing or supervision that involves prompted voiding, habit training, reminders, etc. The person **does not use** any type of catheter or other urinary collection device.
- Control with any catheter or ostomy – Control with use of any type of catheter or urinary collection device.
- Infrequently incontinent – Not incontinent over last 3 days, but does have incontinent episodes (i.e., a recent history of incontinence).
- Occasionally incontinent – Less than daily episodes of bladder incontinence (incontinent on 1–2 of the last 3 days).
- Frequently incontinent – Incontinent daily, but some control present (the person is not incontinent during each episode of urination). Example: During the day, the person remains dry and is continent of urine. At night, the person wets his or her bed.
- Incontinent – No control of bladder; multiple daily episodes all or almost all of the time.
- Did not occur – No urine output from bladder in last 3 days.

Select the response for the actual bladder continence pattern, with urinary device if used. This pattern is the frequency with which the person is wet during the 3-day assessment period. Do not record the level of control that the person **might** have had under optimal circumstances (e.g., had a caregiver been available 24 hours/day to help the person with toileting).

If you are uncertain whether to select "Frequently incontinent" or "Incontinent," decide based on the presence ("Frequently incontinent") or absence (**"**Incontinent**"**) of any bladder control.

Bowel Continence

Intent — To determine and record the person's pattern of bowel continence (control) over the last 3 days.

Definition — The term "bowel continence" refers to control of the person's bowel movements. This item describes the person's bowel continence pattern with any scheduled toileting plans, continence training programs, or appliances in use. It does not refer to the person's ability to toilet him- or herself — for example, a person can require extensive assistance in toileting and still be continent of stool.

Process — The assessment for bowel continence should be completed concurrently with the bladder continence review. Control of bowel function is also a sensitive issue. Be sure to ask about the matter in a sensitive, straightforward manner. If necessary, validate continence patterns with others who know the person (e.g., a family member). Remember to consider continence patterns over the **last 3 days, 24 hours a day.**

Coding — Select the most appropriate code.

- Continent – Complete control; the person **does not use** any type of ostomy device.
- Complete control with ostomy – Control with ostomy device over last 3 days.
- Infrequently incontinent – Not incontinent over last 3 days, but does have incontinent episodes.
- Occasionally incontinent – Incontinent less than daily.
- Frequently incontinent – Incontinent daily, but person has some control.
- Incontinent – No control present.
- Did not occur – No bowel movement in the last 3 days.

Section H. Disease Diagnoses

Diseases

Intent — To document the presence of diseases or infections relevant to the person's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. In general, these types of conditions are associated with the type and level of care needed by the person. Do not include conditions that have been resolved or no longer affect the person's functioning or care needs.

Definitions — ***Musculoskeletal***

Hip fracture during last 30 days (or since last assessment if less than 30 days ago) – Includes any hip fracture that that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, and subcapital fractures.

Other fracture during last 30 days (or since last assessment if less than 30 days ago) – Any fracture other than hip bone (e.g., wrist) due to any condition, such as falls or weakening of the bone as a result of cancer.

Neurological

Alzheimer's disease – A degenerative and progressive dementia that is diagnosed by ruling out other dementias and physiological reasons for the dementia.

Dementia other than Alzheimer's disease – Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurological diseases other than Alzheimer's (e.g., Pick's, Creutzfeldt-Jakob, Huntington's disease).

Stroke/CVA – A sudden rupture or blockage of a blood vessel within the brain, causing serious bleeding or local obstruction.

Cardiac or Pulmonary

Coronary heart disease – A chronic condition marked by the thickening and loss of elasticity of the coronary artery, and caused by deposits of plaque containing cholesterol, lipoid material, and lipophages.

Chronic obstructive pulmonary disease – Any long-standing condition that impairs airflow in and out of the lungs.

Congestive heart failure – A condition in which the heart cannot pump out all the blood that enters it, which leads to an accumulation of blood in the vessels, fluid in the body tissues, and lung congestion.

Psychiatric

Anxiety – A nonpsychotic mental disorder. There are five types, which include:

- Generalized anxiety disorder
- Obsessive-compulsive disorder
- Panic disorder
- Phobias
- Post-traumatic stress disorder

Bipolar disorder – Includes documentation of a clinical diagnosis of either manic depression or bipolar disorder. "Bipolar disorder" is the current term for manic-depressive illness.

Depression – A mood disorder often characterized by a depressed mood (e.g., the person feels sad or empty, appears tearful); decreased ability to think or concentrate; loss of interest or pleasure in usual activities; insomnia or hypersomnia; loss of energy; change in appetite; or feelings of hopelessness, worthlessness, or guilt. May also include thoughts of death or suicide.

Schizophrenia – A disturbance characterized by delusions, hallucinations, disorganized speech, grossly disorganized behavior, disordered thinking, or flat

affect. This category includes schizophrenia subtypes (i.e., paranoid, disorganized, catatonic, undifferentiated, residual).

Other

Cancer – Any malignant growth or tumor caused by abnormal and uncontrolled cell division. The malignant growth or tumor may spread to other parts of the body through the lymphatic system or the bloodstream.

Diabetes mellitus – Any of several metabolic disorders marked by persistent thirst and excessive discharge of urine.

Process — Talk to the person and review any available clinical records. Consult with the person's primary physician or nurse practitioner. Talk with family members.

Coding — Select the most appropriate response for all diseases present.

- Primary diagnosis/diagnoses for current stay – One or more diagnoses that are the main reason(s) used to support and justify services being provided.
- Diagnosis present, receiving active treatment – Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
- Diagnosis present, monitored but no active treatment – Person has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Section I. Health Conditions

Falls

Intent — To determine whether the person has a history of falling, which is an important factor in assessing the person's risk of future falls or injuries. Persons who have sustained at least one fall are at risk of future falls. Falls are a common cause of morbidity and mortality among persons in the home. Serious injury results from 6% to 10% of falls, with hip fractures accounting for approximately one-half of all serious injuries.

Definition — Fall – Any unintentional change in position where the person ends up on the floor, ground, or other lower level; includes falls that occur while being assisted by others.

Coding — Select the most appropriate response:

- No fall in last 90 days
- No fall in last 30 days, but fell 31-90 days ago
- One fall in last 30 days
- Two or more falls in last 30 days

Number of Falls

Intent — To record the number of falls in the last 90 days that resulted in major, minor, or no injury.

Definition — Major injury – refers to injuries such as bone fracture, joint dislocation, closed head injuries with altered consciousness, and subdural hematoma.

Minor injury – refers to injuries such as skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the person to complain of pain.

No injury – refers to no evidence of any injury is noted; no complaints of pain or injury by the member; no change in member's behavior is noted after the fall.

Coding — For each type of injury (major, minor, no injury), enter the number of falls that occurred in the last 90 days. If the number is greater than 99, enter 99.

Problem Frequency

Definition — ***Balance***

Dizziness – The person experiences a sensation of unsteadiness, that he or she is turning, or that the surroundings are whirling around.

Unsteady gait – A gait that places the person at risk of falling. Unsteady gaits take many forms. The person may appear unbalanced or walk with a sway. Other gaits may have uncoordinated or jerking movements. Examples of unsteady gaits include fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

Cardiac

Chest pain – The person experiences any type of pain in the chest area, which may be described as burning, pressure, stabbing, vague discomfort, etc.

Psychiatric

Abnormal thought process – When the person is observed, there are apparent abnormalities in the form or way in which the person is expressing thoughts. Examples of indicators for this item include:

- Loose associations – Person jumps from one topic to another without an apparent connection between the topics.
- Thought blocking – Person suddenly stops in the middle of a sentence and is unable to recover what he or she intended to say or to complete other thoughts.
- Flight of ideas – Person's thoughts are expressed so quickly that the listener has difficulty keeping up.
- Tangentiality – Person digresses from the subject under discussion and introduces thoughts that seem unrelated, oblique, or irrelevant.

- Circumstantiality – Person exhibits lack of goal-directedness, incorporates unnecessary details, and has difficulty getting to an end point in the conversation.
- Clang association – Connection between the person's thoughts is tenuous. The person may use rhyming and punning in his or her speech.
- Incoherence – Person's speech is unclear or confused. The communication does not make sense to the intended listener.
- Neologism – Person makes up a word, which may be condensed from several words. Neologisms are unintelligible to the listener.
- Punning – Person uses words that are similar in sound but different in meaning.

Delusions – Fixed, false beliefs not shared by others that the person holds even when there is obvious proof or evidence to the contrary. For example, the person may believe that he or she is terminally ill, that his or her spouse is having an affair, or that food served at a restaurant or congregate dining room is poisoned.

Hallucinations – The person has false perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (e.g., hearing voices), visual (e.g., seeing people or animals), tactile (e.g., feeling bugs crawling over the skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., experiencing strange tastes).

GI Status

Acid reflux – The regurgitation of small amounts of acid from the stomach to the throat.

Constipation – No bowel movement in 3 days, or difficult passage of hard stool.

Diarrhea – The frequent elimination of watery stools, regardless of cause.

Vomiting – Regurgitation of stomach contents, regardless of etiology (e.g., drug toxicity, influenza, psychogenic).

Sleep Problems

Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep – For example, the person:

- Experiences an extended time gap between the point at which he or she attempted to fall asleep and the time at which sleep was actually initiated;
- Wakes up well before the desired time due to some factor inherent to him or her (exclude situations in which the person is awakened by some external source)
- Experiences sleep that is accompanied by repeated tossing and turning, or dreaming that causes motion or wakefulness, etc., such that the person does not feel relaxed when sleeping and rested when awake
- Suffers from sleep apnea

- Is easily awakened during sleep by sounds or movements, and experiences one or more periods of awakening after sleep is initiated

Too much sleep – An excessive amount of sleep that interferes with the person's normal functioning.

Process Ask the person – he or she may not have told others of his or her symptoms. Ask family members or caregivers. Review any available clinical records.

Coding Select the most appropriate response:

- Not present
- Present but not exhibited in last 3 days
- Exhibited on 1 of last 3 days
- Exhibited on 2 of last 3 days
- Exhibited daily in last 3 days

Dyspnea (Shortness of Breath)

Definition The person has reported being, or has been observed to be, breathless or "short of breath."

Process Ask the person if he or she has experienced shortness of breath. If the answer is affirmative, determine if the symptom occurred with strenuous activity, during normal day-to-day activity, or when resting. If the person is unable to respond, review the clinical record and consult with other clinicians and the person's family.

Coding Select the appropriate response:

- Absence of symptom
- Absent at rest, but present when performed moderate activities
- Absent at rest, but present when performed normal day-to-day activities
- Present at rest

Responses should be for the most severe occurrence during the last 3 days. If the symptom was absent during the last 3 days, but would have been present had the person undertaken activity, select the response according to the activity level (day-to-day or moderate) that would normally have caused the person to experience shortness of breath.

"Moderate activities" include some type of physical exercise, such as walking a long distance, climbing two flights of stairs, or gardening. "Normal day-to-day activities" include all ADLs (bathing, transferring, etc.) and IADLs (meal preparation, shopping, etc.).

Fatigue

Intent To describe gradations of fatigue or impaired stamina. Fatigue is associated with some chronic diseases and end-stage conditions.

Definitions Fatigue – An overwhelming or sustained sense of exhaustion resulting in decreased capacity for physical or mental work.

Normal day-to-day activities – These include all ADLs (bathing, transferring, etc.) and IADLs (meal preparation, shopping, etc.).

Coding Select the appropriate response. If fatigue was absent over the last 3 days, but would have been present had the person undertaken activity, select the response according to the activity level that would normally have caused the person to experience fatigue.

- None
- Minimal – Diminished energy but completes normal day-to-day activities.
- Moderate – Due to diminished energy, **unable to finish** normal day-to-day activities.
- Severe – Due to diminished energy, **unable to start some** normal day-to-day activities.
- Unable to commence any normal day-to-day activities – Due to diminished energy.

Pain Symptoms

NOTE: Always ask the person about frequency, intensity, and control of the pain. Observe the person and ask others who are in contact with the person.

Intent To record the frequency and intensity of any pain the person may be experiencing. This item can be used to identify indicators of pain, as well as to monitor the person's response to pain management interventions. A substantial number of persons with pain receive inadequate or no treatment. In particular, persons with chronic, non-cancer-related pain are often overlooked and not treated. One of the biggest reasons for this is that many persons mistakenly believe that pain is to be expected as one ages, or that nothing can be done to relieve their pain.

Definition Pain – "An unpleasant sensory and emotional experience" that is generally associated with actual or potential tissue damage.

Process Pain is highly subjective. It is what the person says it is. There are no objective markers or tests to indicate when someone is having pain, or to measure its severity. What a person experiences may not be proportional to the type or extent of the underlying tissue damage. Sometimes, a specific cause for chronic pain cannot be identified. Regardless, unless the person refuses, pain must always be treated, even if its cause is unknown.

The most accurate and reliable evidence of the existence of pain and its intensity is what the person tells you. Even in cognitively impaired persons, self-reports of pain should be considered reliable.

You may not get an accurate answer if you simply ask "Are you in pain?" A person may think of "pain" as a more intense experience after an acute event — such as what may be experienced after surgery or spraining an ankle. For example, a woman may have a sore foot that "acts up" when she pivots to transfer

to her wheelchair or the toilet but does not bother her most of the time. So she might deny being "in pain." Persons often use different words in describing pain, referring to what they're feeling as "discomfort," " burning," "hurting," "aching," "tightness," "heaviness," "soreness," or a "twinge" or "pang."

If the person states he or she has pain, ask about the degree of control. If the person is unable to tell you if he or she is experiencing some type of painful sensation, observe the person for indicators of pain such as moaning, wincing, or guarding. In some persons, the presence of pain can be hard to discern. For example, persons with dementia may not be able to verbalize that they are feeling pain, although they may manifest pain by particular behaviors such as calling out. Although such behaviors may not be indicative solely of pain, the assessor needs to make a determination (through assessment) if the behaviors are secondary to pain. If necessary, ask those who have had frequent contact with the person whether he or she complained or showed evidence of pain in the last 3 days. All pain items except "Frequency With Which Person Complains or Shows Evidence of Pain" have a 3 day look back period. However, the person must **first** be asked directly about frequency and intensity.

Frequency With Which Person Complains or Shows Evidence of Pain

Definition — Measures how often the person experiences pain (reports or shows evidence of pain); includes grimacing, teeth clenching, moaning, withdrawal when touched, and other nonverbal signs suggesting pain.

Coding — Select the appropriate response:

- No pain
- Present but not exhibited in last 3 days
- Exhibited on 1-2 of last 3 days
- Exhibited daily in last 3 days

Intensity of Highest Level of Pain Present

Definition — Measures the level of pain reported by or observed in the person.

Coding — Select the appropriate response:

- No pain
- Mild
- Moderate
- Severe
- Times when pain is horrible or excruciating

Consistency of Pain

Definition — Measures the frequency (ebb and flow) of pain from the person's perspective.

Coding — Select the appropriate response:

- No pain
- Single episode during last 3 days

- Intermittent
- Constant

Breakthrough Pain

Definition The person experienced a sudden, acute flare-up of pain one or more times in the last 3 days. Breakthrough pain might appear as a dramatic increase in the level of pain above that addressed by ongoing analgesics, or the recurrence of pain associated with end-of-dose failure.

Pain Control

Definition The ability of the current therapeutic regimen to control the person's pain adequately (from the person's point of view). This item describes the adequacy or inadequacy of pain control measures (such as medications, massage, TENS, or other therapeutic regimen) instituted by the person, caregiver, or clinical staff caring for the person.

Coding Select the appropriate response:

- No issue of pain
- Pain intensity acceptable to person; no treatment regimen or change in regimen required
- Controlled adequately by therapeutic regimen
- Controlled when therapeutic regimen followed, but not always followed as ordered
- Therapeutic regimen followed, but pain control not adequate
- No therapeutic regimen being followed for pain; pain not adequately controlled

Instability of Conditions

Definitions Conditions/diseases make cognitive, ADL, mood, or behavior patterns unstable (fluctuating, precarious, or deteriorating) – For example, the person may have a condition such as ulcerative colitis, rheumatoid arthritis, or multiple sclerosis that causes pain or impairs mobility or sensation, resulting in increased dependence on others and depression.

