COUNTY OF REVIEW

DIAGNOSIS

1. (1) b. Requires minimal (1-4) medications on a regular basis, oral or topical, including

2. MEDICATION MANAGEMENT

(4) f. Requires constant attention and hand feeding by assistant. Tube feedings.

(3) e. Swallowing or choking precautions.

(2) d. Requires specially prepared diet, i.e. calorie specific diabetic, renal dialysis diet, etc.

(1) b. Independently feeds self but needs someone to prepare meals.

(0) a. Independently feeds self.

1. EATING/MEAL PREPARATION/DIET

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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 PHN's 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.