WYOMING DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING - WYOMING MEDICAID
FORM LT101: ASSESSMENT OF MEDICAL NECESSITY FOR LONG TERM CARE

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NF____ LTC/WAIVER_______ CASE MANAGER ______________________________

MEDICAID ID# ____________________________ SSN# ____________________________

NAME OF RESIDENT____
(Last) (First) (MI)

HOME ADDRESS____

COUNTY OF RESIDENCE_________________________ PHONE # __________________

BIRTH DATE________________ REFERRAL SOURCE_________________________

DATE OF REFERRAL________________DATE OF REVIEW________________________

COUNTY OF REVIEW____NO _____________

DIAGNOSIS____

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1. EATING/MEAL PREPARATION/DIET
   - (0) a. Independently feeds self.
   - (1) b. Independently feeds self but needs someone to prepare meals.
   - (2) c. Requires supervision or assistance to assure nutritional needs are met.
   - (2) d. Requires specially prepared diet, i.e. calorie specific diabetic, renal dialysis diet, etc.
   - (3) e. Swallowing or choking precautions.
   - (4) f. Requires constant attention and hand feeding by assistant. Tube feedings.
2. MEDICATION MANAGEMENT
   - (0) a. PRN medication or no medications.
   - (1) b. Requires minimal (1-4) medications on a regular basis, oral or topical, including vitamins.
   - (2) c. Requires multiple (5 or more) maintenance medications as a daily regime, or weekly or monthly injections.
   - (3) d. Requires monitoring for cardiac rate depressors, hypertensives, insulin, anticoagulants, etc. at least once a month.
   - (4) e. Frequent monitoring is required for need or dosage regulations, e.g., insulin, narcotics, anticoagulants, etc. Requires med box or insulin syringes filled. Oxygen is covered here if required on a regular continuing basis.
3. SKIN CARE, DRESSING, TREATMENT
   - (0) a. Skin intact.
   - (1) b. Superficial skin conditions, fragility, rashes or chronic dermatitis.
   - (2) c. Pressure areas, requires daily peri-care, small skin flap with dressing, or lesions that are not infected.
   - (4) d. Open skin lesions present (post-op wounds with complications, decubiti, and sterile/special dressing) that can be cared for by non-licensed personnel for a portion of the day.
4. SPEECH, VISION, HEARING
   - (0) a. Unimpaired or impaired, but not dependent on assistance.
   - (2) b. Communication impairment that results in the need for assistance.
   - (3) c. Completely dependent in areas of communications.
5. DRESSING AND PERSONAL GROOMING
   - (0) a. Appropriate and independent dressing, undressing or grooming with little assistance.
   - (1) b. Inability to button or zip or choose wardrobe.
   - (2) c. Significant assistance or cuing needed on a regular basis.
   - (3) d. Requires total dressing or undressing and grooming.

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ADDITIONAL CRITERIA FOR NURSING FACILITY PLACEMENT: Any of the following qualifies the individual for nursing facility care as opposed to Home and Community-based care. Circle all that apply.

a. Meets Medicare skilled criteria, or in need of daily professional evaluation for modification of treatment or care.

b. Documented need for rehabilitation training for self-feeding, dressing and grooming, self-administration of medications, bowel and bladder program, validation therapy, behavior modification, blind deaf or aphasic rehabilitation, or special groups necessary five or more days a week in accordance with an individual plan of care and reasonable goals are being reached in a predictable period of time.

c. Unable to be cared for in the community due to unavailability of services or resources or lack of support system, or dependent upon institutional environment to maintain functioning.

d. Intermittently confused and/or agitated and in need of structured environment, wanders extensively, total confusion or total apathy.