Experiencing an acute episode or a flare-up of a recurrent or chronic problem – The person is symptomatic for an acute health condition (such as new myocardial infarction, adverse drug reaction, or influenza) or recurrent acute condition (such as aspiration pneumonia or urinary tract infection). Also included are persons who are experiencing an exacerbation or flare-up of a chronic condition (e.g., new-onset shortness of breath in someone with a history of asthma, or increased pedal edema in a person with congestive heart failure). This type of acute episode usually is of sudden onset, has a time-limited course, and requires evaluation by a physician.

Process Consult with the person and the person's family. Review any clinical records.

Self-Reported Health

Process Ask the person: "In general, how would you rate your health?" Record the person's response according to one of the categories below. Do not code based on your own inferences about the person's physical health and do not record ratings given by family, friends, or other informants. This item should be treated strictly as a self-report measure. If the person is unable (e.g., due to cognitive impairment) or refuses to respond, do not dwell on the item and do not presume responses for the person; instead, code that the person could not/would not respond.

Coding Select the appropriate response:

- Excellent
- Good
- Fair
- Poor
- Could not (would not) respond

Tobacco, Alcohol and Substance Abuse

Smokes Tobacco Daily

Intent To determine whether the person smokes tobacco.

Definition Tobacco – Refers to cigar, cigarette, or any other tobacco product that is inhaled.

Process Ask the person directly. This information may be sensitive to the person or create feelings within the assessor. Care must be taken to acknowledge these feelings. Begin asking the person about tobacco usage, with a simple nonjudgmental question, "Do you smoke?" If yes, determine the frequency. Address this issue in a gentle way to avoid the person feeling judged or as though he or she is doing something wrong. For example, you might say "Like the other questions I asked, I am just trying to find out about you. It doesn't mean that what you are doing is wrong." Validate tobacco usage with a family member or caregiver. This discussion should not take place in front of the person.

Coding Select the appropriate response:

- No
- Not in last 3 days, but usually a daily smoker
- Yes

Smokes Safely

Intent To determine whether the person's smoking is a safety risk to self or others.

Definition The person has reported or been observed smoking tobacco products such as cigarettes, cigars, or a pipe in an unsafe manner. Smoking marijuana or other substances may pose a similar risk.

Process Interview the person and/or others living in or visiting the household. Observations of the individual smoking are also valuable in determining whether

the person can safely light, hold, and extinguish the substance. Such behaviors as dropping cigarettes on the floor, carpet, or clothing; failing to properly extinguish a cigarette; smoking while in bed or a recliner are examples of unsafe behaviors which would place the person at risk for burns or starting a fire.

Chews Tobacco Daily

Intent — To determine if the person chews tobacco placing him/her at risk for oral cancer.

Definition — The person has reported or been observed using chewing tobacco.

Process — Ask the person directly. This information may be sensitive to the person or create feelings within the assessor. Care must be taken to acknowledge these feelings. Begin asking the person about tobacco usage, with a simple nonjudgmental question, "Do you use chewing tobacco?" If yes, determine the frequency. Address this issue in a gentle way to avoid the person feeling judged or as though he or she is doing something wrong. For example, you might say "Like the other questions I asked, I am just trying to find out about you. It doesn't mean that what you are doing is wrong." Validate tobacco usage with a family member or caregiver. This discussion should not take place in front of the person.

Coding — Select the appropriate response:

- No
- Not in last 3 days
- Yes

Alcohol

Intent — To determine if a person's consumption of alcohol is a potential problem by identifying the highest number of alcoholic drinks the person had in a "single sitting" during **the last 14 days.**

Definitions — Alcohol – Includes beer, wine, mixed drinks, liquor, and liqueurs.

Single sitting – Refers to any given point in time (e.g., at dinner, after work, while out at a social event, watching television).

Process — Ask the person directly about whether he or she consumes alcohol. Consult with a family member if necessary. Sometimes it is prudent to talk to the person and family separately. Start by asking the person, "Do you drink alcoholic drinks?" If yes, then ask, "When you look back over the last 14 days, what is the highest number of drinks you had in a single sitting?"

Coding — Select the appropriate response based on the highest number of drinks ingested by the person at one sitting over the last 14 days.

- None
- 1
- 2-4
- 5 or more

Presence of Behavioral Indicators of Potential Substance-Related Addiction in Last 90 Days

Intent — To identify behaviours that would indicate the person may have a problem with an alcohol or drug addiction. Note: These observations may be reported by the person him/herself ***or*** by others.

Definitions — Felt the need to or was told by others to cut down on drinking or drug use, or others were concerned about person's substance use — others in his/her life or the person him/herself expresses concern regarding his/her alcohol consumption or use of substances. The concern may have various motivations. For example, a person may be concerned about the amount he/she is drinking since finding out about a friend who recently died from liver disease, or a spouse may express concern that the person has been drinking too much since losing a job. The person, family, or others may also report that there has been trouble because of substance use. For example, family or friends may have withdrawn because of the behavior of the person when drunk or high, or the person's driver's licence may have been taken away because of driving while under the influence of alcohol/drugs.

Has been bothered by criticism from others about drinking or drug use – the person, family members, or others indicate that the person becomes angry or agitated when others express disapproval of the substance use. The person may express that it is "no one else's business how much I drink," or that others are too critical and there is nothing wrong with having a few drinks or using a few drugs.

Has reported feelings of guilt about drinking or drug use – the person, family, or others report that the person has experienced feelings of guilt related to his/her substance use. This guilt could have several origins. For example, the person may feel guilty about the emotional and financial distress it has caused the family, the embarrassment it has caused loved ones, or the way he/she treats others when under the influence of alcohol/drugs.

Had to have a drink or use drugs first thing in the morning to steady nerves, e.g., an "eye opener" – the person, family, or significant others report that the person drinks/uses drugs or had been observed to do so early in the day. The person may use the expression "I need an eye opener."

Feels social environment encourages or facilitates abuse of drugs or alcohol – the person acknowledges (or the family or significant others report) that he/she maintains regular contact with individuals who drink alcohol or use drugs and that this contact makes it more likely that he/she will drink or use drugs when they interact.

Process — Engage the person in a conversation about his/her patterns of substance use. This information may be a sensitive issue for the person and may cause uneasy feelings for the assessor. Care must be taken to acknowledge these feelings. Begin asking about alcohol/drugs with a simple non-judgmental statement like "Do you drink?" or "Do you ever get high?" It is important that the person not feel judged as though he/she is doing something wrong. Address substance use in a gentle way.

For example, say "Like the other questions I asked, I am just trying to find out about you. It doesn't mean that what you are doing is wrong." Ask how he/she feels about his/her drinking/drug use and whether others express disapproval of this behavior. If others express disapproval, ask how this criticism makes the person feel. Discuss the person's substance use with family members, but not with the person present.

Coding: Select the appropriate response based on the presence of indicators in last 90 days, regardless of the amount or number of days of drug/alcohol use, the number of people who were concerned, or the number of times the concerns were raised. Indicators can be reported by the person or by others who know him/her.

Section J. Nutritional Status

Nutritional Issues

Intent Marked, unintended declines in weight can indicate failure to thrive or be a sign of a potentially serious medical problem or poor nutritional intake due to physical, cognitive, or social factors.

Definitions

Process Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS – ask the person or family about weight changes over the course of the past 30 to 180 days. Use actual records of weight if available. A subjective estimate of weight change from the person or caretaker can be used if no written records are available. Identifying a particular time approximately 6 months earlier (such as "compared to last New Year's") may help the person remember his or her approximate weight 180 days ago. You may be able to help the person answer the question by asking "How much weight do you think you have lost?" then mentally compare this with the reported, or your estimated, current weight of the person. You can also ask, "Have you lost a lot of weight? Do you feel much thinner or weaker?" or "Your clothes seem very loose on you. Were you much heavier 6 months ago?"

Dehydrated or BUN/creatinine ratio > 25 – Identifying dehydration can be difficult. Record your clinical judgment based upon signs and symptoms (for example, severe vomiting over a period of time). Alternatively, laboratory results indicating dehydration may be available (that is, BUN/creatinine ratio of >25.

Fluid intake less than four 8 oz. cups per day (or less than 1,000 cc per day) – Person did not consume all/almost all fluids during the last 3 days.

Fluid output exceeds input – Fluid loss exceeds the amount of fluids the person takes in (e.g., loss from vomiting, fever, or diarrhea that exceeds fluid replacement).

Mode of Nutritional Intake

Intent — The ability to swallow safely can be affected by many disease processes and by functional decline. Alterations in one's ability to swallow could result in choking and aspiration, both of which can cause morbidity and mortality. Often, persons with swallowing difficulties require altered consistencies of food and fluids in order to ingest nutrition by mouth. This item details any dietary modifications necessary to address swallowing difficulties.

Process — Observe and talk with the person. If available, review the person's clinical record, including MD, dietitian, and speech-language pathology notes if applicable.

Coding — Select the response that best describes the dietary prescription used to accommodate swallowing difficulties.

- Normal – Person swallows all types of foods.
- Modified independent – For example, liquid is sipped, or person takes limited solid food; need for modification may be unknown.
- Requires diet modification to swallow solid food – For example, mechanical diet (pureed, minced, etc.) is required, or person is only able to ingest specific foods.
- Requires modification to swallow liquids – For example, liquids must be thickened.
- Can swallow only pureed solids AND thickened liquids.
- Combined oral and parenteral or tube feeding.
- Nasogastric tube feeding only.
- Abdominal feeding tube – For example, a percutaneous endoscopic gastrostomy (PEG) tube.
- Parenteral feeding only – Includes all types of parenteral feedings, such as total parenteral nutrition (TPN).
- Activity did not occur – Person did not eat or receive any form of nutritional supplementation during the last 3 days.

Section K. Medications and Allergies

Person Requires Either Prescription or Over-the-Counter medication?

Intent — To facilitate a medication evaluation by having a single listing of all prescribed and non-prescribed medications taken by the person. This section will help clinicians identify potential problems related to the consumption of, or failure to take, medications (such as any physical or emotional problems an individual may experience as the result of taking one or more medications). For example, identifying how frequently an individual uses a PRN (as needed) pain medication, sleeping medication, or laxative may lead the clinician to do further assessment of the underlying problems that prompted their use. It may also help the clinician identify medications that might cause specific problems, such as incontinence or delirium.

Definitions — Medications – These include all prescribed, non-prescribed, and over-the-counter medications that the person consumed in the last 3 days. Medications may be taken by mouth, placed on the skin or in the eyes, injected, given intravenously, etc. This includes prescriptions now discontinued but taken in the last 3 days and drugs prescribed PRN that were taken during this period. It also includes medications that are prescribed on a maintenance schedule, such as vitamin injections given once a month, even if they were not given in the last 3 days.

Process — Ask the person, and family members when appropriate, if any medications were taken in the last 3 days.

Record all prescription and over-the-counter medications in the "Medications" section.

Allergy to Any Drug

Intent — To determine if the individual has any known allergies to either prescription or over-the-counter medications.

Definition — The presence of an allergy would be determined by a history of a serious negative reaction to a particular drug or category of drugs.

Process — Ask the person whether he or she is allergic or has ever had a reaction to any drug(s). Include reactions to both prescription and over-the-counter drugs administered by any route.

Coding — Select the appropriate response:

- No known drug allergies
- Yes

Identify allergic drug or category of drugs

Coding

Enter the name of the drug or category of drugs to which the individual is allergic.

Use the text box to record other allergies of the individual.

Other Non-Drug Allergies

Intent — To identify any known allergies the person may have, other than drug allergies.

Definition — The presence of an allergy would be determined by a history of a serious negative reaction to such allergens as dust, pollen, foods, pets, insect bites, etc.

Process — Ask the person to describe any known allergies and determine if the allergy was reported to and diagnosed by a physician. Determine what remedies or actions were prescribed to treat the allergic reaction. List any allergies that the person appears to have.

Coding — Use the text box to record other non-drug allergies of the individual.

Section L. Treatments and Procedures

Prevention

Intent — This item helps to identify whether the person has unmet needs for health counseling and preventive care.

Process — Ask the person if he or she received the following specific health measures.

Blood pressure measured in LAST YEAR – The person's blood pressure was measured by a clinician during the past year.

Colonoscopy test in LAST 5 YEARS – The entire colon (from anus to cecum) was viewed by means of a fiber-optic colonoscopy within the past 5 years.

Dental exam in LAST YEAR – The person underwent a dental examination by a dentist within the past year.

Eye exam in LAST YEAR – The person underwent an eye examination by an ophthalmologist, optometrist, physician, nurse, or other clinician within the past year.

Per NYS Medicaid Program Vision Care Manual Policy Guidelines, an optometric eye exam is comprised of, at a minimum, a case history, an internal and external eye examination, objective and subjective vision corrections/determination of refractive state, binocular coordination testing, gross visual field testing and tonometry for recipients age 35 and over or others where indicated, performed by licensed professionals within the field.

https://www.emedny.org/ProviderManuals/VisionCare/PDFS/VisionCare_Policy_Guidelines.pdf

If the response is 'Yes' (per NYS Medicaid Program Vision Care Manual Policy Guidelines), document the following information in Section L Comment Box: the name and license number of the professional who conducted the eye exam (if known) and the approximate date the exam was conducted.

Hearing exam in LAST 2 YEARS – The person underwent a hearing examination by an audiologist or other clinician within the past 2 years.

Per NYS Medicaid Program Hearing Aid/Audiology Services Policy Guidelines, other clinician means (in addition to audiologist) hearing aid dispenser, certified clinic or speech and hearing center, with the appropriate specialty. Hearing screening and testing can be provided by any licensed practicing provider who may administer hearing services within their scope of practice using accepted standards and practices for screening, medical clearance, testing and evaluation.

https://www.emedny.org/ProviderManuals/HearingAid/PDFS/HearingAid_Policy_Guidelines.pdf

If the response is 'Yes' (per NYS Medicaid Program Hearing Aid/Audiology Services Policy Guidelines), document the following information in Section L Comment Box: the name of the license number of the professional who conducted the hearing exam (if known) and the approximate date the exam was conducted.

Influenza vaccine in LAST YEAR – The person received a vaccination for influenza prevention during the past year.

Mammogram or breast exam in LAST 2 YEARS (for women) – The person had either a mammogram or a breast examination by a clinician during the past 2 years.

Pneumococcal vaccine in LAST 5 YEARS or after age 65 – The person received the vaccine for prevention of pneumonia within the past 5 years or after age 65.

Hospital Use, Emergency Room Use, Nursing Facility Use, Physician Visit in Last 90 Days (Or Since Last Assessment if Less Than 90 Days Ago)

Inpatient Acute Hospital with Overnight Stay

Intent	To record how many times the person was admitted to the hospital with an overnight stay in the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago).
Definition	The person was formally admitted as an inpatient (by physician's order), and stayed over one or more nights. It does not include admissions for day surgery, outpatient services, etc.
Process	Review prior hospitalizations with the person and family. If available, review the clinical record. Sometimes transmittal or billing records from recent hospital admissions are available.
Coding	Enter the number of hospital admissions in the box. Enter **"0"** in both boxes if no hospital admissions occurred in the last 90 days.

Emergency Room Visit (including overnight observation stay, but not accompanied by an overnight hospital admission.)

Intent	To record whether, during the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago), the person visited a hospital emergency room (e.g., for treatment or evaluation).
Definition	A visit to an emergency room including overnight observation stay, but not accompanied by an overnight hospital admission.
Process	Ask the person and family and review transmittal records if available.
Coding	Enter the number of ER visits in the last 90 days (or since last assessment). Enter **"0"** in both boxes if no ER visits occurred. Do not include instances in which the person was admitted to the hospital for an overnight stay after being seen in the ER.

