Person Information

Demographic Details

First Name | Middle Initial | Last Name | Suffix

Date Of Birth | Gender | SSN

Alias First Name | Middle Initial | Alias Last Name | Suffix

Physical Address

Address Line 1 | Address Line 2

City | State | Zip | County

APO / FPO (For Military Address) | AA / AE/ AP (For Military Address)

Mailing Address

Address Line 1 | Address Line 2

City | State | Zip | County

APO / FPO (For Military Address) | AA / AE/ AP (For Military Address)

Contact Information

Email Address

Cell Phone | Home Phone | Work Phone

(_ _ _) _ _ _-_ _ _ _ | (_ _ _) _ _ _-_ _ _ _ | (_ _ _) _ _ _-_ _ _ _

Preferred Phone Type

What is your preferred language for letters we send you?

Designee Information

Do you want someone else (we call this person a Designee) to get letters we mail from TennCare?

_____

Designee First Name	Middle Initial	Designee Last Name

Designee Relationship	Designee Phone Number
	(_ _ _) _ _ _ - _ _ _ _

Do you or your designee need interpreter services? _____

For what language? _____

Is the designee mailing address different from your mailing address? _____

Address Line 1	Address Line 2

City	State	Zip	County

APO / FPO (For Military Address)	AA / AE/ AP (For Military Address)

Living Arrangement

What is the current Living Arrangement of the person? _____

Describe Living Arrangement _____

Facility Name

Address Line 1 | Address Line 2

City | State | Zip | County

Phone Number (_ _ _) _ _ _-_ _ _ _

Provider ID

Additional Details

Date of Admission | Expected Discharge Date | Anticipated Discharge Date

Date of Incarceration | Anticipated Release Date

Program Request

Select Program

Program Selected

PAE Request Date

Would you like to be considered for CHOICES Group 3?

Actual Discharge Date

Would you like to enroll this person in MFP if they are eligible?

MFP Eligibility Identified Date

Medical Diagnosis

Chronic Diagnoses

Does the person have a presenting chronic diagnosis as determined by a medical professional?

Please enter all presenting chronic diagnoses for which a functional deficit exists.

Medical Diagnosis

Functional Assessment

Activities of Daily Living

Transfers

Can person transfer to and from bed, chair, or toilet without physical help from others ?

☐ Always	Always is always capable of transfer to and from bed, chair, or toilet without physical assistance.
☐ Usually	Person is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others 1-3 days per week.
☐ Usually Not	Person is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others 4-6 days per week.
☐ Never	Person is never capable of transfer to and from bed, chair, or toilet without physical assistance 7 days per week.

Comments

Mobility

Can person walk without physical help from others?

☐ Always	Person is always capable of walking without physical assistance.
☐ Usually	Person is incapable of walking unless physical assistance is provided by others 1-3 days per week
☐ Usually Not	Person is incapable of walking unless physical assistance is provided by others 4-6 days per week.
☐ Never	Person is never capable of walking without physical assistance 7 days per week.

Comments

Activities of Daily Living Contd...

If walking is not feasible, is person capable of using a wheelchair, either manual or electric?

- ☐ Always — Person is always capable of mobility without physical assistance.
- ☐ Usually — Person is incapable of wheelchair mobility unless physical assistance is provided by others 1-3 days per week.
- ☐ Usually Not — Person is incapable of wheelchair mobility unless physical assistance is provided by others 4-6 days per week.
- ☐ Never — Person is never capable of wheelchair mobility without physical assistance 7 days per week.

Comments

Eating

Can the person eat prepared meals without physical help from others?

- ☐ Always — Person is always capable of eating prepared meals or administering tube feedings without assistance.
- ☐ Usually — Person is incapable of eating prepared meals or administering tube feedings unless l assistance is provided by others 1-3 days per week.
- ☐ Usually Not — Person is incapable of eating prepared meals or administering tube feedings unless assistance is provided by others 4-6 days per week.
- ☐ Never — Person is never capable of eating prepared meals or administering tube feedings without assistance 7 days per week.

Comments

Toileting

Can person toilet without physical help from others? (This does not include transferring)

- ☐ Always — Person is always capable of toileting without physical assistance.
- ☐ Usually — Person is incapable of toileting unless physical assistance is provided by others 1-3 days per week.
- ☐ Usually Not — Person is incapable of toileting unless physical assistance is provided by others 4-6 days per week.
- ☐ Never — Person is never capable of toileting without physical assistance 7 days per week.

Comments

Is the person incontinent?

Activities of Daily Living Contd..

Select Incontinency Type(s):

Can the person perform incontinent care without physical assistance from another person on an ongoing basis?

