INSTRUCTIONS FOR COMPLETING THE MEDICAID PREADMISSION EVALUATION FORMS FOR SERVICES PROVIDED IN AN INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED OR ALTERNATIVE COMMUNITY PROGRAMS.

The instructions for completing the Pre-Admission Evaluation (PAE) are listed below. Please complete the form in black ink, if submitting a paper application.

AUTHORIZATION	**This section is for TennCare use only.** TennCare staff will complete the authorization section at the top of page 1 indicating if the PAE review resulted in approval or denial of the requested service. The "Approved From" date is the date on which reimbursement will be provided if the requested service is approved. The "Through" date, is one is indicated, is the last date for which reimbursement of the requested service will be available without further action. "Reviewed By" indicates the name of the TennCare registered nurse that reviewed the PAE application. The Review Date indicates the date the PAE review was completed.

GENERAL INFORMATION: SECTION I

Type of Services Requested	Select "ICF/MR" for individuals applying for reimbursement of care provided in an Intermediate Care Facility for the Mentally Retarded. Select the specific "HCBS-MR" waiver for individuals applying for reimbursement of services in a Home and Community based Services Waiver for persons with mental retardation and developmental disabilities.

PROVIDER INFORMATION

Provider name and address	Enter the name and address of the provider of services. The provider consists of nine digits; add 00+your current seven digits. Following review, a windowed envelope will be used to return the application to the address listed, if submitting the application by paper print or type legibly.
Provider number	Enter the TennCare facility or waiver service

	provider number. Payment cannot be made until this number is provided.
Provider phone number	Enter the business number of the provider including the area code.

REASON FOR PREADMISSION EVALUATION

Reason for Pre-admission Evaluation	Check appropriate box, indicating the reason the PAE is being submitted.

PRIOR SERVICES

Prior Services	Indicate "yes or no". Was the individual receiving Medicaid-reimbursement care in an Intermediate Care Facility for the Mentally Retarded or through a HCBS waiver for persons with mental retardation and developmental disabilities on or before December 31, 1990?

RECIPIENT INFORMATION

Name	Enter the applicant's last name, first name, and middle initial.
Address	Enter the applicant's street address, city, state, and zip code. Note: For new admissions to a facility, this should not be the facility address.
Sex	Enter the applicant's sex: "M" for male and "F" for female.
Date of Birth	Enter the date the applicant was born" Use MM/DD/YY format.
Age	Enter the applicant's age.
Telephone Number	Enter the applicant's telephone number, area Code first.
Medicaid ID Number	Enter the Medicaid applicant's 11 digit Medicaid identification number if the individual is already receiving Medicaid/TennCare long-term care services. If the applicant is not yet eligible for Medicaid/TennCare long-term care services, print "Applying" or "Pending" in these spaces.

Social Security Number	Enter the applicant's social security number.
Designated Correspondent name, address and telephone number	Enter the name, address, and telephone number of the person who has been designated by the applicant to receive copies of any correspondence or notice pertaining to the application. This should not be anyone employed by the provider.

PSYCHOLOGICAL EVALUATION: SECTION II

Level of mental retardation	Check the box that is appropriate to indicate Mild, Moderate, Severe, or Profound level of mental retardation.
IQ Test Score	Enter the full-scale IQ test score, the date of test and the type of IQ test. If the person is a very young child and an IQ test can not be appropriately administered due to the young age of the person, please attach a letter of explanation with information about the person's diagnosis and developmental disabilities.
Psychological Examination (required)	Attach a psychological examination performed no more than 365 days prior to the certification date. A clinical psychologist or Doctor of Education must sign the psychological examination. The PAE will not be approved without a current, signed and dated psychological examination report. The PAE will not be approved unless the psychological evaluation was preformed prior to the PAE request/certification date.

ASSESSMENT OF CAPABILITIES AND NEEDS: SECTION III

Assessment of the Applicant	Choose the single best answer for each of the following assessment perimeters: bathing, expressive communication, receptive communication, eating, mobility, orientation, self-administration of prescription medication, toileting, transfer, and vision. Clarifying comments may be hand written on the paper form

Need for Behavior Intervention	Select "yes" or "no". If "yes" is marked, describe the behavior in the provided space. Attach supporting documentation (i.e. behavior incident reports).
Previous Habilitative Training for ADLs	Select "yes" or "no".
Nursing Services Needed	List any licensed nursing services that are needed and the frequency of the service provided.
Signature of Physician, Physician's Assistant, Licensed Nurse, Social Worker (BSW/MSW), Or Special Education Teacher/Instructor	Provide the signature of the individual completing the assessment and the date completed in the individual's original handwriting. The assessment must be completed by a Physician, Physician's Assistant, a Licensed Nurse, a Social Worker ((BSW/MSW), or a Special Education Teacher/Instructor. The title of the individual must be indicated. Social Workers or Special Education Teachers who complete the assessment must have had ongoing involvement with the person for one year and must indicate the initial contact date with the applicant.

MEDICAL EVALUATION: SECTION IV

Diagnoses	Indicate currently applicable diagnoses relevant to the request for approval for reimbursement of ICF/MR or HCBS Waiver services.
Medical History & Physical Exam	A History and Physical addressing all body systems which has been completed no more than 365 days prior to the request date is required. The physician may summarize pertinent medical history and physical examination facts in the space provided or a history and physical report may be attached. The PAE will not be approved unless the medical history and physical examination was performed prior to the PAE request/certification date.
Plan of Care	The Plan of Care submitted on or with the PAE serves as the initial Plan of Care until the facility plan or HCBS Individual Support Plan is developed. The Initial Plan of Care must be

	noted on the PAE form or attached for ICF/MR applicants. If attached, "see attached" should be noted on the form. For applicants seeking reimbursement of HCBS Waiver services, the Initial Plan of Care must be listed on the PAE form. At a minimum, the PAE Plan of Care shall include the type, amount, frequency and duration of each service to be provided upon enrollment.
Current Medications	List all current medications the applicant is Taking. Physician's orders or a current medication administration record may be attached if "see attached" is noted on the form.
Certification	The name of the physician should be legibly PRINTED on the 1st line. The physician must sign and date the physician's signature line. Stamped signatures will not be accepted. Both the signature and date must be completed by the physician. The certification/request date must be a date after the performance of the psychological evaluation and the medical history and physical. The update lines are to be used of the PAE expires before it is used and an update is requested. PAEs expire in 90 days from the "Approved From" date at the top of page 1 of the PAE. Updates are not appropriate and will be denied of there is a significant change in the applicant's condition. A new PAE is required if a significant change has occurred since the original request.
RETRO ACTIVE LINE (NOT ON PAE ELECTRIC FORM)	The Retroactive request line is to be signed and dated if approval is needed prior to an originally Approved date (i.e. if retroactive financial eligibility is determined).