Physician Visit (Or Authorized Assistant or Practitioner)

Intent — To record the person's visits to (or from) doctors and authorized assistants or practitioners during the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago).

Definition — A visit to a medical provider's office or clinic by the person, or a medical provider's visit to the person's home. This item includes a very broad spectrum of medical providers and specialists — for example, MDs or osteopaths who may be either the primary physician or consultant(s); authorized physician's assistants; or nurse-practitioners.

Coding — Enter the number of visits with a physician or authorized assistant or practitioner during the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago). Enter "0" in both boxes if no visits occurred.

Nursing Facility Use

Intent — To record the person's use of a nursing facility during the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago).

Definition — The person was in an approved nursing facility (nursing home) for rehabilitation, respite or long-term care services.

Coding — Enter the number of days the individual used a nursing facility during the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago). Enter "0" in both boxes if no use occurred.

Clinical Reason(s) For Hospitalization

Coding — If the individual had an overnight hospital stay as an inpatient, record the clinical reason for the hospitalization using the reasons below. Up to four (4) reasons may be selected. The possible responses are:

- Improper medication administration, medication side effects, toxicity, anaphylaxis
- Injury caused by fall or accident at home
- Respiratory problems (SOB, infection, obstruction, COPD, pneumonia)
- Wound or tube site infection, deteriorating wound status, new lesion/ulcer
- Hypo/Hyperglycemia, diabetes out of control
- GI bleeding, obstruction
- Exacerbation of CHF, fluid overload, heart failure
- Myocardial infarction, stroke
- Chemotherapy or other cancer-related admission
- Scheduled surgical procedure
- Urinary tract infection
- IV catheter-related infection
- Deep vein thrombosis, pulmonary embolus
- Uncontrolled pain (including back pain)
- Psychotic episode or other change in mental status

- Other than above reasons
- Unknown

Clinical Reason(s) For Emergency Room Use

Coding If the individual visited a hospital ER for treatment or evaluation, not including any ER visits that were accompanied by an overnight hospital stay, record the clinical reason for the visit using the reasons below. Up to four (4) reasons may be selected. The possible responses are:

- Improper medication administration, medication side effects, toxicity, anaphylaxis
- Nausea, dehydration, malnutrition, constipation, impaction
- Injury caused by fall or accident at home
- Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction)
- Wound infection, deteriorating wound status, new lesion/ulcer
- Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain)
- Hypo/Hyperglycemia, diabetes out of control
- GI bleeding, obstruction
- Other than above reasons
- Reason unknown

Reason(s) For Nursing Home Use

Coding If the individual used a nursing facility within the last 90 days (or since last assessment if less than 90 days), record the clinical reason for the use using the reasons below. Up to four (4) reasons may be selected. The possible responses are:

- Therapy services
- Respite care
- End of life care
- Permanent placement
- Unsafe for care at home
- Other
- Unknown

Section M. Social Supports

Strong and Supportive Relationship with Family

Definition The person indicates he or she has a supportive relationship with family members. The person may feel able to "rely on" family members. Family members may be actively involved in the person's physical care, maintaining the household, managing finances, or helping the person make medical decisions.

Strong and Supportive Relationship with Surrounding Community

Definition — The person indicates he or she has a supportive relationship with members of the surrounding community. The person may feel able to "rely on" members of the surrounding community. Members of the surrounding community may be actively involved in the person's physical care, maintaining the household, managing finances, or helping the person make medical decisions.

Section N. Environmental Assessment

Finances

Intent — To determine if limited funds prevented the person from receiving required medical and environmental support.

Definition — Limited funds – Because of insufficient funds during the last 30 days, the person made trade-offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care.

Process — Ask the person, or caregiver, if prescribed medications, sufficient home heat (electricity, gas), necessary medical care, or adequate food were not obtained due to insufficient funds. Asking financial questions can be a sensitive area. Questioning must be sensitive and respectful to the person.

SIGN/FINALIZE

This section is designed to record the RN Assessor signature and sign/finalize the assessment. Signing/Finalizing an assessment in the UAS-NY consists of an electronic signature (or e-signature) process; no paper is involved.

RN Assessor Signature: Only one RN Assessor may conduct and sign/finalize an assessment. The RN Assessor indicates they are the only contributor to the assessment (if true) and signs/finalizes the assessment. Once the RN Assessor signs/finalizes the assessment, it cannot be further edited without supervisor intervention. Only an RN Assessor Supervisor can unsign/unfinalize an assessment once it has been signed/finalized by an RN Assessor. The original RN Assessor must then re-sign/re-finalize the assessment before the system locks the assessment.

- **IMPORTANT:** The Community Health Assessment is a nursing assessment and, as such, New York State Education Department Law (NYS Education Law, Article 139, Nursing aka the Nurse Practice Act) requires the assessment be conducted and signed/finalized by a licensed Registered Nurse (RN). As the UAS-NY is a legal document, in order to maintain the integrity of their RN license, the RN cannot delegate any portion of the *Community Health Assessment*, including any triggered supplements, or any data entry of the assessment to other staff.

Process

The RN Assessor will complete and review the entire assessment. The RN Assessor will then record their name, license number, title, and any comments. The RN Assessor will click the box to "sign/finalize" the assessment. The UAS-NY will automatically populate the user id, user name as it appears in the HCS (this is separate from the signature), organization name, date, and time fields.

Once this process is complete, the UAS-NY Community Health Assessment may not be further edited without an RN Assessor Supervisor unsigning/unfinalizing the assessment.

[Deprecated as of version 1.13] Optional Social Assessor Signature **(Local Department of Social Services (LDSS) only)**: Social Assessor contribution is allowed but not required when conducted by an LDSS (UAS-NY Policy 18.1 *Change to LDSS Assessment Requirements*). A Social Assessor may conduct parts of the assessment, as appropriate to their education level and as directed by their organization, collaboratively with RN Assessor oversight. Under no circumstances can a Social Assessor conduct the majority of the assessment. Only one Social Assessor contribution and signature is permitted. *The RN Assessor will have final word on all assessment questions as they are responsible for reviewing and signing/finalizing the assessment under their RN license*. If a Social Assessor did not contribute to the assessment, then this signature is not required.

[Deprecated Process]

Once the Social Assessor, if applicable (LDSS Only), has completed his/her sections of the UAS-NY Community Health Assessment, the Social Assessor will enter his/her name, title, and any comments. The Social Assessor will then click the box to

"sign" the UAS-NY Community Health Assessment. The UAS-NY will automatically populate the user id, user name as it appears in the HCS (this is separate from the signature), organization name, date, and time fields.

Service Needs

Intent — To assist in determining the person's appropriateness for community-based services.

Process — Upon completion of the UAS-NY Community Health Assessment, the assessor will use the information gathered during the assessment with his/her clinical judgement to respond to each of the following items:

- Is the person expected to need continued services for a period of 120 days or more from the assessment date?
- Can care to address the person's needs be scheduled? – Based on the information gathered during the assessment, assessor will indicate if a regular, periodic schedule can be arranged to provide the anticipated services. This would exclude care that is required 24 hours per day, 7 days per week, because the frequency of care throughout the 24-hour period cannot be anticipated. If services **cannot** be scheduled, documentation MUST be made in Assessor Comments.
- Can person be left alone safely?

Coding — Select the most appropriate response.

- No
- Yes

ASSESSMENT OUTCOMES

[Deprecated as of February 13, 2020] *The original Assessment Outcomes section was retired on February 13, 2020 as it is no longer required. Assessments completed prior to this date will contain Assessment Outcomes legacy data, which is accessible in read only mode.*

For Persons under 18 years of age

Process — Has the person been determined physically disabled based on SSI criteria?

Coding — Select the most appropriate response.

- No
- Yes

Process — If the person could not be cared for at home he/she would require:

Coding The assessor will also determine the level of care required if the person cannot be cared for at home. The potential responses are:

- Skilled Nursing Facility (SNF)
- Hospital (technology dependent, e.g., vent)
- Other Level of Care (LOC)

Referral Recommendation: Community

Intent To identify the type of residence a person will require in order to receive community-based services.

Coding Select the appropriate response for each program.

- In own home or home of a friend or family member
- In Adult Care Facility or assisted living with additional support and supervision

Referral Recommendation: Not Community

Intent To identify the reasons why community-based services are not appropriate for the person and why nursing home placement may be necessary.

Coding Select all of the relevant reasons for not recommending community-based services. The reasons may be:

- Adequate informal supports for assistance and/or emergency back-up are not available, and person cannot be left alone.
- Person is medically complex, and skilled nursing services and monitoring required is not available in the home, in an adult day health-care program/assisted-living program, or on an outpatient basis.
- Restorative therapy services are required, and the type, frequency, and duration cannot be provided in the community.
- Person does not have an available home in the community (does not own or rent a home, is not eligible for an Adult Care Facility/Assisted Living or cannot live with family or friends).
- Person has a home but it is not safe, adequate, or accessible to support community-based services.
- Appropriate community-based living cannot be arranged because person's behaviors are a risk to self and others.
- Nursing home placement has been requested by the person and confirmed.

Assessor Recommendations

Intent To record the assessor program/plan recommendations.

Coding Use the drop-down menu to select **up to** three long-term care program/plan recommendations.

Assessor Signature

Intent To record a signature in the outcomes of the nurse who conducted the assessment.

Coding Enter the following information:

- Assessor Name
- Assessor Title
- Assessor Comments

Practitioner Order

The Practitioner Order (PO) is a required node if the assessed individual potentially qualifies for Personal Care Services (PCS) or Consumer Directed Personal Assistance Program (CDPAP) services or has a legacy status.

Practitioner Name

Intent To document the practitioner who is conducting the medical exam.

Definition The Practitioner Name is the practitioner conducting the medical exam and completing the Practitioner's Order Form for the individual.

Coding Enter the name of the practitioner conducting the medical exam and completing the Practitioner's Order Form.

Practitioner License Number

Intent To document the associated license number of the practitioner conducting the medical exam and completing the Practitioner's Order Form for the individual.

Definition The six-digit license number associated with the practitioner conducting the exam and whose name is entered above.

Coding Enter the license number of the practitioner conducting the exam.

Date of medical exam

Intent To document the date that the qualifying medical exam, performed by a clinician, occurred.

Definition The date of the medical exam is the date the medical exam was performed.

Coding Enter the date of the medical exam in the following format: MM/DD/YYYY.

Is individual's condition stable?

Intent To designate whether the individual's condition is stable, per the medical exam referenced in the Practitioner's Order Form.

Definition A stable medical condition shall be defined as follows:

(a) the condition is not expected to exhibit sudden deterioration or improvement; and

(b) the condition does not require frequent medical or nursing judgment to determine changes in the individual's plan of care; and

(c) (1) the condition is such that a physically disabled individual is in need of routine supportive assistance and does not need skilled professional care in the home; or

(2) the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.

Coding Select the appropriate response:

- No selection
- No
- Yes

Practitioner Order Attachment

The Practitioner's Order Form must be obtained from a medical professional contracted with the Department of Health's Independent Practitioner Panel. The attributes of the Practitioner Order section must be reflective of the uploaded PDF file. The uploaded file must be the completed, signed DOH Practitioner's Order Form. The Practitioner's Order Form contains sensitive Protected Health Information whose management should adhere to current HIPAA guidance.

Independent Review Panel

Independent Review Panel

An Independent Review Panel (IRP) Report and Recommendation Form for High Needs Cases is required for cases with a proposed care plan that includes more than 12 hours of PCS and CDPAS per day on average.

Lead Physician Name

Intent To capture the name of the physician (MD or DO) overseeing the IRP's work and signing the report and recommendation.

Definition The Lead Physician Name is the physician selected to coordinate the activities of the independent review panel and sign the IRP report form.

Coding Enter the name of the physician leading the independent review panel and signing the IRP report form.

Lead Physician License Number

Intent To ensure the identity of the lead physician (MD or DO) coordinating the IRP and signing the report and recommendation.

Definition The six-digit license number associated with the physician leading the independent review panel and whose name is entered above.

Coding Enter the license number of the lead physician of the independent review panel.

Referring MCO/LDSS Name

Intent To capture the authorizing entity that developed the plan of care under IRP review.

Definition The name of the entity (MCO or LDSS) referring the individual's plan of care to the IRP.

Coding Enter the name of the entity (MCO or LDSS) referring the individual's plan of care to the IRP.

Date of Plan of Care

Intent To capture the date on the plan of care being reviewed by the IRP.

Definition The date of most recent Plan of Care that is being reviewed by the panel.

Coding Enter the date of most recent Plan of Care that is being reviewed by the panel in the following format: MM/DD/YYYY.

Signature Date of IRP Form

Definition The signature date of the IRP form is the date the lead physician signed and certified the report.

Coding Enter the signature date of the IRP form in the following format: MM/DD/YYYY.

Is the patient's plan of care reasonable and appropriate to maintain the patient's health and safety in her or her own home?

Definition Based on the thorough review of the patient's most recent independent medical professional evaluation, plan of care, community health assessment and, where applicable, other relevant medical records and meetings with the individual and/or the individual's provider(s), the Panel provides a recommendation on the reasonableness and appropriateness of the proposed plan of care to maintain the patient's health and safety in his or her own home, in accordance with regulatory standards.

Coding Select the appropriate response:

- No
- Yes

IRP Report Form Attachment

The independent medical review must be performed by an independent panel of medical professionals, or other clinicians, employed by or under contract with an entity designated by the Department of Health. The attributes of the Independent Review Panel (IRP) Report section must be reflective of the uploaded PDF file. The uploaded file must be the completed, signed Independent Review Panel Report and Recommendation Form for High Needs Cases. The IRP Report contains sensitive Protected Health Information whose management should adhere to current HIPAA guidance.

FUNCTIONAL SUPPLEMENT

One of the unique aspects of the UAS-NY Community Health Assessment is the inclusion of the Functional Supplement. This supplement enables the assessor to review an expanded set of items related to a person's function, health, social support, and service use. Particular Functional Supplement items also identify persons who could benefit from further evaluation of specific problems or risks for functional decline. The Functional Supplement may be "triggered" based on responses in the Community Health Assessment. Assessors have the option to complete the Functional Supplement if it is not triggered.

Section A. Identification Information

Functional Supplement Reference Date

Intent — To establish a common period of observation as a reference point for each completed assessment.

Definition — The designated end point of the common observation period for items on the Functional Supplement. Except where otherwise noted, all information gathered about the person pertains to the 3-day period prior to and including the Functional Supplement Assessment Reference Date for items pertaining to the person's status or performance.

Home-based assessments are usually completed using information gathered during a single visit. However, when an assessment carries over to a second visit, information for the remaining Functional Supplement items must be for the time period established by the original Functional Supplement Assessment Reference Date.

This date can be different from date of Community Health Assessment Reference Date.

Coding — Use the calendar to select the correct month, day, and year.

Living Arrangement

Intent — To record with whom the person lives and the duration of this arrangement. These items will help the staff determine the need for more, fewer, or different services.

Definition/ Process — As compared to 90 DAYS AGO (or since last assessment), person now lives with someone new – This item indicates whether a person's living situation has changed in the last 90 days. For example, the person has moved in with another person; someone else has moved in with the person; or the person's spouse has died in the last 90 days. For this item, ask the person or family member.

Person or relative feels the person would be better off living elsewhere – For this item, ask the person and family member/caregiver, separately, whether either believes there should be a change in living arrangements. Be sensitive to how the question is raised. Variants on the question "Do you believe the person would be better off living elsewhere?" might include asking whether the person would be happier/less isolated living elsewhere, would have his or her needs met better, would be safer, or would have access to more nutritious meals.