- ☐ Always — Person is always capable of performing incontinence care without physical assistance.
- ☐ Usually — Person is incapable of performing incontinence care and requires physical assistance 1-3 days per week.
- ☐ Usually Not — Person is incapable of performing incontinence care and requires physical assistance 4-6 days per week.
- ☐ Never — Person is never capable of performing incontinence care and requires physical assistance 7 days per week.

Comments

Does the person have a catheter/Ostomy?

Can the person perform catheter/ostomy care without physical assistance from another person on an ongoing basis?

- ☐ Always — Person is always capable of performing catheter/ ostomy care without physical assistance.
- ☐ Usually — Person is incapable of performing catheter/ ostomy care and requires physical assistance 1-3 days per week.
- ☐ Usually Not — Person is incapable of performing catheter/ ostomy care and requires physical assistance 4-6 days per week.
- ☐ Never — Person is never capable of performing catheter/ ostomy care and requires physical assistance 7 days per week.

Comments

Activities of Daily Living Contd..

Orientation

Is person oriented to PERSON (fails to remember own name, or recognizes family), PLACE (does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make decisions that prevent risk of harm)?

☐ Always	Person is always oriented to person, place and event/situation.
☐ Usually	Person is not oriented to person or place or event/situation 1-3 days per week.
☐ Usually Not	Person is not oriented to person or place or event/situation 4-6 days per week.
☐ Never	Person is never capable of performing catheter/ ostomy care and requires physical assistance 7 days per week.

Comments

Expressive Communication

Can person reliably communicate basic wants and needs?

☐ Always	Person is always capable of reliably communicating basic needs and wants.
☐ Usually	Person is incapable of reliably communicating basic needs and wants and requires continual intervention 1-3 days per week.
☐ Usually Not	Person is incapable of reliably communicating basic needs and wants, and requires continual intervention 4-6 days per week.
☐ Never	Person is never capable of reliably communicating basic needs and wants, and requires continual intervention 7 days per week.

Comments

Activities of Daily Living Contd..

Receptive Communication

Can person understand and follow very simple instructions without continual intervention?

- ☐ Always — Person is always capable of understanding and following very simple instructions and commands without continual intervention.
- ☐ Usually — Person is incapable of understanding and following very simple instructions and commands without continual intervention 1-3 days per week.
- ☐ Usually Not — Person is incapable of understanding and following very simple instructions and commands without continual intervention 4-6 days per week.
- ☐ Never — Person is never capable of understanding and following very simple instructions and commands without continual intervention 7 days per week..

Comments

Medication

Is person physically or cognitively able to self-administer medications with limited assistance from others? This excludes sliding scale insulin which is documented in the skilled services section.

- ☐ Always — Person is always capable of self-administration of prescribed medications.
- ☐ Usually — Person is incapable of self-administration of prescribed medications without physical intervention 1-3 days per week.
- ☐ Usually Not — Person is incapable of self-administration of prescribed medications without physical intervention 4-6 days per week.
- ☐ Never — Person is never capable of self-administration of prescribed medications without physical intervention 7 days per week.

Comments

Please list medications for which assistance is needed

Medication	Can the person self-administer? (Yes/No)	If No, Why?
Pills / Tablets		
Eye Drops		
Inhaler / Nebulizer		
Topical / Patches		
Injections		
Meds via Tube		

Activities of Daily Living Contd..

Behavior

Does person require persistent intervention for an established and persistent pattern of behavioral problems not primarily related to a mental health or substance abuse disorder?

- ☐ Always — Person always requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 7 days per week.
- ☐ Usually — Person requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 4-6 days per week.
- ☐ Usually Not — Person requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 1-3 days per week.
- ☐ Never — Person requires persistent intervention due to an established and persistent pattern of behavioral problems.

Comments

Please specify the behavioral problems requiring continual staff or caregiver intervention:

Behavior Type	Intervention

Skilled Services

Indicate if the person need skilled nursing or rehabilitative services:

Skilled Nursing & Rehabilitative Services

Please add all the applicable services below and the frequency needed.

Name	Requested Start Date	Requested End Date

Enhanced Respiratory Care

Does the person need Enhanced Respiratory Care?

Name	Requested Start Date	Requested End Date

Safety Determination Summary

- ☐ I am aware that a safety determination request may be initiated by an person or person representative. I have talked to the person about meeting NF LOC for Medicaid reimbursement of NF services, including safety determinations. A safety determination has not been requested.
- ☐ I am aware that a safety determination request may be initiated by an person or person representative. I have talked to the person about meeting NF LOC for Medicaid reimbursement of HCBS, including safety determinations. A safety determination has not been requested.
- ☐ I am a TennCare Qualified Assessor and I attest that this person a) appears to qualify for CHOICES Group 3 based on an acuity score below 9 and his needs can be safely met within the Group 3 expenditure cap. Or b) appears to qualify for CHOICES Group 2 and his needs can be safely met within his individual CN cap.

