DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

Pre-Admission Evaluation (PAE)
Long Term Care Tool-001

Service Requested Choice:

- ☐ 30 Day Acute Care Hospitalization
- ☐ Out of State Rehabilitation
- ☐ Assisted Living Facility
- ☐ Home & Community Services
- ☐ Nursing Facility Payment Only **(Client is no longer in NF)**
- ☐ Nursing Facility (NF)
- ☐ PASRR Only
- ☐ PACE Program (when effective)

Applicant: Name (Last, First, Middle) _____

Date of Birth _____ Sex _____ Race _____

SSN _____-_____-_____ Marital Status _____ Primary Language_____

Living Arrangement: Alone _____ Spouse _____ Child _____ Parent _____ Other _____

Applicant's Address _____

City _____ State _____ Zip Code _____

Phone: (H) _____ (W) _____ (Cell) _____ Email _____

Current Location _____ Room # _____ Admission Date _____

Medically Stable: Yes _____ No _____ Discharge Plan _____

Mental Status: Alert _____ Oriented: Person _____ Place _____ Time _____ Occasionally Confused _____

Delaware Resident: Yes _____ No _____ POA or Guardianship: Yes _____ No _____

If yes, who is principle POA/Guardian? _____

Can referral source be revealed? Yes _____ No _____

Is applicant aware this referral is being made? Yes _____ No _____

If no, why not? _____

Referral Source _____ Relationship to Applicant _____

Phone: (H) _____ (W) _____ (Cell) _____ Email _____

Address _____

City _____ State _____ Zip Code _____

Diagnosis, Presenting Problem, Reason for Referral: _____

_____

Is applicant knowledgeable of diagnosis? Yes _____ No _____

Applicant's Name: _____

Primary Physician or Clinic Name: _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Financial Information:

Financial Contact _____ Relationship to applicant _____

Phone: (H) _____ (W) _____ (Cell) _____ Email _____

Address _____

City _____ State _____ Zip Code _____

Total Monthly Income $ _____ None _____

Health Insurance Information: ☐ Medicare ☐ Medicaid ☐ Other

Source:

☐ Social Security
☐ Veterans Benefits
☐ Railroad Pension
☐ Supplemental Security Income (SSI)
☐ Pension
☐ Social Security Disability Income (SSDI)
☐ Other Income

Resources:

☐ Checking $ _____
☐ Savings $ _____
☐ Money Market Account $ _____
☐ Stocks/Bonds $ _____
☐ CDs $ _____
☐ IRA $ _____
☐ Life Insurance $ _____
☐ Prepaid Burial
☐ Prepaid Burial Plot
☐ Other
☐ Owns car (s)
☐ Owns home
☐ Owns other property
☐ No Resources

Preferred location for financial interview:

☐ Wilmington ☐ Newark ☐ Smyrna ☐ Dover ☐ Milford ☐ Georgetown

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"FOR DMMA USE ONLY"

Referral taken by: _____ **Date:** _____

Applicant's Name: _____

FUNCTIONAL AND SOCIAL ASSESSMENTS (Complete **ALL** areas; circle **ONLY ONE** answer for each area)
0=Independent 1= Supervision 2= Moderate Assistance 3= Maximum Assistance

I. EATING: Process of obtaining nourishment, by any means, from a receptacle, into the body.

- ○ 0 Eats or tube feeding independently without any physical assistance (feeds self)
- ○ 1 Feeds self with reminders or verbal encouragement (supervision/coaching)
- ○ 2 Constant observation is required and/or fed part of each meal (1-3 days per week)
- ○ 3 Fed entire meal or requires tube feeding for greater than 50 percent of daily nutrition (4 or more days per week)

II. TRANSFER: Applicant's ability to move between the bed, chair, wheelchair, etc…

- ○ 0 Transfers independently without staff assistance
- ○ 1 Transfers with standby staff supervision
- ○ 2 Transfers with physical assistance of one staff member. (1-3 days per week)
- ○ 3 Transfers with physical assistance of two or more staff or a mechanical lift. (4 or more days per week)

III. MOBILITY: Applicant's ability to walk without physical assistance from others.

- ○ 0 Independently mobile (without staff physical assistance) with or without assistive devices (cane, wheelchair, walker)
- ○ 1 Mobile with standby supervision
- ○ 2 Physical assistance is always necessary for walking and wheeling. Actively participates in mobility. (1-3 days per week)
- ○ 3 Totally dependent on others for mobility. Unable to actively participate in mobility. (4 or more days per week)

Applicant's ability to self-propel a wheelchair without physical assistance from others.