Coding — Select the appropriate response:

- No
- Yes, other community residence
- Yes, institution

Time since Last Hospital Stay

Intent — To document the time of the most recent instance of hospitalization during the last 90 days. This information can be useful in assessing the stability of the person's condition(s) and whether post-acute care is needed.

Process — Ask the person how long it has been since he or she was last discharged from an inpatient hospital setting. Calculate the period counting back from the Functional Supplement Assessment Date.

Coding — Select the appropriate response for the most recent instance in the last 90 days:

- No hospitalization within 90 days
- 31 to 90 days ago
- 15 to 30 days ago
- 8 to 14 days ago
- In the last 7 days
- Now in hospital

Section B. Cognition

It is important to determine the person's actual performance in remembering, making decisions, and organizing daily self-care activities. These items are crucial factors in many care-planning decisions, in part because of their effect on the person's ability to follow instructions and treatment regimens, and to make independent decisions in the community.

Memory/Recall Ability

Intent — To determine a person's ability to remember past events (situational memory).

Process — Situational memory OK — This measure of orientation assesses the person's cognitive ability to recognize both people and places. To be coded as OK, the person must **both** recognize the names/faces of frequently encountered family members or caregivers **and** know the location of places regularly visited (bedroom, dining room, places visited outside the home). It is not necessary for the person to know the street number of the house or apartment, but he or she should be able to find the way to his or her room, recognize the purposes of particular rooms, etc.

Coding — Select the appropriate response based on what was learned or known:

- Yes, memory OK
- Memory Problem

NOTE: When you are selecting the responses for this item, the person must demonstrate positive abilities in BOTH types of situations (i.e., caregiver names/faces AND locations) for "Yes, memory OK." If the person demonstrates difficulty in one or both areas, "Memory problem" must be selected.

Periodic Disordered Thinking or Awareness

Intent

To record behavioral signs that may indicate that delirium is present. Frequently, delirium (an acute confusional state) is caused by a treatable illness, such as an infection or a reaction to medications.

The characteristics of delirium are often manifested behaviorally and, therefore, can be observed. For example, disordered thinking may result in rambling, irrelevant, or incoherent speech.

A recent and perhaps rapid deterioration in cognitive function is likely indicative of delirium, which may be reversible if detected and treated in a timely fashion. Signs of delirium can be easier to detect in a person with intact cognitive function at baseline. When a person has a pre-existing cognitive impairment or pre-existing behaviors such as restlessness, calling out, etc., detecting signs of delirium is more difficult. Despite this difficulty, it is possible to detect signs of delirium by being attuned to recent changes in the person's usual functioning. For example, a person who is usually noisy or belligerent may suddenly become quiet, lethargic, and inattentive. Conversely, one who is normally quiet and content may suddenly become restless and noisy.

Definitions

Easily distracted – For example, episodes of difficulty paying attention; person gets sidetracked.

Episodes of disorganized speech – For example, speech is nonsensical, irrelevant, or rambling from subject to subject; person loses train of thought.

Mental function varies over the course of the day – Sometimes better, sometimes worse; behaviors sometimes present, sometimes not.

Process

Ask the person, or others who know the person, if any of the behaviors have been noticed during the last 3 days. If the response is yes, determine whether the behavior is different from the person's normal functioning.

Coding

Select the appropriate response for the person's behavior during the last 3 days, regardless of what you believe the cause to be, focusing on when the manifested behavior first occurred and whether it is different from the person's usual pattern.

Select the most appropriate response:

- Behavior not present
- Behavior present, consistent with usual functioning
- Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)

Acute Change in Mental Status from Person's Usual Functioning

Definition — Any sudden or recent change in the person's usual level of functioning; such changes may include restlessness, lethargy, being difficult to arouse, or altered environmental perception.

Section C. Mood and Behavior

Mood distress is a serious condition and is associated with significant morbidity. Associated factors include poor adjustment to one's living situation, functional impairment, resistance to daily care, inability to participate in activities, social isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain. It is particularly important to identify signs and symptoms of mood distress, because they are treatable.

It would be very unusual for family members to have received specific training in how to evaluate persons exhibiting distressed mood or behavioral symptoms. Therefore, although family may sense that something is wrong, mood distress is often underdiagnosed and undertreated in community settings. Thus, this assessment may serve as a crucial first opportunity to identify whether such problems are present.

Indicators of Possible Depressed, Anxious, or Sad Mood

Intent — To record the presence of indicators observed in the last 3 days, irrespective of the assumed cause of the indicator/behavior.

Definitions — The mental state indicators may be expressed verbally through direct statements, or through nonverbal indicators or behaviors that can be monitored by observing the person during usual daily routines.

Recurrent statements that something terrible is about to happen – For example, believes he or she is about to die, have a heart attack, etc.

Expressions, including nonverbal, of a lack of pleasure in life (anhedonia) – For example, saying "I don't enjoy anything anymore."

Process — Feelings of psychic distress may be expressed directly by the person who is depressed, anxious, or sad. Distress can also be expressed through nonverbal indicators. Initiate a conversation with the person, being cognizant of earlier statements by (or observations of) the person. Some persons are more verbal about their feelings than others and will either tell someone about their distress or will at least tell someone when asked directly how they feel. For persons who verbalize their feelings, ask how long these conditions have been present. Other persons may be unable to articulate their feelings (perhaps because they cannot find the words to describe how they feel, or lack insight or cognitive capacity).

Observe the person carefully for any indicator, both at the time of the planned assessment and in any direct contacts you may have with the person during the 3 days covered by this assessment. Consult with family members who have direct knowledge of the person's typical and current behavior, and any other clinicians working with the person (such as the primary care provider, if available).

Remember to be aware of cultural differences in how these indicators may be manifested. Some persons may be more or less expressive of mental health concerns, emotions, or feelings because of their cultural norms. Be cautious not to minimize your interpretation of an indicator based on your expectations about the person's cultural background. On the other hand, it is important to be especially sensitive to these indicators when assessing a person whose culture may make him or her more stoic in his or her expressions.

Coding

Based on your interaction with and observation of the person, select the appropriate response for each indicator based on the person's behavior over the last 3 days. Remember, score each item based on what you see or what is reported to you, regardless of what you believe the cause to be. One of the following responses may be selected:

- Not present.
- Present but not exhibited in last 3 days — Use this code if you know the condition is present and active, even though it was not observed over the last 3 days.
- Exhibited on 1–2 of last 3 days.
- Exhibited daily in last 3 days.

Section D. Functional Status

Locomotion/Walking

Timed 13-foot (or 4-meter) walk

Intent

This performance test provides a measure of the person's stamina. It is designed to establish an objective benchmark for comparison with the person's performance upon subsequent reassessments.

Process

Lay out a straight, unobstructed course. Use a tape measure to measure off the 13 feet (4 meters). If possible, mark the beginning and end of the measured distance using non-staining tape or another device that can be easily removed and will not damage the person's dwelling. You will need to stand very close to the person while he or she is trying to complete the test. Have a chair at hand; if the person becomes weak or is unable to continue, you should have him or her sit on the chair.

Say: "When I tell you, begin to walk at a normal pace (with cane/walker if used). This is not a test of how fast you can walk. Stop when I tell you to stop. Is this clear?"

You should then demonstrate the test for the person.

Have the person stand still, with both feet just touching the starting line. Then say:

"Begin to walk now."

Start stopwatch (alternately, you can count off seconds out loud — "one one-thousand, two one-thousand," and so forth) when the person's foot hits the ground with the first step. Stop counting when the person's foot falls beyond the 13-foot (or 4-meter) mark.

Then say: "You may stop now."

Coding — Select the most appropriate response:

- Unable to create 13-foot course
- Stopped before test complete
- Refused to do test
- Not tested - e.g., does not walk on own
- Test completed

Note:

- This test cannot be done with persons who need any type of physical weight-bearing assistance to walk. For persons who need this type of assistance, select "Not tested."
- If the person is capable of doing the test but chooses not to, select "Refused to do the test."
- For persons who do the test, use the scoring guidelines that follow:
  - If the person completes the test in less than 30 seconds, enter the number of seconds.
  - If the person took 30 or more seconds to complete the test, enter **"30"** as the score.

Distance walked

Intent — To assess the person's independence in walking around the home or the community.

Definition — Farthest distance walked in the **last 3 days**, at one time, without sitting down, and with support as needed.

Process — Ask the person and family member about the person's walking in the home or community during the last 3 days. Record the farthest distance walked without sitting down.

Coding — Select the most appropriate response based on the following:

- Did not walk
- Less than 15 feet (under 5 meters)
- 15–149 feet (5-49 meters)
- 150-299 feet (50-99 meters)
- 300+ feet (100+ meters)
- ½ mile or more (1+ kilometers)

Distance Wheeled Self

Intent — To monitor a person's independence in moving about the home or community in a non-motorized wheelchair (or scooter).

Definition — The farthest distance the person wheeled him- or herself at one time in the **last 3 days.** If the person used a motorized wheelchair, select "used a motorized wheelchair/scooter" and do not record distance wheeled.

Process — Ask the person and family member about the person's movement in the home or community during the last 3 days. Record the farthest distance traveled without a prolonged stop.

Coding — Select the most appropriate response.

- Wheeled by other
- Used motorized wheelchair / scooter
- Wheeled less than 15 feet (under 5 meters)
- Wheeled 15-149 feet (5 - 49 meters)
- Wheeled 150-299 feet (50 - 99 meters)
- Wheeled 300+ feet (100+ meters)
- Did not use wheelchair

Physical Function Improvement Potential

Intent — To assess the likelihood that the person has the capacity for greater independence and involvement in his or her care.

Definitions — Person believes he or she is capable of improved performance in physical function – This question records the person's own opinion.

Care professional believes person is capable of improved performance in physical function – This question records the opinion of a care professional who knows the person.

Process — Assess for indications that the person thinks he or she can be more self-sufficient. Ask what health professionals have told the person and family. Do their statements seem reasonable? Is the person's description clear and unequivocal? Could the person be more self-sufficient if mood or motivational problems were addressed? Speak with caregivers. What is their perception of the person's capacity? How does this relate to the person's perception and your observations? Assess whether the person's functional performance has recently changed. Has there been an intervening acute episode? What is the likelihood that the person will recover from the current disease or condition?

Section E. Continence

Urinary Collection Device (Excludes Pads/Briefs)

Definitions — Condom catheter – A urinary collection device worn over the penis.

Indwelling catheter – A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by suprapubic incision.

Cystostomy – An opening to the bladder made by a surgical incision and covered by a urinary collection appliance (urostomy bag).

Nephrostomy – A tube, stent, or catheter that is used to provide urinary drainage when a ureter is obstructed. In some cases, the catheter drains urine out of a person's body into a drainage bag. In other cases, the catheter drains urine directly into the bladder.

Ureterostomy – A surgical urinary diversion where the ureter(s) is(are) detached from the bladder and brought to the surface of the abdomen, with a urinary collection device placed over it.

Process Ask the person or caregiver, and check any clinical documentation. Be sure to ask about any items that are usually hidden from view because they are worn under street clothing (such as a ureterostomy collection bag).

Coding Select the most appropriate response:

- None
- Condom catheter
- Indwelling catheter
- Cystostomy, nephrostomy, ureterostomy

Pads or Briefs Worn

Definition Any type of absorbent, disposable, or reusable undergarment or item, whether worn by the person (e.g., a diaper or adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads on beds when the person is never or rarely incontinent.

Section F. Disease Diagnoses

Diseases

Intent To document the presence of diseases or infections relevant to the person's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. In general, these types of conditions are associated with the type and level of care needed by the person. Do not include conditions that have been resolved or no longer affect the person's functioning or care needs.

Definitions ***Neurological***

Hemiplegia – Paralysis (temporary or permanent impairment of sensation, function, and motion) of both limbs on one side of the body. This is usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor.

Multiple sclerosis – A disease in which there is demyelination throughout the central nervous system. Typical symptoms are weakness, lack of coordination, paresthesias, speech disturbances, and visual complaints.

Paraplegia – Paralysis (a temporary or permanent impairment of active motion) of the lower part of the body, including both legs.

Parkinson's disease – A disorder of the brain characterized by tremor and difficulty with walking, movement, and coordination.

Quadriplegia – Paralysis (temporary or permanent impairment of sensation, function, and motion) of all four limbs and trunk.

Infections

Pneumonia – Inflammation of the lungs, most commonly of bacterial or viral origin.

Urinary tract infection in last 30 days – Includes chronic and acute symptomatic infection(s) in the last 30 days. Code only if there is current supporting documentation and significant laboratory findings in the clinical record.

Process — Talk to the person and review any available clinical records. Consult with the person's primary physician or nurse practitioner. Talk with family members.

Coding — For all diseases present, select the most appropriate response.

- Not Present.
- Primary diagnosis/diagnosis for stay/placement – One or more diagnoses that are the main reason(s) used to support and justify services being provided.
- Diagnosis present, receiving active treatment – Treatment can include medications, therapy, or other skilled interventions such as wound care or suctioning.
- Diagnosis present, monitored but no active treatment – Person has a diagnosis that is being monitored (e.g., with laboratory tests or vital signs), but no active treatment is being provided.

Section G. Health Conditions

Problem Frequency

Definitions

Balance

Difficult or unable to move self to standing position unassisted.

Difficult or unable to turn self around and face the opposite direction when standing.

Pulmonary

Difficulty clearing airway secretions – In the last 3 days, the person reports being unable, or has been observed to be unable, to cough effectively to expel

respiratory secretions (e.g., secondary to weakness or pain) or has been unable to mobilize secretions or sputum from mouth (e.g., secondary to dysphagia or pain) or tracheostomy (e.g., secondary to viscosity of sputum; inability to physically remove secretions from tracheostomy entrance). Examples include a person with pneumonia who is too weak to cough and expel sputum or someone with amyotrophic lateral sclerosis (ALS) who requires suctioning to manage secretions.

Neurological

Aphasia – A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (speaking or writing) or difficulty understanding spoken or written language.

Other

Aspiration – The inhalation of food or fluid into the person's lungs.

Fever – A rise in the person's body temperature, frequently as a result of infection.

GI or GU bleeding – "Gastrointestinal (GI) bleeding" is any documented bleeding as diagnosed by a gastrointestinal evaluation, or any evidence of current bleeding through rectal exam or guaiac testing. Bleeding may be frank (such as bright red blood) or occult (such as black, guaiac-positive stools). "Genitourinary (GU) bleeding" is bleeding that occurs anywhere along the genitourinary tract. Urine that is dark or cloudy should be tested for the presence of blood. There may also be visible blood in the person's urine or frank, bright red blood coming from the urethral opening.

Hygiene – Unusually poor hygiene, unkempt, disheveled. The person is observed to have unusually poor hygiene well beyond what is considered culturally appropriate. Poor hygiene puts the person at risk for skin breakdown and has other health and psychological ramifications.

Peripheral edema – The person has an abnormal buildup of fluid in foot/ankle/leg tissues.

Process — Ask the person – he or she may not have told others of his or her symptoms. Ask family members or caregivers. Review any available clinical records.

Coding — Select the most appropriate response:

- Not present
- Present but not exhibited in last 3 days
- Exhibited on 1 of last 3 days
- Exhibited on 2 of last 3 days
- Exhibited daily in last 3 days

Instability of Conditions

Definition — End-stage disease, 6 or fewer months to live – The person or family has been told that, in the best clinical judgment of the physician, the person has end-stage disease with approximately 6 or fewer months to live.

Process — Ask the person – he or she may not have told others of his or her symptoms. Ask family members or caregivers. Review any available clinical records.

Section H. Oral and Nutritional Status

Height and Weight

Intent — To record the person's current height and weight in order to monitor nutrition, hydration status, and weight stability over time. For example, a person who has had edema may experience an expected weight loss as a result of taking a diuretic. Weight loss can also be the intended result of limiting caloric intake and participating in an exercise program, or the unintended consequence of poor intake and malnutrition.

