

Choices for Care - Clinical Eligibility Worksheet
REASSESSMENT

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 physical limitation resulting from a physical condition (including stroke, arthritis, spinal cord 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.**

REASSESSMENT

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 Stage 3 or 4 Skin Ulcers Suctioning
 Parenteral Feedings 2nd or 3rd Degree Burns Ventilator/Respirator
 Naso-gastric Tube Feeding IV Medications

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 Internal Bleeding Dialysis
 Cerebral Palsy Aspirations Oxygen Therapy
 Multiple Sclerosis Vomiting Radiation Therapy
 Quadriplegia Gastric Tube Feeding Tracheostomy
 Pneumonia Open Lesions Transfusions
 Septicemia Wounds Respiratory Therapy
 Dehydration Chemotherapy 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: Require Daily assistance with at least one of the following: 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

Requires skilled teaching (rehab) on a daily basis to regain control of, or function with at least one of the following: 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 decision making skills =**Moderate** or impaired judgment that requires constant or frequent re-direction for 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 Behavioral 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: _____

DAIL LTCCC Signature: _____

Date: _____

Date of Follow Up if Necessary: _____