Safety Determination Request

Safety Justification

- ☐ An approved acuity score of at least (5) but no more than eight (8).
- ☐ Has an intellectual or developmental disability and a General Maladaptive Index value of -21 or lower.
- ☐ An individual acuity score of at least 2 for the Behavior measure.
- ☐ An individual acuity score of at least 3 for the Orientation measure.
- ☐ An individual acuity score of at least 3 for the mobility or transfer measures.
- ☐ An individual acuity score of at least 2 for the toileting measure.
- ☐ Significant change in physical or behavioral health or functional needs for person.
- ☐ Significant change in physical or behavioral health or functional needs for person's primary caregiver.
- ☐ Pattern of recent falls resulting in injury.

Safety Determination Request Contd..

☐ Pattern of recent emergent hospital admissions, NF admissions, or ER visits.

Type	Admit/Visit Date	Discharge Date	Reason

☐ Self-negligence resulting in involvement by law enforcement or Adult Protective Services.

☐ Recently discharged from a community-based residential alternative setting.

☐ Has diagnosed complex acute or chronic medical conditions.

Medical Condition	Acute or Chronic	Licensed Staff Required	Intervention Required

☐ Requires post-acute inpatient treatment for a specified period of time.

☐ MCO has determined person's needs cannot be safely met if enrolled in Group 5.

☐ None of the criteria have been met, but other safety concerns which impact the person being safely served in CHOICES Group 5 exist.

☐ MCO has determined person's needs cannot be safely met if enrolled in Group 3.

☐ None of the criteria have been met, but other safety concerns which impact the person being safely served in CHOICES Group 3 exist.

☐ Person is a current CHOICES Group 1 or 2 or PACE Member enrolled on or after 7/1/2012 and no longer meets NF LOC requirements.

Safety Attestation

Please read and attest by selecting at least one of the statements below. (Select ALL that apply)

☐ I do NOT believe this individual can be safely served in the community in CHOICES Group 3.

☐ I believe this individual CAN be safely served in the community in CHOICES Group 3.

☐ This safety determination form was completed at the request of the person/representative.

Fall History

Fall History Information

Fall History Information Contd..

How many falls did the person experience in the last 6 months?

Location of Fall

Date of Fall

Time of Fall

Factors Contributing to Fall:

Additional Factors

Was an injury sustained related to fall?

Describe the person's sustained injuries.

What mechanisms are in place to prevent falls?

Why were these prevention mechanisms unsuccessful?

Cost Neutrality Details

Name	Service Type	Amount	Frequency
Total Annual Cost			

Home and Community Based Services

Does this person require ongoing Home and Community Based Services?

Supporting Documentation

Certification of Assessment

Please read the statement below before you continue.

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 person's eligibility and/or reimbursement for long-term care services in a Nursing Facility, Home and Community Based Services or care in an Intermediate Care Facility for Individuals with Intellectual Disabilities. 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 TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties.

I have read and understand the statement above. I agree to submit this form by electronic means. By selecting my name below and signing this form electronically, I understand that an electronic signature has the same legal effect and can be enforced in the same ways as a written signature.

Qualified Assessor Credentials

PAE Certification Date (mm/dd/yyyy)

Qualified Assessor Name

Qualified Assessor Code

MFP Attestation

I am requesting participation in the Money Follows the Person Demonstration for this individual and certify this is an eligible individual transitioning to a qualified residence who has signed consent for participation.

Eligible Individual

☐ I certify this is an eligible individual who-

- resides for at least 60 days in a qualifying inpatient facility (hospital, nursing facility, institution for mental diseases [IMD] for eligible individuals, intermediate care facility for individuals with intellectual disability [ICF/ID]); and
- receives Medicaid; and
- requires institutional care; and
- Medicaid has paid for at least one day of services received in the institution, except in the case of a qualifying SNF stay

MFP Attestation **Contd..**

Qualified Residence

☐ I certify this is transitioning to a qualified residence, defined as-

- a home owned or leased by the individual or the individual's family
- an apartment with an individual lease with lockable access and egress, and living, sleeping, bathing, and cooking areas they control; or
- requires institutional care; and
- a residence, in a community-based residential setting in which no more than four unrelated individuals reside

Signed Consent

☐ I certify that I have received signed consent for participation from the individual

I have read and understand the statement above. I agree to submit this form by electronic means. By selecting my name below and signing this form electronically, I understand that an electronic signature has the same legal effect and can be enforced in the same ways as a written signature.

Certifier Name

Credentials

Entity Association

Physician Certification of LOC

LOC Certifier Name

NPI

Medicaid ID

Credentials

Certification Date

Review and Submit

MOPD

MOPD Date

Submit

PAE Request Date

Comments

CHOICES Group 3 Interest

Would you like to be considered for CHOICES Group 3?

Actual Discharge Date