Coding — Height – Measure height in inches with a tape measure or other device. If the last recorded height was more than 1 year ago, measure the person's height again. Wherever possible, use a calibrated measure. In its absence, use estimates from the person, family member, or caregiver. Round height up to nearest whole inch. Measure height consistently over time in accordance with standard agency practice (shoes off, etc.). Enter the height in inches.

Weight – Base weight on most recent weight measured within the last 30 days. Round the person's weight up to the nearest whole pound. Measure weight consistently over time in accordance with standard agency practice (after voiding, before meal, etc.). Wherever possible, use a calibrated scale. In its absence, use estimates from the person, family member, or caregiver. Enter the weight in pounds. Base weight on most recent measure in the last 30 days.

Dental or Oral

Intent — To record any oral problems present in the last 3 days.

Definitions — Wears a denture (removable prosthesis) – The person wears a device that may replace all or some of the teeth of the upper or lower jaw. A denture is removable by the person or a helper.

Has broken, fragmented, loose, or otherwise non-intact natural teeth – The person has natural teeth that are broken, fragmented (i.e., a piece of tooth is missing), or loose (i.e., tooth is movable when touched).

Reports having dry mouth – The person reports having a dry mouth or difficulty in moving a food bolus in his or her mouth.

Reports difficulty chewing – The person is unable to chew food easily and without pain or difficulties, regardless of cause (e.g., the person might use ill-

fitting dentures or have a neurologically impaired chewing mechanism, temporomandibular joint pain, or a painful tooth).

Process — Ask the person about difficulties in these areas. If possible, observe the person during a meal. Inspect the mouth for abnormalities that could contribute to chewing or swallowing problems or mouth pain.

Section I. Skin Condition

Intent — To determine the condition of the person's skin, identify the presence and stage of ulcers, document other skin conditions, and note any foot problems that may be present. Select the appropriate response even if no problem exists. Documentation should be entered in the comments section to support response options.

Most Severe Pressure Ulcer

Intent — To record the highest stage of pressure ulcers on any part of the body present in the last 3 days.

Definition — Pressure ulcer – Any lesion caused by unrelieved pressure. Pressure ulcers usually occur over bony prominences and are staged to classify the degree of tissue damage observed.

Process — Consult with the person and family about the presence of an ulcer. If an ulcer exists, the assessor may have to observe the ulcer to determine its stage (see "Coding" below).

Ask if the person has been examined for the presence of pressure ulcers or other skin conditions. It could be difficult to examine the person's entire skin, as you are a guest in the person's home. For persons who are cognitively intact, you can get good information about their skin condition without conducting a skin examination. For a chair-bound or bedfast person, conduct a skin examination, paying particular attention to the person's hips, thighs, buttocks, lower back, and heels.

It is sometimes difficult to determine the presence of a reddened area (a Stage 1 ulcer) in persons with darker skin tones. To recognize Stage 1 ulcers, look for:

- Any change in the feel of the tissue in a high-risk area
- Any change in the appearance of the skin in high-risk areas, such as an "orange-peel" look or a subtle purplish hue
- Extremely dry crust-like areas that, upon closer examination, are found to cover a tissue break

Coding — Select the most appropriate response:

- No pressure ulcer.
- Any area of persistent skin redness – An area of skin that appears continually reddened and does not disappear when pressure is relieved. There is no break in the skin. Also known as "Stage 1."

- Partial loss of skin layers – A partial-thickness loss of skin that presents clinically as an abrasion, blister, or shallow crater. Also known as "Stage 2."
- Deep craters in the skin – A full thickness of skin is lost, exposing the subcutaneous tissue. Presents as a deep crater, with or without undermining of adjacent tissue. Also known as "Stage 3."
- Bre aks in skin exposing muscle or bone – A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. Also known as "Stage 4."
- Not codable – For example, because necrotic eschar is predominant.

Prior Pressure Ulcer

Intent — To document a history of pressure ulcers, which is a risk factor for the development of pressure ulcers in the future.

Process — Ask the person if he or she has ever had a pressure ulcer that is now healed. A review of old records including discharge summaries, clinical progress notes, flow sheets, or care plans may also yield this information. If necessary, check with a family member or care provider who has prior knowledge of the person's skin condition.

Presence of Skin Ulcer Other Than Pressure Ulcer

Intent — To identify the presence of any skin ulcer that is not a pressure ulcer — for example, a venous ulcer, arterial ulcer, mixed venous-arterial ulcer, or diabetic foot ulcer.

Definition — An open lesion caused by poor circulation in the lower limbs.

Major Skin Problems

Definitions — Major skin problems – This item includes lesions, second- or third-degree burns, and healing surgical wounds.

Burn – Injury to tissues resulting from thermal, electrical, chemical, or radioactive exposure. The effect of the injury may be local or systemic.

Skin Tears or Cuts (Other Than Surgery)

Definition — Any traumatic break in the skin penetrating to the subcutaneous tissue. Does not include surgical incisions.

Other Skin Conditions or Changes in Skin Condition

Intent — To document the presence of skin problems other than ulcers, skin tears, or cuts, and the major skin problems represented in the earlier items.

Definitions — Other skin conditions or changes in skin condition – For example, bruises, rashes, itching, mottling, herpes zoster, intertrigo, or eczema.

Rash – A transient eruption of the skin.

Mottling – A condition characterized by areas of skin discoloration.

Eczema – Major features include pruritus, atypical morphology and distribution, and a tendency toward dry skin and itching. Flaking of skin may occur.

Foot Problems

Definition Includes bunions, hammertoes, overlapping toes, structural problems, infections, and ulcers.

Coding Select the appropriate response:

- No foot problems
- Foot problems, no limitation in walking
- Foot problems limit walking
- Foot problems prevent walking
- Foot problems, does not walk for other reasons

Section J. Medications

Adherent with Medications Prescribed by Physician

Intent To determine whether the person is receiving medications as prescribed by a physician, nurse practitioner, or physician's assistant.

Definition The person is actually taking medications **as prescribed**.

Process You will have already solicited information from the person about his or her medications. Compare the person's responses with available medication and known medication orders. Does the supply remaining seem appropriate considering when the prescription was filled? Did the person and caregiver give accurate information about medication administration? Remember, this item is not intended to evaluate the appropriateness of the medication prescribed.

Coding Select the most appropriate response:

- Always adherent.
- Adherent 80% of time or more – Over the last 3 days, 24 hours a day, the person deviated from prescribed medication regime 20% or less of the time.
- Adherent less than 80% of the time, including failure to purchase prescribed medications – Over the last 3 days, 24 hours a day, person deviated from prescribed medication regime more than 20% of the time.
- No medications prescribed – Person is not receiving any prescribed medication.

Section K. Treatments and Procedures

Treatments and Programs Received or Scheduled in the Last 3 Days (Or Since Last Assessment If Less Than 3 Days)

Intent

To review prescribed treatments and determine the extent of the person's adherence to the prescription. This item includes special treatments, therapies, and programs received or scheduled during the last 3 days (or since the last assessment if fewer than 3 days have passed), as well as adherence to the required schedule. It includes services received in the home or on an outpatient basis.

Definitions

Treatments

Chemotherapy – Includes any type of chemotherapy (anticancer drug) given by any route.

Dialysis – Includes peritoneal or renal dialysis that occurs at home or at a facility.

Infection control – For example, isolation or quarantine. Enforced isolation or restriction of free movement imposed to prevent the spread of a contagious disease.

IV medication – Includes any drug or biological (e.g., contrast material) given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication.

Oxygen therapy – Includes continuous or intermittent oxygen via mask, cannula, etc.

Radiation – Includes radiation therapy or having a radiation implant.

Suctioning – Includes oropharyngeal, nasopharyngeal, or tracheal aspiration.

Tracheostomy care – Includes removal of cannula and cleansing of tracheostomy site and surrounding skin with appropriate solutions.

Transfusion – Includes transfusion of whole blood or any type of blood product.

Ventilator or respirator – Mechanical device designed to provide adequate ventilation in persons who are, or may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed-system mechanical ventilatory support device. Includes any person who was in the process of being weaned off the ventilator or respirator in the last 3 days.

Wound care – Includes the application of bandages (e.g., dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, or dressings with hydrocolloid or hydroactive particles); wound irrigation; the application of ointments and topical medications to treat skin conditions (e.g., cortisone, antifungal preparations, or chemotherapeutic agents); debridement (chemical or surgical) to remove dirt or dead tissue from a wound; and suture removal.

Ostomy Care – Includes any care related to surgically created openings in the body that are used for the discharge of body waste. Such care would include cleansing around the stoma; changing collection appliances; colostomy irrigation; and instructing the person in self- care of the ostomy.

Programs

Scheduled toileting program – The person is taken to the toilet room, given a urinal, or reminded to go to the toilet on a regular and ongoing basis. In the home, this may be done by family members or paid help. Includes any habit training or prompted voiding program.

Palliative care program – A formal program in which care is focused on the relief of pain and other uncomfortable symptoms (such as dyspnea). Persons receiving palliative care generally have end-stage disease, but may or may not have a prognosis of 6 months or less to live (i.e., the person may live for many months or years).

Turning/repositioning program – The person is periodically turned from side to side and onto his or her back while in bed. Once the person has been turned to the new side, staff ensures that the head, torso, and limbs are positioned to minimize pain, promote function, and minimize pressure on bony prominences.

Process Ask the person if he or she received specific treatments or programs.

Coding Select the most appropriate response:

- Not ordered AND did not occur
- 1-2 days of last 3 days
- Daily in last 3 days
- Ordered, not implemented

Formal Care — Days and Total Minutes of Care in Last 7 Days

Intent To capture the number of minutes spent by formal caregiving agencies in providing care or care management in the last 7 days (or since the last assessment or admission, if fewer than 7 days have passed).

Definitions Care – Includes direct services provided to the person (both ADL and IADL support), the management of care received (e.g., making medication schedules, planning for future needs), and the provision of therapeutic care by any formal agency or service provider.

Home health aides – Aides who traditionally provide "hands-on" ADL support and simple monitoring (such as taking blood pressure).

Home nurse – Licensed or registered nurses who traditionally provide assessment and complex or invasive interventions (skilled treatments), education, and referral.

Homemaking services – Services that traditionally include IADL support, usually in the form of housekeeping services, shopping, and meal preparation.

Meals – Prepared meals that are delivered to the person for immediate or later consumption (e.g., meals-on-wheels).

Congregate Meals – Prepared meals that are provided in a congregate, setting such as a senior center, to persons who cannot prepare or obtain nutritionally

adequate meals for themselves and who may benefit from the social interaction of the setting.

Physical therapy – Therapy services that are provided or directly supervised by a qualified physical therapist. A qualified physical therapy assistant may provide therapy but may not supervise others giving therapy.

Occupational therapy – Therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified occupational therapy assistant may provide therapy, but may not supervise others giving therapy.

Speech-language pathology and audiology services – Services provided by a qualified speech-language pathologist. Services may involve assessment of swallowing ability or hearing ability, swallowing therapy, speech therapy, communication therapy, and providing hearing appliances and education.

Psychological therapy – Therapy given by a licensed mental-health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker.

Personal care aides – Aides who provide "hands-on" ADL support but are not trained to provide the simple monitoring and health-related tasks provided by home health aides.

Respiratory Therapy – Therapy services that are provided by a qualified respiratory therapist.

Consumer directed personal assistant – Workers that are hired, trained, assigned tasks, and supervised by the person, with the administrative support of the Consumer Directed Personal Assistant Program (CDPAP).

Adult day health care – A day care center which provides medical services such as nursing, physician, or dental exams, therapy or personal-care services in addition to meals and social activities.

Social Day care – A day center that provides meals, social activities, supervision, and a minimal amount of personal care.

Process

Ask the person or helper(s) about the agencies involved with care, the nature of the relationship, and the amount of time spent in providing care or care management. If possible, contact the agencies providing services or care management to confirm responses. Consult logbooks that the person may have in the home, and review agency documentation if available.

Coding

Enter the appropriate number of days, up to a maximum of 7.

Enter the appropriate number of minutes

Based on the information available to you, select the best category for the type of support provided. **Do not code twice for the same service.** If the agency did not provide a particular form of care, enter **"0"** in the appropriate box(es).

Physically Restrained

Definition — For example, the person's limbs were restrained, the person used bed rails, or the person was restrained to the chair when sitting.

Coding — Indicate whether the person was physically restrained in the last 3 days, regardless of the stated intent of restraint.

Section L. Responsibility/Legal Guardian

Legal Guardian

Intent — To record who has responsibility for participating in decisions about the person's health care, treatment, financial affairs, and legal affairs. Depending on the person's condition, multiple options may apply. For example, a person with moderate dementia may be competent to make decisions in certain areas, although in other areas, a family member will assume decision-making responsibility; or a person may have executed a limited power of attorney to someone responsible only for legal affairs.

Definition — Legal guardian – Someone who has been appointed as per the laws of New York State and is authorized to make decisions for the person, including giving and withholding consent for medical treatment. Once appointed, the decision-making authority of the guardian may be revoked only through appropriate legal processes within New York State.

Other legal oversight – Use this category for any other situation in New York State whereby someone other than the person participates in or makes decisions about the person's health care and treatment.

Health care proxy – Documentation that someone other than the person is legally responsible for health-care decisions if the person becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker and may include instructions concerning the person's wishes for care. Unlike a guardianship, health-care proxy terms can be revoked by the person at any time.

Durable power of attorney/financial – Documentation that someone other than the patient is legally responsible for financial decisions if the person becomes unable to make decisions.

Family member responsible – Includes immediate family or significant other(s) as designated by the person. Responsibility for decision-making may be shared by both the person and the family.

Process — Legal oversight, such as guardianship, health-care proxy, durable power of attorney, and living wills are generally governed by New York State. Consult the person and the person's family. Review records. Where the legal oversight or guardianship is court ordered, a copy of the legal document must be included in the person's record in order for the item to be checked on the UAS-NY.

Advance Directive

Intent: To document the existence of any legal directives to guide the health-care team in making treatment decisions. The directives may have been made by the person him/herself or by a legal proxy/responsible party. The absence of pre-existing directives provides an opportunity for the clinical team to discuss the person's wishes with the person and the family. Any discrepancies between the person's current stated wishes and what is contained in legal documents in the person's file should be resolved immediately.

Definition: Advance directives for not resuscitating – In the event of respiratory or cardiac failure, no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore the person's respiratory or circulatory system. This choice must be documented.

Advance directives for not intubating – There is to be no insertion of a tube to facilitate breathing (e.g., endotracheal tube, tracheal tube). This choice must be documented.

Advance directives for not hospitalizing – A document specifying that the person is not to be hospitalized, even after developing a medical condition that usually requires hospitalization. This choice must be documented.

Advance directives for not tube feeding – The person or responsible party (family or legal guardian) does not wish the person to be fed by artificial means (e.g., tube, intravenous nutrition) if unable to be nourished by oral means. This choice must be documented.

Advance directives for medication restrictions – The person or responsible party (family or legal guardian) does not wish the person to receive life-sustaining medications (e.g., antibiotics, chemotherapy). These restrictions may not be appropriate, however, when such medications could be used to ensure the person's comfort. In these cases, the directive should be reviewed with the responsible party. This choice must be documented.

Process: Review the person's medical record for documentation of the person's advance directives. Documentation must be available in the record for a directive to be considered current and binding. Some persons, at the time of admission, may be unable to participate in decision-making. Staff should make a reasonable attempt to determine whether the person has ever created an advance directive (e.g., ask family members, check with the primary physician). Lacking any directive, treatment decisions will likely be made in concert with the person's closest family members or, in their absence or in the case of conflict, through legal guardianship proceedings.

Coding: The following comments provide further guidance on how to code these directives.

The person (or proxy) should always be involved in the discussion to ensure informed decision-making. If the person's preference is known, and the attending physician is aware of the preference but the preference is not recorded in the

record, check the Functional Supplement item only after the preference has been documented.