COMMENTS/REFERRALS:

F/CM-WHITE HCF-CANARY DFS-PINK PHN-GOLDENROD
LT101 7/96
C-300

TYPE: ADMIT/ELIGIBILITY ____ LEVEL II ____ 6 MO. HCBS RENEWAL__
CONTINUED STAY REVIEW: 3 MO. _____ 6 MO. ______ YEARLY ________
SITE: HOSP____ NF____ RESIDENCE____ OTHER____ PHONE ________________
SOURCES: CLIENT____ PROFESSIONAL____ CAREGIVER____ RECORDS__

IS RESIDENT EXPECTED TO REMAIN IN A MEDICAL INSTITUTION FOR 30 CONSECUTIVE DAYS OR MORE? YES ____ NO _________

ENTERING NF FROM: HCBS WAIVER ____ HOME ___ HOSP ___ OTHER _
ENTERING HCBS FROM: HOME ____ HOSP ____ NF ____ OTHER ____
RECEIVING HOME HEALTH SERVICES? YES_____ NO______________

FACILITY OF RESIDENT____
ADMIT DATE______________ PROGNOSIS_______________________________________
IF LESS THAN 13 POINTS OR LTC/HCBS ADMISSION, HAS CARE PLAN BEEN PREPARED?
YES ____ NO ____ IN MAIL _________
RN SIGNATURE____

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6. BATHING
   - (0) a. Independent bathing with little assistance.
   - (1) b. Mobile, but unable to safely bathe without regular assistance and supervision.
   - (3) c. Cannot bathe without total assistance. (tub, shower, whirlpool or bed bath).
7. CONTINENCE
   - (0) a. Continent of bowel and bladder.
   - (2) b. Occasional incontinence or stress incontinence, requires toileting or reminder by another, needs help to clean self.
   - (3) c. Frequent to total incontinence and unable to participate in a training program; maintenance of colostomies and ileostomies.
   - (3) d. Requires catheter and catheter care.
8. MOBILITY
   - (0) a. Independently and appropriately able to transfer and/or ambulate with or without device.
   - (2) b. Able to transfer and/or ambulate with minimal or stand-by assistance; unstable, weak, frequent falls.
   - (4) c. Completely dependent, frequent transfers or frequent positioning.
   - (4) d. Requires two person transfer.
   - (4) e. Participating in a specialized rehabilitative training in accordance with individual plan of care.
9. BEHAVIOR/MOTIVATION
   - (0) a. Appropriate behavior, well-motivated to and capable of performing ADLs. Comatose or unresponsive.
   - (1) b. Intermittently confused and/or agitated; requires occasional reminders as to person, place or time.
   - (2) c. Potential for substance abuse, including alcohol or prescription drugs, alone or in combination.
   - (3) d. Frequently aggressive, abusive or disruptive.
   - (4) e. Forgetful, may wonder, safety concerns. In danger of self-inflicted harm or self-neglect due to depression.
10. SOCIALIZATION
   - (0) a. Independent participation in social or therapeutic activities by choice. Isolated or reclusive by personal history.
   - (2) b. Requires special assistance or encouragement for participation in planned social activities because of depression or confusion.
   - (3) c. Requires one-on-one assistance to maintain contact with reality.
   - (4) d. Potential for abuse or neglect. Unable to defend self due to confusion, fragility or fear.

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PLACEMENT SUMMARY:

Total Points ________ If 13 or more, individual meets medical necessity for Long Term Care.

_____ (1) Has 13 points AND meets Nursing Facility criteria. Client may be served either on LTC/HCBS Waiver or in the Nursing Facility.

_____ (2) Has 13 points but does not meet Nursing Facility criteria. May be served on LTC/HCBS Waiver.

_____ (3) Has 13 points and does not meet Nursing Facility criteria, but CHOOSES Nursing Facility care due to social or geographic isolation, safety concerns, insufficient home support.

_____ (4) Has 13 points AND meets Nursing Facility criteria, but LTC/HCBS Waiver slot is not available. May be served in the Nursing Facility

_____ (5) Does not have 13 points but meets one or more Nursing Facility criteria. May be served in the Nursing Facility only.

_____ (6) Does not have 13 points, but current placement remains medically necessary to maintain optimal functioning and continued safety and welfare of the client. May be served on the LTC/HCBS Waiver (Documentation attached).

I give permission for sharing of information directly related to my health, social, environmental, and economic status with those agencies providing LTC/HCBS Waiver services as necessary to determine if I am appropriate for Waiver services.

Signature:_____________________________________ Date: ____________________

Witness: _______________________________________ Date: ____________________

GUIDELINES FOR COMPLETING THE LT101:THIS ASSESSMENT MUST BE PERFORMED PRIOR TO NURSING HOME ADMISSION, OR UPON TRANSFER TO A NEW FACILITY, OR UPON APPLICATION FOR TITLE XIX (MEDICAID) BENEFITS FOR NURSING HOME OR LTC/HCBS WAIVER SERVICES. THIS FORM MUST BE COMPLETED BY A PHN WITHIN THREE (3) DAYS OF THE REFERRAL AND MUST BE SUBMITTED WITHIN ONE (1) DAY OF PERFORMANCE.