NOTE: Response is required IF applicant is usually not (2) or never (3) able to walk without physical assistance from others.

- ○ Not applicable
- ○ 0 Always able to self-propel a wheelchair without physical assistance from others
- ○ 1 Physical assistance is required 1-3 days per week to propel a wheelchair
- ○ 2 Physical assistance is required 4 or more days per week to propel a wheelchair.
- ○ 3 Never able to self-propel a wheelchair without physical assistance from others

IV. TOILETING: Applicant's physical ability to get into, onto, and from a bathroom, toilet, commode, bedpan or urinal.

- ○ 0 Toilets independently without staff physical assistance
- ○ 1 Requires supervision, reminders or verbal cueing for toileting. Does not need staff physical assistance
- ○ 2 Requires direct staff physical assistance and attendance during toileting (toileting, incontinence, ostomy or foley care) daily. Actively participates in toileting
- ○ 3 Always requires complete staff physical assistance with toileting (toileting, incontinence, ostomy or foley care) daily

V. BATHING: Applicant's ability to bath self without physical assistance from others.

- ○ 0 Independent with bathing
- ○ 1 Requires physical assistance 1-3 days per week with bathing
- ○ 2 Requires physical assistance 4 or more days per week with bathing
- ○ 3 Totally dependent on others for bathing

Applicant's Name: _____

VI. HYGIENE: Applicant's ability to perform personal hygiene (shaving, shampooing, nail and oral care) without physical assistance from others.

- ○ 0 Independent with personal hygiene
- ○ 1 Requires physical assistance 1-3 days per week with personal hygiene
- ○ 2 Requires physical assistance 4 or more days per week with personal hygiene
- ○ 3 Totally dependent on others for personal hygiene

VII. DRESSING: Applicant's ability to dress self without physical assistance from others.

- ○ 0 Independent with dressing
- ○ 1 Requires physical assistance 1-3 days per week with dressing
- ○ 2 Requires physical assistance 4 or more days per week with dressing
- ○ 3 Totally dependent on others for dressing

VIII. ORIENTATION: Applicant's orientation to both person (remembers name, recognizes family) and place (knows where s/he is and able to locate common areas in living environment).

- ○ 0 Always oriented to both person and place
- ○ 1 Usually oriented to both person and place. (disoriented to person and/or place 1-3 days per week)
- ○ 2 Usually not oriented to person and/or place. (disoriented to person and/or place 4 or more days per week)
- ○ 3 Never oriented to person and/or place

IX. COMMUNICATION

EXPRESSIVE: Applicants ability to express basic wants and needs.

- ○ 0 Always able to express basic wants/needs using verbal/written language or assistive communication device
- ○ 1 Usually able to communicate basic wants/needs using verbal/written language or assistive communication device. (requires assistance 1-3 days per week)
- ○ 2 Usually not able to communicate basic wants/needs using verbal/written language or assistive communication device. (requires assistance 4 or more days per week)
- ○ 3 Never able to communicate basic wants/needs

RECEPTIVE: Applicant's ability to understand and follow simple instructions (e.g., perform basic activities of daily living such as dressing or bathing) without continual caregiver intervention.

- ○ 0 Always able to understand and follow simple instructions
- ○ 1 Usually able to understand and follow simple instructions. (1-3 days per week)
- ○ 2 Usually not able to understand and follow simple instructions. (4 or more days per week)
- ○ 3 Never able to understand and follow simple instructions

X. MEDICATION: Applicant's ability to self-administer medications with limited assistance from others (e.g., reminding, encouraging, reading labels, opening bottles, handing to applicant, monitoring dosage.) This includes PO, IV, IM Enteral, RX Otics, Optics, Topicals, Inhalers, and continuous SQ pain management.

- ○ 0 Always physically and mentally capable of self administering prescribed medications
- ○ 1 Usually physically and mentally capable of self administering prescribed medications with limited assistance. (requires assistance 1-3 days per week)
- ○ 2 Usually not physically and mentally capable of self administering prescribed medications despite availability of limited assistance. (requires assistance 4 or more days per week)
- ○ 3 Never able to self administer prescribed medications, despite the availability of limited assistance

INSULIN ADMINISTRATION: If on a fixed dose of insulin, applicant's ability to inject insulin with a pre-filled syringe; or if on a sliding scale, applicant's ability to draw up and inject insulin.