If the person's preference is in areas that require supporting orders by the attending physician (e.g., do not resuscitate, do not hospitalize, feeding restrictions, and other treatment restrictions), check the Functional Supplement item only if the document has been recorded or after the physician provides the necessary order. Where a physician's current order is recorded but the person's or proxy's preference is not indicated, discuss with the person's physician and check the Functional Supplement item only after receiving documentation confirming that the person's or proxy's wishes have been entered into the record.

Section M. Social Supports

Two Key Informal Helpers

Intent — To assess the person's informal caregiver support system. This is different from a formal relationship that the person may have with a home care agency. The level of support for up to two key informal helpers may be reported.

Definitions — Helper 1 – This is the primary informal helper, who may be a family member, friend, or neighbor, but not a paid service provider. It is not required that the caregiver actually live with the person, but he or she must visit regularly and respond to the person's needs. This is the individual the person views as most helpful to him or her (i.e., who can most be relied on).

Helper 2 – This is the secondary informal helper, the individual on whom, after the primary helper, the person most relies to help or give advice and counsel when needed.

Relationship to person – This refers to the nature of the relationship(s) between the person and the informal helper(s).

Family Employed Substitute – A person hired by the person being assessed to provide care and assistance in place of a family member.

Lives with person – Informal helper is said to live with the person if the person and helper share the same space (house, apartment). This does not include living in an adjacent or neighboring apartment/house.

Process — Ask the person to identify his or her two most important informal helpers. Shape the questions with specific statements: "Who helps you shop?" "Who helps with cleaning around the house?" "Who helps you with your meals, bathing, dressing, etc.?" "Who helps you pay your bills?" "Who drives you when you need a ride?" If the person does not currently have a "helper," ask if there is someone who "would help" if needed; the person may be able to identify several people. If the person is not able to understand or respond to questions, or gives responses that are unclear, evasive, or untrue (e.g., refers to her husband when you know the husband is deceased), review any agency documentation or ask informal helpers if available.

It is important to understand that some helpers may not be described as such by the person. They do things consistent with "expected" social relationships — it is what the person expects a daughter or wife to "do." Thus, it is useful to focus the person's attention on who provides needed assistance or support, rather than using the label "caregiver."

Ask the person and the helper (where available) about the nature of their relationship. Validate the significance of their relationship, as they define it.

Coding Select the appropriate responses for both helpers:

- Relationship to person
  - Child or child-in-law
  - Spouse
  - Partner/significant other
  - Parent/guardian
  - Sibling
  - Other relative
  - Friend
  - Neighbor
  - Family employed substitute
  - No informal helper
- Lives with person
  - No
  - Yes, 6 months or less
  - Yes, more than 6 months
  - No informal helper

Areas of Informal Help During the Last 3 Days

Process IADL Help – Includes activities such as meal preparation, ordinary housework, managing finances or medications, phone use, shopping, and transportation. Ask the person and informal helper(s), when available, if support is given in meal preparation, ordinary housework, managing finances or medications, phone use, shopping, and transportation. Such support from the helper(s) can range from doing light housework only to doing all of the shopping and housework.

ADL Help – Includes activities such as bed mobility, transferring, walking, dressing, eating, toilet use, personal hygiene, and bathing. Ask the person and informal helper(s), when available, if support is given in ADL areas such as bed mobility, transferring, walking, dressing, eating, toilet use, personal hygiene, and bathing. Such support from the helper(s) can range from "being there just in case" (to provide reassurance or ensure safety) to providing complete ADL care.

Coding Select the appropriate response:

- No
- Yes
- No informal helper

Informal Helper Status

Intent To assess the status of the informal caregiver support system.

Definitions Informal helper(s) is (are) unable to continue in caring activities – For example, a decline in the health of a caregiver/helper makes it difficult to continue. The caregiver, person, or assessor believes that the caregiver(s) is (are) not able to continue in caring activities. This can be for any reason — for example, lack of desire to continue; geographical inaccessibility; other competing requirements, such as child care or work requirements; or personal health issues.

Person is unaccepting of the informal caregiver's involvement in her/his care – Caregiver's are willing and available to assist with care, but the person being assessed has indicated they do not want the caregiver's assistance.

Informal caregiver is unwilling to assist with care – The person or assessor believes the caregiver is able to assist with care, but the caregiver is unwilling to provide assistance to the person being assessed.

Process Ask the informal caregiver(s) and person, separately, about the ability of the caregiver(s) to continue providing care. For these items, you need to consider the current situation and project future needs. The caregiver may be willing and able to continue, but the person may believe him- or herself to be a burden and state that the caregiver cannot continue. Take this information into consideration and use your clinical judgment to make the assessment. This is a sensitive issue and should be handled carefully. Listen carefully to what is being said.

Family and Friends

Intent To assess the ability and willingness of the informal caregivers to provide support and care to the person.

Definitions Primary informal helper expresses feelings of distress, anger, or depression – Primary caregiver expresses, by any means, that he or she is distressed, angry, depressed, or in conflict because of caring for the person.

Family or close friends report feeling overwhelmed by person's illness – Family members or close friends of the person indicate that they are having trouble handling the illness. They may vocalize their feelings of being "overwhelmed" or "stressed out.

Process Ask the informal caregiver(s) about the ability of the caregiver(s) to continue providing care. For these items, you need to consider the current situation and project future needs. This is a sensitive issue and should be handled carefully. Listen carefully to what is being said.

Hours of Informal Care and Active Monitoring During Last 3 Days

Intent — To capture the number of hours informal helpers spent over the last 3 days assisting the person in instrumental and personal activities of daily living, including active monitoring by looking in on the person.

Definitions — Informal care – This means care by all the family, friends, neighbors, and so forth who provide assistance to the person, including but not limited to the primary caregiver (Helper 1).

Process — Consult with the person about hours of care. Confirm information with the primary caregiver.

Coding — Enter the total amount of help the person received from family, friends, or neighbors over the last 3 days. For example, if family members, friends, and neighbors provided 120 minutes (2 hours) each day, the total number of hours for help received during the last 3 days is 6. If more than one individual provided help, at the same time or at different times, add up the hours for each individual – for example, if two neighbors spent an hour together doing housecleaning for the person, this would count as 2 hours.

Round minutes to the nearest hour. For example, 12 hours and 45 minutes should be entered as 13 hours.

If the person did not receive any informal care during the last 3 days, enter **"0."**

Section N. Environmental Assessment

Home Environment

Intent — To determine whether the home environment is hazardous or uninhabitable.

Definitions — Disrepair of the home – For example, hazardous clutter; inadequate or no lighting in living room, sleeping room, kitchen, toilet, or corridors; holes in floor; or leaking pipes.

Squalid condition – For example, extremely dirty. There may be dried urine, feces, or dried food on the floor, or infestation by insects or vermin (such as mice or rats). For an environment to be coded as "squalid," the condition must be much more deteriorated than the "usual" clutter and household dust and dirt accumulated over a week or so.

Inadequate heating or cooling – Heating and cooling systems may be inadequate (e.g., too hot in summer or too cold in winter) or inappropriate (e.g., too cold in summer or too hot in winter and not controllable by the person or caregiver).

Lack of personal safety – For example, fear of violence, a safety problem in going to the mailbox or visiting neighbors, or heavy traffic in the street. The person is (or feels) at risk for violence within or immediately outside of his or her home. This can include a real or perceived risk of someone breaking into the home, or of being attacked while getting mail or when leaving or returning home.

Limited access to home or rooms in home – For example, the person has difficulty entering or leaving the home, is unable to climb stairs, or has difficulty maneuvering within rooms. This item includes physical problems with the building that limit access — for example, the person lives on the second floor and must enter or leave on unstable outside stairs, or the person lives in a multistory building in which the elevator is often broken, or in which stairs do not have the needed railings.

Process — Ask the person (or family member) for permission to walk through the home. Look for evidence of the problem areas noted in this section. Talk to the person (and family member if necessary) about any areas that you cannot assess yourself through visual inspection.

Lives in Apartment or House Re-Engineered Accessible for Persons with Disabilities

Definition — Re-engineered Accessible – This includes, but is not limited to, widening doorways to make rooms more accessible for persons in wheelchairs; installing grab bars in bathrooms; lowering kitchen cabinets to a height suitable for persons in wheelchairs; adding a ramp to make a primary entrance accessible for persons in wheelchairs; or altering a walkway to provide access to a public or common use area.

Outside Environment

Definitions — Availability of emergency assistance – For example, telephone, alarm response system. The person indicates that he or she has access to emergency assistance. This could be by means of a telephone, or a speed dialing option on the telephone, or an emergency response system.

Accessibility to grocery store without assistance – The person is able to go to the grocery store and make purchases without assistance. The person may travel to the grocery store by walking, driving or riding in a car, or riding in a bus, trolley, subway or cab.

Availability of home delivery of groceries – Code regardless of whether or not the person is using such a service at the present time.

MENTAL HEALTH SUPPLEMENT

The Mental Health Supplement includes mental health–related diagnoses, symptoms, treatments, and life experiences. The goal is to use this information to identify individual needs and implement appropriate interventions.

Discussions about mental health issues can be difficult and should always be approached with sensitivity and an awareness of the person's emotional response. It is also important to take an approach that validates and affirms the person's thoughts and feelings. Interviewing skills are an integral part the assessment process, but it is also recognized that not all assessors have the same skill or comfort level with discussing mental health issues. The following discussion provides a brief overview for how to approach the assessment. If the assessor is new to this type of interviewing, it is important to seek out learning opportunities in this area.

There is no one correct way to approach the issues covered in the Mental Health Supplement; however, reflective listening is an effective method for proceeding with the discussion. The assessor listens to what the person is saying, takes cues from the content or emotional tone of what is being said, and uses this to guide the conversation. For example, the assessor may reflect back to the person what he or she understood the person to be saying (i.e., provide a summary of what was said), repeat or rephrase a statement made by the person and then say, "I'm wondering if you can tell me a bit more about that," or make an empathic observation about how the assessor perceives the person to be feeling, such as, "You seem sad and down," or "It sounds like that was an emotionally painful experience." Statements that devalue the person's experiences (e.g., "You shouldn't think/feel that way") or place the person on the defensive (e.g., asking the person, "Why did you do or say that?") should be avoided. It is also suggested that "open-ended questions" be used. Ask questions that present the opportunity for comments beyond simple "yes" or "no" responses. For example, the question "Do you feel hopeless?" is likely to get a response of "yes," "no," or "sometimes." However, the question "What are your thoughts about the future?" is likely to provide information about feelings of hopelessness, if they are present. It may also open the door to discussion about other issues that would not be addressed with a "yes/no" response.

If, at any time during the interview, the person indicates that he or she does not want to continue discussing an issue, the assessor should respect this. You might want to say, "Maybe we'll come back to this later," and then move on to another topic. If necessary, revisit the issue when the person is more comfortable. If the person takes the conversation in a direction that is not related to the assessment or is providing more details than necessary, the assessor can suggest, "I would like to hear more about this, but right now, I'd like to move on to something else. If we have time later, we can come back to it."

If the assessor becomes concerned that the person is a danger to him- or herself, the immediate concern should be for the person's safety. Likewise, if at any time the assessor is concerned for his or her own safety, the assessor's safety must be protected. All assessors should be aware of and adhere to the policies and practices of his or her organization when safety concerns arise. The assessment can be completed later. Safety issues must always come first.

While the examples in this section are included to illustrate how to determine responses to the various items, many of them also demonstrate how an assessor might go about seeking information required for the Mental Health Supplement. The assessor should not feel constrained to using the words exactly as shown in the examples. The assessor should use phrases with which

he or she is comfortable and which are appropriate for the person's culture, level of education, fluency, and current circumstances.

Basic Principles of the Mental Health Supplement

Your purpose is to expand on your understanding of the person's mental health status. Information collected using the Mental Health Supplement can serve to:

- Provide a basis for further evaluation of unrecognized or unmet needs
- Develop a care plan tailored to the unique life circumstances of that person, ensuring that each limiting or potentially limiting factor is managed to maximize his or her quality of life

When introducing the assessment to a person, you should emphasize that the assessment is an integral part of the overall service program. Any acute mental health matter should be brought to the attention of the person immediately, and the person should be helped to obtain appropriate medical care. As would be expected in standard practice for psychiatry, **instances of risk of harm to self or others warrant special and immediate intervention**.

Section A. Identification Information

Mental Health Supplement Reference Date

Intent	To establish a common period of observation as a reference point for each completed assessment.
Definition	The designated end point of the common observation period for items on the Mental Health Supplement. Except where otherwise noted, all information gathered about the person pertains to the 3-day period prior to and including the Mental Health Supplement Reference Date for items pertaining to the person's status or performance. Home-based assessments are usually completed using information gathered during a single visit. However, when an assessment carries over to a second visit, information for the remaining Mental Health Supplement items must be for the time period established by the original Mental Health Supplement Reference Date This date can be different from date of Community Health Assessment Reference Date.
Coding	Use the calendar to select the correct month, day, and year.

Section B. Mental Health Service History

This section provides information about the person's contact with mental health services.

Number of Lifetime Psychiatric Admissions

Intent	To record the total number of admissions to a mental health facility or unit during the person's lifetime.

Definition Psychiatric admission – Person was admitted to a hospital for mental health services and stayed for one or more nights. Outpatient services are not included here.

Process Ask the person or family, or other health care workers who know the person's mental health history. Refer to the process section for "Time since Last Contact with Community Mental Health Agency or Professional in PAST YEAR" for suggestions to approaching the two items related to "Mental Health Service History." The record, if available, may also contain this information.

Coding Select the appropriate response:

- None
- 1–3
- 4–5
- 6 or more

Time Since Last Contact with Community Mental Health Agency or Professional in Past Year

Intent To identify the person's involvement with a community-based mental health service in the past year.

Definition Community mental health service – Includes any mental health service provided through a community mental health agency, outpatient clinic, or private office of a mental health professional. Included are the services of psychiatrists, psychologists, social workers, and other therapists who practice in mental health. Not included in this item are general practitioners, family doctors, internists, and other physicians.

Process Consult with the person and family if necessary, and with records and other community workers, if available.

Asking about involvement with mental health services can be a sensitive issue and should be approached as such. However, most persons are open to discussing this if asked about it. The assessor can begin the conversation by reinforcing that these questions are all part of getting to know about the person in order to provide help. Questions about past mental health service involvement should be presented in a straightforward, yet sensitive manner. For example, "Earlier in our conversation, you mentioned that you have been feeling depressed lately. Are you seeing anyone, like a social worker or psychologist, to help you with this?" If the person's response is "no," ask if he or she has ever seen anyone in the past for counseling or has ever been hospitalized because of experiencing similar feelings. If the response is "no," there is no need to ask further questions about this item or "Number of Lifetime Psychiatric Admissions.**"** However, if the response is "yes" to a hospital admission, the assessor can ask if the hospitalization was on a psychiatric unit and, if so, was there more than one admission. If the response is "yes" to involvement with a mental-health professional, a question such as "when did you last see the social worker/psychologist?" should follow. If, at any point, the person becomes anxious, move on to discuss another issue and return to

exploring information about mental health service history later in the conversation.

Coding — Select the appropriate response for the most recent contact with a community mental health agency or professional in past year:

- No contact in past year
- 31 days or more
- 30 days or less

Section C. Mental State Indicators

An assessment of mental status can provide information about a person's quality of life, his or her responsiveness and adherence to treatment regimens, and resource requirements. Assessment and documentation of mental status are key to care planning and evaluation of outcomes.

Mental State Indicators

Intent — To record the presence of indicators observed in the last 3 days, irrespective of the assumed cause of the indicator/behavior. When combined with other observations in the assessment, these indicators can provide information about the severity of the person's condition.

Definitions — The mental state indicators may be expressed verbally through direct statements, or through nonverbal indicators or behaviors that can be monitored by observing the person.

Self-deprecation – Subjective report indicating a negative view of self (e.g., "I'm nothing," "I'm of no use to anyone").