ALL FIELDS ARE REQUIRED.

WAIVER/NF: Check the service the client is requesting.
CASE MANAGER: Name of Case Manager chosen for LTC/HCBS Waiver.
MEDICAID ID#: If known.
SOCIAL SECURITY #: Required. Form will be returned if SSN is missing.
NAME OF RESIDENT: Resident's legal name, last name first; no nicknames, please.
HOME ADDRESS: Client's home address.
COUNTY OF RESIDENCE: County in which the resident will apply for Medicaid.
PHONE: Client's home phone number.
BIRTH DATE: According to SSA or DFS records, if possible.
REFERRAL SOURCE: Name of nursing home, hospital or agency requesting LT101.
DATE OF REFERRAL: Date request was received by PHN.
DATE OF REVIEW: Date review was performed by PHN.
COUNTY OF REVIEW: County of performance. If by phone, list PHN's county.
NO.: County code number.
DIAGNOSIS: List current diagnosis first; include dementia, mental illness or mental retardation where appropriate.

TYPE: Check purpose of review: admission to NF or applying for Medicaid eligibility; or MR/MI Level II screening.
CONTINUED STAY REVIEW: Check time period that applies. 3 month review is at PHNs discretion.
SITE: Where the LT101 was performed: hospital, nursing home, residence, or other (Adult Day Care or PHN office), or by telephone.
SOURCES: How information was obtained. PHN SHOULD SEE THE RESIDENT IN PERSON or Medicaid will not pay for the review. In case of telephone review, a re-review must be done in person at the earliest opportunity.
IS RESIDENT EXPECTED TO REMAIN IN A MEDICAL INSTITUTION FOR 30 CONSECUTIVE DAYS OR MORE? This includes hospital, inpatient rehab, nursing home or LTC/HCBS Waiver and is part of eligibility determination.
ENTERING NF FROM: Indicate present location of client.
ENTERING HCBS FROM: Indicate present location of client.
FACILITY OF RESIDENT: Name of facility seeking admission.
ADMIT DATE: Date of admission to facility.
PROGNOSIS: Current prognosis of client.
IF LESS THAN 13 POINTS OR LTC/HCBS ADMISSION, HAS CARE PLAN BEEN PREPARED? Check yes or no.
RN SIGNATURE: Must be performed and signed by Public Health RN only.

PLACEMENT SUMMARY:

Add total points from items 1-10 above. Check appropriate box numbered 1-5.

Select (1) if client has 13 or more points in items 1-10 and has at least one of items a-d circled. Client is qualified to be served on either the LTC/HCBS Waiver or in the nursing facility.

Select (2) if client has 13 or more points in items 1-10, but has no ADDITIONAL CRITERIA FOR NURSING FACILITY PLACEMENT. The client may be served on the LTC/HCBS Waiver.

Select (3) if client has 13 or more points in items 1-10, has no ADDITIONAL CRITERIA FOR NURSING FACILITY PLACEMENT, but chooses nursing facility care. The client may be served in the nursing facility.

Select (4) if client has 13 or more points in items 1-10, has no ADDITIONAL CRITERIA FOR NURSING FACILITY PLACEMENT, but there are no LTC/HCBS Waiver slots available. The client may be served in the nursing facility.

Select (5) if client scores less than 13 points in items 1-10, but meets one or more of the ADDITIONAL CRITERIA FOR NURSING FACILITY PLACEMENT. The client may be served in the nursing facility, but not on the LTC/HCBS Waiver.

Select (6) if client is on the LTC/HCBS Waiver and because of the intervention of waiver services no longer meets 13 points but it is anticipated that removal of those services may cause a decline that will result in the need for higher cost services. Documentation of rationale must accompany LT101.

A new LT101 is required for a LTC/HCBS Waiver client with a placement code of (2) or (6) before entering a nursing facility.

SEE LT101 TRAINING MANUAL FOR DETAILS ON COMPLETING THE FORM.