471-000-5 Instructions for Completing Form DM-5-DD-LTC. "Long Term Care Evaluation for Intermediate Care Facilities for the Individuals with Developmental Disabilities"

Use: Form DM-5-DD-LTC is used to establish level of care for a client admitted to an intermediate care facility for individuals with developmental disabilities (ICF/DD).

Completion: Facility staff and local office staff shall complete Form DM-5-DD-LTC within 15 days after the client's admission. It is essential that all pertinent information regarding the client's medical, social, and habilitative needs be included. Form DM-5-DD-LTC is completed as follows:

Refer to 471 NAC 31-ff for use - distribution

Attached Are (upper right corner): The facility shall attach to this form copies of –

- Form DM-5 or a history & physical
- Interdisciplinary team's pre-admission evaluation and meeting
- Independent QIDP Assessment
- MC-9NF

Resident's Name: Enter the client's name.

Social Security Number: Enter the client's last 4 digits of their Social Security number.

Date of Birth: Enter the client's date of birth.

Diagnosis Primary: Enter the client's current primary diagnosis. ICD codes may be used.

Eligibility Date: Enter the date the client became eligible for Nebraska Medicaid.

Date of Admission: Enter the date the client was admitted to the ICF/DD level of care at this facility. This date requires three conditions be met: The interdisciplinary team agreed to admission, the client physically resides in the facility and the client uses a bed certified for ICF/DD level of care. (See 471 NAC 31-ff).

Diagnosis Secondary: Enter the client's current secondary diagnosis. ICD codes may be used.

Date Completed: Enter the date this form was completed at the facility.

Facility Name and Address: Enter the name and address of the facility in which the client resides.

Physician: Enter the name of the client's current attending physician.

Date Last Seen: Enter the date on which the physician last visited the client.

Attending QIDP: Enter the name of the client's QIDP.

1A. Physician's Plan of Care Includes: Check all areas included in the physician's plan of care (physician's orders).

1 B. Team's Plan Also Includes: Check the areas included in the client's pre-admission evaluation by the team. Note: Items already included under the "Physician's Plan of Care" are considered part of the team's pre-admission evaluation but are not repeated) in this section.

2. List Medications: List or attach a list of all prescribed medications and dosages. If medications are ordered PRN, list the frequency the client has required the medication. Attachments may not exceed three pages.

The nurse for the client's living unit shall sign this section. The nurse is responsible for the medical information on this form.

3. Indicate Individual's Needs/Strengths: Check all characteristics which apply to the client and provide further description of the client's skills, behaviors, and characteristics, as appropriate. This section identifies the client's needs and corresponds to the areas addressed in Section 1, Physician's and Team's Plans of Care, and "Current Habilitative Training."

For example, if a client is incontinent, indicate this in the third column. If incontinency is addressed through a toileting schedule, indicate this in the first column. If incontinency is addressed through a formal toileting training program, indicate this in "Current Habilitative Training" (following).

Current Habilitative Training: List the training programs/services currently implemented, including further evaluations or baselines, and the reason for admission; or refer to the client's interdisciplinary team pre-admission evaluation if these items are listed in the evaluation.

On and Off Living Unit: List the current training programs/services provided to the client.

Reason for Admission: Enter a short summary of why this is the best available plan for the client, including the alternatives explored (see 471 NAC 31-ff).

Signatures: The nurse for the client's living area and the QIDP shall sign sections 2 and 3 respectively. The facility staff member shall sign and date the form after completion.

Distribution (see 471 NAC 31-ff):

1. The form and all attachments go to the Medicaid ICF/DD Review Team responsible for that facility's reviews.
2. The Medicaid ICF/DD Review Team makes a determination and returns a copy of Form DM-5-DD-LTC to the facility and ACCESS NE.

Retention: The forms will be retained per HIPAA requirements by Medicaid, the provider, and ACCESS NE.

Form DM-5-DD-LTC, “ICF/ID CARE EVALUATION INTERMEDIATE CARE FACILITIES” is available at http://public-dhhs.ne.gov/FORMS/Home.aspx. Search for DM-5-DD-LTC