Expressions of guilt or shame – Any statements suggesting a feeling of self-blame, self-reproach, self-accusation, or shame, regardless of the legitimacy or cause of the feelings (e.g., "I've done something awful," "This is all my fault," "I'm a terrible person").

Expressions of hopelessness – For example, "There's no hope for the future," "Nothing's going to change for the better."

Note that this indicator is distinct from the first question in Section D: Mood & Behavior of the CHA, "Made negative statements," because it deals with the person's subjective outlook for the future, either personally or in a more general sense. The aim is to identify feelings of despair about the future and not simply a pessimistic disposition.

Inflated self-worth – For example, exaggerated self-opinion, arrogance, inflated belief about one's own ability.

Irritability – Marked increase in being short-tempered or easily upset.

Pressured speech or racing thoughts – Rapid speech or rapid transition from topic to topic.

Labile affect – Objective observation of rapid, abrupt shifts in affect (e.g., person may have periods of tearfulness alternating with laughter, with or without an external explanation).

Flat or blunted affect – Objective observation of an absence of or severe reduction in the intensity of affective expression (e.g., person appears indifferent, nonresponsive, or hard to get to smile).

Obsessive thoughts – Unwanted, intrusive ideas or irrational thoughts that cannot be eliminated through conscious attempts to ignore or suppress them (e.g., thoughts about being responsible for a tragedy, sinister thoughts about his or her children, or reporting that he/she "just can't get this thought out of my head").

Compulsive behavior – An uncontrollable, persistent urge to perform an act repetitively, often according to certain rules, manner, or pattern (e.g., hand washing, repetitive checking of room or appliances, counting, avoiding stepping on cracks on the sidewalk or tiled flooring).

Intrusive thoughts or flashbacks – Disturbing memories or images that intrude into thoughts, or unexpected recall of adverse events.

Episodes of panic – Cascade of symptoms of fear, anxiety, or loss of control.

Unusual or abnormal physical movements – Objective observation of unusual facial expressions or mannerisms (e.g., looking over to the side with no external stimuli to prompt such a gesture), peculiar motor behavior or body posturing (e.g., stereotypies, waxy flexibility), or maintaining an unusual body position for an extended period.

- Stereotypies – Repetitive motor movement (such as hand flapping, swinging of legs) where the person resists changing or stopping the movement.
- Waxy flexibility – Person's limbs will remain in the position into which they were placed by another person.

Hygiene – Person is observed to have unusually poor hygiene (well beyond what is considered culturally appropriate) or has an unkempt or disheveled appearance.

Process

Interview the person directly. Keep in mind previous statements made by the person and observations you or others have made of the person's verbal and nonverbal indicators of mental health concerns.

Some people are more verbal than others, and they will make direct statements about their feelings. Others will only disclose those feelings when asked directly. When the person verbalizes feelings or reports on the occurrence of behavioral indicators of distressed mood (e.g., crying), ask how long these conditions have been present.

Others may be unable to articulate their feelings because they cannot find the words to describe how they feel, they lack insight, or they have impaired cognitive capacity. Observe the person carefully for any indicator, both at the time of the planned assessment and in any direct contacts you may have with the person during the 3-day observation period covered by this assessment.

Remember to be aware of cultural differences in how these indicators may be manifested. Some people may be more or less expressive of mental health concerns, emotions, or feelings because of their cultural norms. Be cautious not to minimize your interpretation of an indicator based on your expectations about the person's cultural background. On the other hand, it is important to be especially sensitive to these indicators when assessing a person whose culture may make him or her more stoic in expressing concerns.

Consult with others who work with the person or with family/friends who have direct knowledge of the person's typical and current behavior. Relevant information may also be found in the record, although the level of detail in the record can vary. In situations where there is a discrepancy between what is reported by the person, what you observe, and/or what is reported by others, use your clinical judgment to determine the best response.

Coding — Select the appropriate response for the presence of each indicator over the last 3 days, regardless of what you believe to be the underlying cause of the indicator. Remember to code for both the presence of the indicator and the number of days in which it was exhibited, no matter how often it was exhibited per day. Use the following responses:

- Not present.
- Present but not exhibited in last 3 days — Use this response if you know the condition is present and active, even though it was not observed in the last 3 days.
- Exhibited on 1–2 of last 3 days.
- Exhibited daily in last 3 days.

Section D. Substance Use

Number of Days in Last 30 Days Consumed Alcohol to Point of Intoxication

Intent — To determine the person's pattern of alcohol consumption during the **last 30 days**.

Definitions — Alcohol – Includes beer, wine, liquor, and liqueurs.

Intoxication – A condition following alcohol consumption in which the person experiences any one or more of the following: slurred speech, lack of coordination, unsteady gait, attention or memory difficulties, impaired judgment, stupor, or coma.

Process — When introducing this section to the person, refer back to the alcohol items addressed earlier in the assessment. The assessor can begin with a statement such as, "I noticed earlier that you mentioned you drink alcohol." Then ask the person directly if he or she has become intoxicated or drunk at any time during the last 30 days. If the response is yes, determine the frequency of occurrence in the last 30 days. You may consult family or friends if necessary. Sometimes, it is prudent to talk to the person and family separately. If there is a discrepancy in the reporting of the number of days the person was intoxicated, use your clinical judgment to

code this item. (It is not necessary to know the exact number of days, just the appropriate range.)

Coding — Select the appropriate response for the number of days of intoxication in the last **30 days**:

- None
- 1 day
- 2–8 days
- 9 or more days but not daily
- Daily

Section E. Harm to Self and Others

A review of indicators of self-harm, harm to others, and any forensic involvement will assist clinicians in identifying those at risk. For those who are at risk of engaging in these behaviors, it is critical that care planning focus immediately on interventions that address safety and prevention.

Self-Injurious Ideation or Attempt

Intent — To identify persons who are engaging or who are at risk of engaging in self-injurious behavior.

Definitions — Considered performing a self-injurious act — Person has thought about performing an act of self-injury. This includes a command hallucination that is telling the person to harm him- or herself.

Most recent self-injurious attempt — Includes both lethally motivated suicidal behavior (intentional, self-inflicted attempt to kill oneself) and behavior that inflicts intentional self-injury without suicidal intent (e.g., self-mutilation). Non-intentional, accidental, or unconscious self-destructive behaviors that may lead to injury or premature death (e.g., chronic substance abuse, hyper-obesity, noncompliance with treatments for illness, risk-taking behavior) are not considered self-injurious behaviors for the purposes of this item.

Process — Interview the person and consult with others. Family, if available, should be interviewed separately from the person so that they may express their feelings openly.

When exploring thoughts of self-harm, one might begin by acknowledging that people cope with stress or difficult times in different ways, and sometimes it can be so difficult that people consider harming themselves or wanting to end it all. Then the assessor can ask a question like, “I’m wondering if you have had any similar thoughts, or has there ever been a time when you’ve acted on these thoughts.” If the person acknowledges that he or she has acted on the self-harm thoughts, the assessor can ask something similar to, “When you attempted to harm yourself, was it to help you cope with the pain or stress of the situation, or were things so bad or hopeless that you truly wanted to end your life?”

An empathic and sensitive approach that allows the person to speak comfortably about issues such as thoughts of self-harm and actions may well provide an opportunity to help them better manage these difficult feelings.

Coding Select the appropriate response:

- Never
- More than 1 year ago
- 31 days-1 year ago
- 8-30 days ago
- 4-7 days ago
- In last 3 days

Intent of Any Self-Injurious Attempt Was to Kill Him- or Herself

Intent To determine whether the intent of the self-injurious act was to kill him- or herself.

Definition Self-injurious action was intentionally undertaken with the aim of ending the person's life (regardless of the potential lethality of the method).

Process Interview the person and consult with family, if available. Family should be interviewed separately from the person, if possible. Check the clinical record.

Coding Select the appropriate response:

- No
- Yes
- No attempt

Family, Caregiver, Friend, or Staff Expresses Concern That Person Is at Risk for Self-Injury

Definition Person's behavior indicates to someone else that he or she is at risk for self-injury, whether or not the person has verbalized thoughts of harming him- or herself.

Process Consult with family or friends, or any other individual who knows the person well. Ask them if they have any concerns about the possibility that the person might harm him or herself. This item would include recognizing any concerns that the assessor might have.

Violence

Intent To identify those who are at risk of becoming violent. These items focus on acts of ill-will, active opposition, hostility, or antagonism that may be directed toward others or inanimate objects. Past violence is often the best predictor of future violence. Awareness of those with violent tendencies can help the care team with management strategies and protect the person, other patients, staff, and others.

Definitions Intimidation of others or threatened violence – Attempts by the person to force or deter someone, by using threatening gestures, a threatening stance with no physical contact, shouting angrily, aggressive or intimidating staring, yelling personal insults or curses, using foul language in anger, kicking the wall,

throwing furniture, etc. The person may also make explicit threats of violence against others.

Violence to others – Violent acts that result in physical harm to another person. These are characterized by **purposeful, malicious, or vicious intent** by the perpetrator and can include violence driven by command hallucinations. Violent actions can include, but are not limited to, any physical act of harm to another, such as stabbing, choking, or hitting/beating (with or without a weapon).

Process — Violence and police intervention should be addressed with sensitivity and with an awareness that a history of violence or police contact are difficult subjects to discuss openly. With any indication that the discussion is aggravating the person, it is appropriate to end the discussion and either return to it later or rely on other sources of information.

It is important to adopt a nonjudgmental approach and seek the information in a nonthreatening manner. The assessor might approach the subject by noting that he or she asks this of everyone as part of the assessment. The following are some examples of ways to start the conversation that addresses the information needed: "What do you do when you get really angry?" or "How do you show others that you are really frustrated, angry, or feeling threatened?" or "Has your anger ever led you to hurt someone else?" or "How do you deal with disagreements or conflict?" The assessor would then follow up by asking for more detail if the person acknowledges a history of intimidating others, threatening others, or committing violent acts that resulted in physical harm to another person. The assessor might ask, "Have you ever had any brushes with the law?"

Coding — Select the appropriate response:

- Never
- More than 1 year ago
- 31 days-1 year ago
- 8-30 days ago
- 4-7 days ago
- In last 3 days

Police Intervention

Intent — To determine whether the person has been involved with the police (other than as a victim) and the nature of the involvement. This information is important for understanding the nature of the person's history as it relates to any involvement with the police. It is important for care planning and provides a marker regarding the intensity of the problem behavior.

Definitions — Police intervention – Any history of police contact/intervention (e.g., arrests, police escort to hospital for psychiatric examination, police intervention to de-escalate a situation with no resulting charges). This item excludes any contact with the police that involved the person as a victim.

Nonviolent behavior – Many circumstances that lead to police intervention fall under this broad category (e.g., fraud, automotive theft, trespassing). Property

damage would be included here, unless the intent was to intimidate or threaten others (which would be classified as a violent circumstance).

Violent behavior – Violent circumstances include incidents that result in (or could potentially result in) some form of bodily harm to others. Included are threats, intimidations, and attempts to be violent toward others. Robbery is often categorized as a violent crime, because it involves face-to-face contact between perpetrator and victim. In contrast, "break and enter" is more likely to be classified as nonviolent, because the intent is to avoid contact with and detection by victims.

Process — This item can be approached along with the gathering of information in Violence. There may be an opportune time during the discussion of Violence to ask if the person has ever "had any brushes with the law" or "had any contact with the police." If the response is yes, ask the person to describe, in his or her words, the circumstances leading up to the police contact. From this, the assessor can determine if the contact was of a violent or nonviolent nature.

Coding — Select the most appropriate response for most recent instance of police intervention for nonviolent and violent behavior:

- Never
- More than 1 year ago
- 31 days-1 year ago
- 8-30 days ago
- 4-7 days ago
- In last 3 days

Section F. Stress and Trauma

A person's physical and emotional state of well-being can be affected by life events. This section provides a review of major events that may cause a disruption in the person's ability to cope effectively.

Life Events

Intent — To identify specific life events or changes that may affect the person's well-being.

Definitions — Life events – Objective experiences that either disrupt or threaten to disrupt a person's current daily routine and that impose some degree of readjustment.

Death of close family member or friend — Person has experienced the death of someone he or she considers a close family member or friend.

Victim of crime – Person has been a victim of a crime, such as robbery, break and enter, or vandalism. Do not include physical assault or abuse in this item.

Victim of sexual assault or abuse – Any form of sexual abuse/assault experienced by the person, regardless of his or her age when the incident(s) occurred (e.g., an adult being subject to non-consenting fondling, exposure of genitals, sexual intercourse/rape, or having had similar experiences as a child). This area should

be approached with sensitivity. The recording of the response should not reflect what you believe may have occurred but rather what the person or the record indicates.

Victim of physical assault or abuse – Any form of physical abuse experienced by the person, regardless of his or her age when the incident(s) occurred (e.g., any incident resulting in non-accidental injury, physical confinement, excessive physical discipline, or withdrawal of necessities of life, such as food and shelter).

Victim of emotional abuse – Person has been in a pervasive and hostile emotional environment created by an abuser for the purposes of control. The abused person's self-esteem, identity, energy, ability to feel and question, wants, and needs are invalidated by the abuser.

Process — Ask the person about any of the specified events that have had an important impact on his or her life. Although there are other potentially serious life events, only code those that fit into these major categories.

Coding — Select the appropriate response for the time of most recent occurrence of each event:

- Never
- More than 1 year ago
- 31 days-1 year ago
- 8-30 days ago
- 4-7 days ago
- In last 3 days

Describes One or More of These Life Events as Invoking a Sense of Horror or Intense Fear

Intent — For care-planning purposes, it will be necessary to assess the intensity of the subjective impact that any one of these life events is having on the person, as a potential indicator of post-traumatic stress.

Process — If the person acknowledges experiencing one or more of the events noted above, ask how he or she is dealing with the memory of having experienced such an event. The person may describe (or others may have knowledge of the person reporting) intense fear or horror as a result of experiencing any of the specified situations. For example, the person (or others on the person's behalf) may also describe the presence of disturbing nightmares, episodes of anxiety when he or she thinks of the experience, or periods of intense unexplained anxiety. Do not code what you or someone else believes **should** be the person's response; code for what the person reports or for what someone else has heard from the person and then shared with you. For example, a soldier may or may not have reacted with intense fear or horror to his or her experience in a war zone. Your assessment should be based on the person's subjective reaction.

Coding — Select the most appropriate response to reflect whether the person describes one or more of these life events as invoking a sense of horror or intense fear. Select "No or not applicable" if the person did not experience a sense of horror or fear as

a result of experiencing one or more of these events, or if the person did not experience any of the events listed above. Use one of the following options:

- No Selection
- No, not applicable
- Yes
- Could not (would not) respond

Section G. Medication

Medications can be used for both psychiatric and non-psychiatric treatment. Knowledge of the person's actual drug intake can help ensure appropriate treatment, provide information about compliance with medication regimen, and assist with identifying and managing possible adverse drug effects related to side effects of specific medication or drug interactions.

Stopped Taking Psychotropic Medication in Last 90 Days Because of Side Effects

Intent — To determine if the person stopped taking psychotropic medication in the **last 90 days** because of side effects he or she experienced. This knowledge will be useful for care-planning purposes. If the person had side effects in the past, chances are that he or she will again, and this information will ensure that preventative steps can be taken.

Definitions — Psychotropic medication – Medication used in the treatment of mental illness.

Side effects – Undesirable, unintended consequences of taking medication. Examples include sedation, extrapyramidal symptoms, sexual dysfunction, and sleeping difficulties.

Process — Ask the person or family if the person has stopped taking medication, either on his or her own or as ordered by a physician, because of medication side effects. Psychotropic medication is generally, but not always, used to address mental health symptoms, such as those that are typically associated with depression, anxiety, bipolar disorder, and schizophrenia. Determine if the drug involved was a psychotropic (versus other) medication. It is critical to determine that an **unwanted side effect** was the reason the person stopped taking the medication, rather than general noncompliance (such as forgetfulness) or a desire not to experience a therapeutic effect (such as a reduction in creativity when taking medication to control symptoms of hypomania).

