Category: ☐HIGHEST ☐HIGH

NEW Applicants- Clinical Eligibility Worksheet (Choices for Care)

Individual's Name: _____

NOTE: Steps 2-6 indicate HIGHEST Need criteria. Steps 7-11 indicate HIGH Need criteria.

STEP 1. Pre-eligibility Screening – For NEW applicants only

1. Is the applicant a Vermont resident and age 18 or over? ☐Yes ☐No **IF NO, STOP.**

2. Can the needs of the individuals be adequately met by services available through other sources (including but not limited to trusts, contracts for care, private insurance, Medicare, Community Medicaid, VA, VHAP, etc)? ☐Yes ☐No **IF YES, STOP.**

3. HB or ERC setting only: Does the individual have a functional limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging? ☐N/A ☐Yes ☐No **If NO, STOP**.

4. NF setting only: If the individual has an active mental health or developmental disabilities treatment plan, have they "passed" a PASSAR screening? ☐N/A ☐Yes ☐No **If NO, STOP.**

STEP 2. ADL's: Toileting, Eating, Bed Mobility or Transfer = **3 (extensive assist) or 4 (total assist) AND** any other ADL= **2 (limited assist)** or greater.

YES ☐**- Eligible: HIGHEST Need Group** **NO** ☐-Continue

STEP 3. Cognition: Decision making skills severely impaired.

YES ☐**- Eligible: HIGHEST Need Group** **NO** ☐-Continue

STEP 4. Cog & Behavior: Decision making skills moderately impaired **AND** a behavior not easily altered.

__Wandering __Verbal Abuse __Physical Abuse __Inappropriate Behavior __Resist Care

YES ☐**- Eligible: HIGHEST Need Group** **NO** ☐-Continue

STEP 5. Conditions/Treatments

Does the individual have any of following conditions or treatments that requires skilled nursing on a **daily basis**?

__End Stage Disease
__Parenteral Feedings
__Naso-gastric Tube Feeding
__Stage 3 or 4 Skin Ulcers
__2nd or 3rd Degree Burns
__IV Medications
__Suctioning
__Ventilator/Respirator

YES ☐**- Eligible: HIGHEST Need Group** **NO** ☐-Continue

STEP 6. Unstable Medical Conditions

Does the individual have an **unstable medical condition**, which requires skilled nursing on a **daily basis** related to but not limited to the following conditions?

__Aphasia
__Cerebral Palsy
__Multiple Sclerosis
__Quadriplegia
__Pneumonia
__Septicemia
__Dehydration
__Internal Bleeding
__Aspirations
__Vomiting
__Gastric Tube Feeding
__Open Lesions
__Wounds
__Chemotherapy
__Dialysis
__Oxygen Therapy
__Radiation Therapy
__Tracheostomy
__Transfusions
__Respiratory Therapy
__OTHER:_____

YES ☐**- Eligible: HIGHEST Need Group** **NO** ☐- Continue to High Need Group Worksheet

OTHER: Does the individual meet the **HIGHEST Need** criteria for reasons other than above?

YES ☐**- Eligible HIGHEST Need Group** **NO** ☐-Continue *If YES, use comment space on back to explain.*

Step 7. ADL's: Daily assistance with Bathing, Dressing, Eating, Toileting, Physical Assistance to Walk = **3 (extensive assist) or 4 (total assist).**

YES ☐**- Eligible: HIGH Need Group** **NO** ☐-Continue

Step 8. Skilled Teaching

Does the individual require skilled teaching (rehab) on a daily basis: gait training, speech, range of motion, bowel and/or bladder program.

YES ☐**- Eligible: HIGH Need Group** **NO** ☐-Continue

Step 9. Cognition & Cueing

Impaired judgment or impaired decision making skills (**Moderate)** that require constant or frequent direction for at least on of the following: bathing, dressing, eating, toileting, transferring or personal hygiene.

YES ☐**- Eligible: HIGH Need Group** **NO** ☐-Continue

Step 10. Behaviors

Does the individual exhibit at least one of the following behaviors that require a controlled environment to maintain safety for self?

__Constant or Frequent Wandering __Verbally abusive __Physically Abusive __ Behavior Symptoms

YES ☐**- Eligible: HIGH Need Group** **NO** ☐-Continue

Step 11. Conditions/Treatment & Aggregate Daily Services

Does the individual have a condition or treatment that requires skilled nursing assessment, monitoring and care on a less than daily basis including but not limited to:

__Severe Pain Management __Wound Care
__End Stage Disease __Medication Injections
__Parenteral Feedings __Suctioning
__OTHER: _____

-AND-

Who require an aggregate of other services (personal care, nursing care, medical treatments or therapies) on a daily basis.

YES ☐**- Eligible: HIGH Need Group** **NO** ☐**-NOT Eligible**

OTHER: Does the individual meet the **HIGH Need** criteria for reasons other than above?

YES ☐**- Eligible HIGH Need Group** **NO** ☐-Ineligible

Comments: _____
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DAIL LTCCC Signature:_____ Date:_____

Date of Follow Up if Necessary: _____