- Not applicable.
- 0 Always able to inject a fixed dose of insulin with a pre-filled syringe; or, if on a sliding scale, is able to draw up and self inject insulin
- 1 Requires physical assistance 1-3 days per week to inject a fixed dose of insulin with a pre-filled syringe; or, if on a sliding scale, requires physical assistance 1-3 days per week to draw up and/or inject insulin
- 2 Requires physical assistance 4 or more days per week to inject a fixed dose of insulin with a pre-filled syringe; or, if on a sliding scale, requires physical assistance 4 or more days per week to draw up and/or inject insulin
- 3 Requires physical assistance with insulin administration on a daily basis

XI. BEHAVIORS: Does applicant require continual staff intervention for a persistent pattern of behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement)?

- 0 Does not have a persistent pattern of behavior problems requiring caregiver intervention
- 1 Requires caregiver intervention 1-3 days per week due to an established and persistent pattern of behavior problems
- 2 Requires caregiver intervention 4 or more days per week due to an established and persistent pattern of behavior problems
- 3 Requires caregiver intervention daily due to an established and persistent pattern of behavioral problems

XII. TRANSPORTATION

- 0 Has own or other means of reliable transportation consistently available
- 1 Requires occasional assistance with transportation
- 2 Resides in an area not served or under served by public transportation
- 3 Lack of transportation is a serious contributing factor to lack of regular medical care

XIII. HOUSING/LIVING ARRANGEMENTS

- 0 Living situation is stable or receiving Section 8/DHAP assistance
- 1 Formerly independent but temporarily residing with family or friends
- 2 Requires assistance accessing housing program and/or occasional assistance with rent and utilities.
- 3 Homeless, living in an emergency shelter, pending eviction and/or unable to live independently

XIV. MENTAL HEALTH AND/OR SUBSTANCE ABUSE

- 0 No history of mental illness or addiction
- 1 Past history of mental illness and/or addiction
- 2 Currently in treatment or on medication for mental health issues
- 3 Fails to access needed therapy for mental health issues and/or substance abuse

XV. ORAL AND VISION CARE

- 0 Receives regular dental and vision exams.
- 1 Requires assistance accessing dental and vision care.
- 2 Significant difficulty related to oral and/or vision problems.
- 3 Does not make and/or keep dental and/or scheduled ophthalmology appointments.

XVI. LEGAL ISSUES

- 0 Currently not involved with the legal system
- 1 Currently involved with the legal system for non-criminal matter (e.g., divorce, child custody)
- 2 Applicant reports current charges/pending court date
- 3 Currently involved with probation/parole

Applicant's Name: _____

XVII. RISK REDUCTION

- ○ 0 No behavior placing applicant at risk
- ○ 1 Some risky behavior , describe _____
- ○ 2 Minimal understanding of risky behavior but accepting of formal supports
- ○ 3 Refuses to engage in risk reduction discussions and refuses to accept formal supports.

XVIII. SOCIAL SUPPORT

- ○ 0 Applicant reports strong support system
- ○ 1 Social support system but estranged from at least 1 source of social support (e.g., family, friends, spiritual)
- ○ 2 Minimal social support from family, friends, or spiritual contacts
- ○ 3 None or refuses social support system

SKILLED NURSING SERVICES (Check all that apply and indicate frequency needed)
These services must be ordered by a physician and supported by documentation. All services must be performed by professional nursing staff. **Any services checked require the italicized documentation faxed with the PAE.**

Skilled nursing service	Frequency
☐ Tube Feeding (PEG, NG, GT) ***Physician's orders***	None
☐ Pressure Ulcer Care including Wound Vacuum • Pressure ulcer must be stage 3 or 4 in severity. ***Physician's orders and wound assessment describing characteristics and measurements***	None
☐ IV or Hyperal Therapy ***Physician's orders-specify frequency and duration***	None
☐ Daily Intermittent Catheterization ***Physician's orders***	None
☐ Complex Dressing Changes (excludes pressure ulcer care, peg site care, and skin tears) usually more than once per day. • May include the following: • Wound Vacuum, Trach Care, Surgical Wounds, Stasis Ulcers, Skin Graft Sites ***Physician's orders***	None
☐ Suctioning (nasopharyngeal, trach) excludes trach care and oral suctioning ***Physician's orders***	None
☐ 24 Hour Skilled Nursing • 24 hours skilled nursing observation, assessment, and/or intervention for unstable conditions that is provided 24 hours per day, including but not limited to: • Ventilator Care, Unstable Insulin Dependent Diabetics • Specify symptoms of unstable condition: _____ ***Physician's orders***	None

Applicant adheres to medical care: Yes ☐ **No** ☐
If no, give a brief description and include any other comments in regards to client's assessment:

Applicant's Name: _____

CERTIFICATIONS

CERTIFICATION OF ASSESSMENT

I certify that the level of care information provided in this PAE is accurate. I understand that this information will be used to determine the applicant's eligibility for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's DSHP Plus program and Title XIX of the Social Security Act. I further understand that, under the Delaware False Claims and Reporting Act, any person who presents or causes to be presented to the State a claim for payment under the DSHP Plus program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties.

Assessor's Signature: _____ Credentials: _____ Date: _____

DMMA ONLY:

I certify that the LOC is justified based on the information I have received and reviewed as contained in this document

YES ◯ NO ◯ LOC Approved YES ◯ NO ◯ LOC Denied

PAS RN Signature: _____ Date: _____

DIAGNOSES relevant to applicant's functional, social, and/or skilled nursing needs:

REQUIRED ATTACHMENTS (In addition to the completed PAE, the following attachments must be submitted):

- ☐ Completed and signed release of information form including the Awareness Statement
- ☐ History and Physical or a Comprehensive Medical Report (MAP 25) completed within 365 days
- ☐ Completed Medication Record **IF** current medications are not listed on one of the following: the MAP, physicians' monthly orders, facility medication record, discharge summary, or H&P.
- ☐ **Out of State Rehab Request:** Letter of Denial from each Delaware Acute In-patient Rehabs indicating the individual's care cannot be met in their facility and a written Plan of Care from the prospective Out of State Rehabilitation facility.

CERTIFICATION OF LEVEL OF CARE (Choose one certification only) (Must be completed by MD, NP or PA). Certification is not required IF: A fully completed MAP with physician signature is sent with the PAE. OR: Client is in a Nursing Facility and a signed monthly physician order sheet (POS) and H&P are sent with the PAE.

◯ **YES** ◯ **NO:** I certify that the applicant meets a Nursing Facility Level of Care in a Facility or Community setting.

◯ **YES** ◯ **NO:** I certify that the applicant meets and Acute Hospital Level of Care (**AIDs/HIV population only**) and that the requested long term care services are medically necessary for this applicant.

I understand that this information will be used to determine the applicant's eligibility for long term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the State's DSHP Plus program and Title XIX of the Social Security Act. I further understand that under Delaware's False Claims and Reporting Act, any person who presents or causes to be presented to the State a claim for payment under the DSHP Plus program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties.

Signature of Physician:_____ **Date:** _____

NOTE:

- Submission of an incomplete PAE may result in processing delays or in denial of the PAE.
- Completion of all elements does not guarantee Long Term Care approval; the applicant must satisfy medical and financial eligibility requirements for Long Term Care services.

DMMA is to Maintain a copy of signed PAE form in the applicant's file.

Applicant's Name: _____

Medication Name and Dosage	**Start date, if known.**

"The medications on this list were offered to DMMA by the client, their caregiver or their doctor. It is not meant as Physician's orders for medication."

AUTHORIZATION TO DISCLOSE INFORMATION TO DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Name of Person Whose Records Are to be Disclosed:	
Date of Birth (MM/DD/YYYY):	Social Security Number:

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of the information listed below to Delaware Health and Social Services for determining my eligibility for medical assistance and/or food benefits. This release may be used to ask for, receive and/or release information that is pertinent to my eligibility determination.

☐ **All my medical records:**

1. All records and other information regarding treatment, hospitalizations, and outpatient care for my impairment(s).
2. Information about how my impairment(s) affect my ability to complete tasks, activities of daily living, and specifics functions in the work environment.

☐ **All Financial records:**

1. All records from financial institutions, including information of any accounts closed within the last 60 months.
2. Information from all sources of income (Social Security Administration, current and past employers, Annuity companies, etc).
3. All life insurance companies.

Awareness Statement:

I understand that I have the choice of either Long Term Care Community Services or Residential Placement.

I choose to apply for (**check only one**):

- ◯ Assisted Living
- ◯ Long Term Care Community Services
- ◯ Nursing Facility

(PACE – to be added when effective)

This authorization ends when the information asked for is received, or 12 months from the date signed or until revoked by me in writing, whichever comes first.

Signature of Individual Authorizing Disclosure:			
If not signed by subject of disclosure, specify basis for authority to sign (provide supporting documentation): ☐ Parent of Minor ☐ Power of Attorney ☐ Guardian ☐ Other			
Date Signed	Address		
Telephone Number:	City	State	Zip Code