Coding — Select the most appropriate response for discontinuation of psychotropic medications in **last 90 days** because of side effects. Select "No, or no psychotropic medications**"** if the person did not take psychotropic medication, **or** if the person has not stopped taking psychotropic medication because of side effects in the **last 90 days**.

Intentional Misuse of Prescription or Over-the-Counter Medication in Last 90 Days

Intent	To document if misuse of medication is occurring or has occurred at any time in the **last 90 days**. This is important to know, because it has implications for possible drug interactions, as well as physical and mental health.
Definition	Misuse – Overuse or underuse of the recommended or prescribed dosage (e.g., taking a greater dose of an analgesic, taking an anxiolytic more often than recommended or prescribed) or using medication for a purpose other than its intended use (e.g., taking a diuretic for the purpose of weight control). This item includes the misuse of both prescription and over-the-counter medications.
Process	This item involves comparing for any evidence of misuse, the person's self-report of how he or she is taking his or her medication with how the medication is prescribed. Ask the person if he or she is taking the medication as prescribed. For example, the assessor might ask if the person sometimes takes an extra dose or perhaps skips a dose. This information may already have been obtained when the person was reviewing his or her medication regimen earlier in the assessment process. (See the first item in Section K of the CHA.) Use clinical judgment to determine if there is evidence of misuse, because the person may not readily admit to misusing medication. Consultation with family members may assist in discovering medication misuse. Also determine if the person is self-medicating. If so, this may be an indicator of intentional misuse (e.g., using a laxative for weight loss).
Coding	Select the most appropriate response for intentional misuse of medication over the **last 90 days**. Select "no" if the person did not take any medication over the **last 90 days**.

Section H. Social Relations

Conflict With or Repeated Criticism of Family or Friends

Intent	To identify a factor that may adversely affect the quality and nature of the person's relationships with family and friends.
Definition	A reasonably consistent pattern of hostility and/or criticism (expressed verbally or with physical gestures) directed toward family or friends.
Process	Ask the person for his or her point of view. Is he or she generally content in relationships with family and friends, or are there feelings of unhappiness? If the person is unhappy, about what specifically is he or she unhappy? It is also important to talk with family members or close friends who visit or who have frequent telephone contact with the person. To assess the person's family support network, ask how he or she views his or her relationships with family members. Family members, if available, can also provide insight into the nature of the relationship. If there are discrepancies in how different people view the relationship, the assessor should use clinical judgment to code this item.

Coding Select the most appropriate response for the presence of conflict or criticism in the last 3 days.

New York
Independent Assessor
New York State's Assessment Program in collaboration with New York Medicaid Choice

June 29, 2022

[redacted]

Important Notice About Your Assessment

Dear [redacted] [redacted]

We are writing about your assessment and clinical exam with the New York Independent Assessor. Your assessment and clinical results were completed on **June 22, 2022**.

Your assessment helps show what kind of help you need and is used to develop your plan of care.

The clinical exam helps find out if your health condition is stable to get personal care services (PCS) or Consumer Directed Personal Assistance Services (CDPAS) at home. It also helps find out if you can direct your own care.

Your clinical exam shows your health condition(s) is not stable to get PCS or CDPAS at home. The health condition(s) includes:

- Chronic Obstructive Pulmonary Disease (COPD)
- Gait and Mobility
- Femur fracture, weakness, dyspnea

This assessment also helps see if you meet the requirements to join a Medicaid Managed Long Term Care Plan. You may qualify to receive other long term services and support through a Managed Long Term Care (MLTC) plan.

Please turn this page for more information

Questions? Call **1-855-222-8350** (TTY: 1-888-329-1541).
Monday–Friday, 8:30 a.m. to 8:00 p.m. and Saturday, 10:00 a.m. to 6:00 p.m.

What happens next:

- Call us to learn about the long term services and support options that are available to you. You can call us at **1-855-222-8350**.
- The MLTC plan you choose will discuss your plan of care with you. We can help you choose a plan.

This action has been taken under Sections 505.14 and 505.28 of title 18 of New York Codes Rules and Regulations (18 NYCRR §§ 505.14 and 505.28). If you would like to talk to someone about this decision, you may ask for a conference. If you think this action is wrong, you may ask for a State fair hearing. Please read the "Right to a Conference and Fair Hearing" page that came with this letter.

Questions? Call Us.
If you have any questions about this letter, please call us. You can call us at **1-855-222-8350** (TTY: 1-888-329-1541). We can help you in any language.

Thank you,
New York Independent Assessor

Information about The Independent Consumer Advocacy Network

The Independent Consumer Advocacy Network (ICAN) is the ombudsman program for health plan members. ICAN can answer your questions and give you free, independent advice about your coverage, complaint, and appeal options. To learn more about ICAN, go to www.icannys.org, or call 1-844-614-8800. TTY: 711. All services are free.

RIGHT TO A CONFERENCE AND FAIR HEARING

If you do not understand or disagree with the actions on this notice, you have a right to a conference and/or a fair hearing. A conference is an informal meeting where you have an opportunity to review the notice with the New York Independent Assessor (NYIA) and address information that you feel is not accurate. A fair hearing is a hearing held in the presence of an administrative law judge who hears your argument to appeal the actions of the notice.

Your right to a conference

You may request a conference to review the actions on this notice. If you want a conference, you should make your request as soon as possible. If NYIA discovers at the conference that the wrong decision was made or decides to change the actions of the notice because of the information you provided, corrective action will be taken and you will be sent a new notice. Note that if you have a conference, you are still entitled to a fair hearing.

Here's how to ask for a conference:

- **Call** New York Independent Assessor at **1-855-222-8350** (TTY: 1-888-329-1541)
- **Fax:** Send a written request by fax to **1-917-228-8899**
- **Mail:** Send a written request by mail to:

  Conference Unit
  New York Medicaid Choice
  P.O. Box 5016
  New York, NY 10274

Note that the numbers and address above are only to ask for a conference. They are not for requesting a fair hearing. To ask for a fair hearing, you must ask separately.

Your right to a fair hearing

You may request a fair hearing to appeal the actions of this notice. You should request a fair hearing within 60 days of the date of this notice. There are five ways to ask for a fair hearing:

- **Call 1-800-342-3334.** Have this notice with you when you call. The call is free.
- **Fax:** Fill in the information below and fax a copy of all the pages of this notice to **1-518-473-6735**.
- **Walk-in:** Fill in the information below and bring all pages of this notice to:

  Office of Administrative Hearings
  New York State Office of Temporary and Disability Assistance

IMMEDIATE NEED FOR PERSONAL CARE SERVICES/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES

If you think you have an immediate need for Personal Care Services (PCS) or Consumer Directed Personal Assistance Services (CDPAS), such as housekeeping, meal preparation, bathing, or toileting, your eligibility for these services may be processed more quickly if you meet the following conditions:

- You have no informal caregivers available, able and willing to provide or continue to provide care;
- You are not receiving needed help from a home care services agency;
- You have no adaptive or specialized equipment or supplies in use to meet your needs; and
- You have no third party insurance or Medicare benefits available to pay for needed help.

If you don't already have Medicaid coverage, and you meet the above conditions, you may ask to have your Medicaid application processed more quickly by sending in: a completed Access NY Health Insurance Application (DOH-4220); the Access NY Supplement A (DOH-5178A), if needed; a physician's order (DOH-4359 or HCSP-M11Q) or Practitioner Statement of Need (DOH-5779) for services (see NOTE below); and a signed "Attestation of Immediate Need" (page 3 of this notice).

If you already have Medicaid coverage that does not include coverage for community-based long term care services, you must send in a completed Access NY Supplement A (DOH-5178A); a physician's order (DOH-4359 or HCSP-M11Q) or Practitioner Statement of Need (DOH-5779) for services (see NOTE below); and a signed "Attestation of Immediate Need" (page 3 of this notice).

If you already have Medicaid coverage that includes coverage for community-based long term care services, you must send in a physician's order (DOH-4359 or HCSP-M11Q) or Practitioner Statement of Need (DOH-5779) for services (see NOTE below) and a signed "Attestation of Immediate Need" (page 3 of this notice).

NOTE: If you are under 18 years of age, you must have a physician's order form (DOH-4359 or HCSP-M11Q). If you are 18 or older, you can have either a Practitioner Statement of Need form (DOH-5779) or a physician's order (DOH-4359 or M11Q).

If you don't already have Medicaid coverage or you have Medicaid coverage that does not include coverage for community-based long term care services: All of the required forms (see the appropriate list, above) must be sent to your local social services office or, if you live in NYC, to the Human Resources Administration (HRA). As soon as possible after receiving all of these forms, the social services office/HRA will then check to make sure that you have sent in all the information necessary to determine your Medicaid eligibility. If more information is needed, they must send you a letter, no later than four days after receiving these required forms, to request the missing information. This letter will tell you what documents or information you need to send in and the date by which you must send it. By no later than 7 days after the social service office/HRA receives the necessary information, they must let you know if you are eligible for Medicaid. By no later than 12 days after receiving all the necessary information, the social services office/HRA will also determine whether you could get PCS or CDPAS if you are found eligible for Medicaid. You cannot get this home care from Medicaid unless you are found eligible for Medicaid. If you are found eligible for Medicaid and PCS or CDPAS, the social services office/HRA will let you know and you will get the home care as quickly as possible.

If you already have Medicaid coverage that includes coverage for community-based long term care services:
The physician's order (DOH-4359 or HCSP-M11Q) or Practitioner Statement of Need (DOH-5779), and the signed Attestation of Immediate Need must be sent to your local social services office or HRA. By no later than 12 days after receiving these required forms, the social services office/HRA will determine whether you can get PCS or CDPAS. If you are found eligible for PCS or CDPAS, the social services official/HRA will let you know and you will get the home care as quickly as possible.

The necessary forms may be obtained from your local department of social services or are available to be printed from the Department of Health's website at: http://www.health.ny.gov/health_care/medicaid/#apply

Attestation of Immediate Need for Personal Care Services/Consumer Directed Personal Assistance Services

I, _____ (Name)

attest that I am in need of immediate Personal Care Services or Consumer Directed Personal Assistance Services.

I also attest that:

- No voluntary informal caregivers are available, able and willing to provide or continue to provide needed assistance to me;
- No home care services agency is providing needed assistance to me;
- Adaptive or specialized equipment or supplies including but not limited to bedside commodes, urinals, walkers or wheelchairs, are not in use to meet, or cannot meet, my need for assistance; and
- Third party insurance or Medicare benefits are not available to pay for needed assistance.

I certify that the information on this form is correct and complete to the best of my knowledge.

_____ _____

SIGNATURE OF APPLICANT/ REPRESENTATIVE DATE SIGNED

Individuals Receiving Long Term Care Services in a Nursing Home or Hospital Setting

If you are receiving long term care services in a nursing home or a hospital setting and intend to return home, you may have your eligibility for Personal Care Services or Consumer Directed Personal Assistance Services processed more quickly. Follow the directions on the previous page and fill in the information requested below.

I am in a nursing home or a hospital setting and have a date set to return home on

_____

DATE

Contact me or my legal representative by calling _____ .

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Program Development and Management

Practitioner Statement of Need for Personal Care/ Consumer Directed Personal Assistance Services For Adults 18 and Over (for Immediate Needs)

This form is intended for adult patients (age 18 or older) who have an immediate need for personal care and/or consumer directed personal assistance services. This includes care in the home to ensure continued patient safety through aide assistance with activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs).

For patients under age 18, practitioners cannot use this form and instead must continue to complete the Physician's Order for Personal Care/Consumer Directed Personal Assistance Services form (DOH-4359 or HCSP-M11Q).

Complete All Items **Incomplete forms will be returned to the practitioner**

1. Patient Identifying Information

Last Name		First Name	
Date of Birth	Medicaid CIN	Social Security Number	Telephone Number
Address: Street			
Address: City		State	ZIP Code

2. Practitioner Information

Last Name	First Name	
License #	Profession (MD, DO, NP, PA, SA)	Telephone Number
Address: Street		
Address: City	State	ZIP Code

I, the undersigned practitioner, certify I have direct knowledge of the patient's condition and it is my opinion that they are in need of personal care and/or consumer directed personal assistance services.

Practitioner Signature

Date Signed

Instructions

Complete all items. Incomplete forms will be returned to the practitioner. Incomplete or missing information may delay services to this patient.

1. Patient Identifying Information

- **Last Name.** Enter the patient's last name.
- **First Name.** Enter the patient's first name.
- **Telephone Number.** Enter the patient's telephone number.
- **Date of Birth.** Enter the patient's date of birth.
- **Medicaid CIN.** Found on the patient's Medical Assistance ID card.
- **Social Security Number.** Enter the patient's social security number.
- **Address.** Enter the patient's address.

2. Practitioner's Information. Enter information for the practitioner signing the order. The medical professional must be a physician licensed in accordance with article 131 of the Education Law, a physician assistant or a specialist assistant registered in accordance with article 131-B of the Education Law, or a nurse practitioner certified in accordance with article 139 of the Education Law. Enter the practitioner's license number as issued by the New York State Department of Education.

3. Practitioner's Signature/Date Signed. The signature of the practitioner identified in item 2. Note that by signing this document, the practitioner certifies that they have direct knowledge of the patient's condition and that the patient is in need of personal care and/or consumer directed personal assistance services.

4. Return Form To:

A. The Patient. The practitioner may provide the form directly to the patient to include with the other information required for immediate need of personal care and/or consumer directed personal assistance services to be submitted to their Local Department of Social Services.

B. The Local Department of Social Services. This form may be faxed directly to the Local Department of Social Services if the form is provided to the practitioner with the information filled out below:

County Name

Fax Number

IMMEDIATE NEED TRANSMITTAL TO THE HOME CARE SERVICES PROGRAM

NYC Human Resources Administration
Department of Social Services

HCSP-3052 (E) 09/19/2016

DATE: _____ CONSUMER'S NAME:_____ LAST 4 DIGITS OF CONSUMER'S SSN: _____

From
NAME OF SUBMIITING ORGANIZATION
STREET ADDRESS
CITY, STATE, ZIP CODE

To:
HOME CARE SERVICES PROGRAM – IMMEDIATE NEEDS
785 ATLANTIC AVENUE, 7th Floor
BROOKLYN, NY 11238

I am submitting this application package on behalf of the above named consumer for processing as an "Immediate Need" for home care services. S/he wishes to be enrolled in the following program (check one):

☐ Personal Care (PCS) ☐ Consumer Directed Personal Assistance (CDPAS)

I understand that the documentation listed in the table(s) below is **required** for this request to be processed. All are attached and appear to be fully completed.

For **all** Immediate Need Requests

OHIP-0103, **Attestation of Immediate Need**	HCSP M-11q, **Medical Request for Home Care**	OCA-960, **Authorization for Release of Health Information Pursuant to HIPAA**

Also required, in addition to the three items listed above, **if** the consumer already has Medicaid coverage, but it does not include long term care coverage

DOH-4495A, **Access NY Supplement A**	All necessary proofs that apply to this supplemental form **only**, as detailed in the DOH-4220 "**Documents Needed When You Apply For Public Health Insurance**" section

Also, required in addition to everything listed in both tables above, **if** the consumer does not already have Medicaid coverage at all

DOH-4220, **Access NY Insurance Application**	All necessary proofs as detailed in the DOH-4220 "**Documents Needed When You Apply For Public Health Insurance**" section

Though not required, I understand that submission of a cover letter that includes an explanation of the immediate need, the status of consumer's current whereabouts, a listing of submitted documents, the type of service requested (PCS or CDPAS), is strongly recommended.

☐ I have attached a cover letter ☐ I have not submitted a cover letter

Print Name:	Sign Name:	Telephone Number: