

Pre-PAS Screening Tool

FOR MEMBERS AT LEAST 12 YEARS OLD

Pre-PAS Guidelines

To be eligible for ALTCS, an applicant has a combination of factors that put the applicant at risk for being at an institutional level of care (i.e., at risk of being in a nursing home [SNF] or an intermediate care facility).

Individuals in an intermediate care facility or SNF/ ICF-IID require treatment or rehabilitation in a protected residential setting where they receive ongoing evaluations, planning, 24 hour supervision, coordination and integration of health or rehabilitative services. These programs occur on a daily basis and require active treatment, which is an aggressive and well coordinated program.

Individuals in this environment need more than the informal care characterized by verbal reminders, occasional physical assistance or informal behavioral methods. In order to meet the ALTCS criteria, an individual must require a level of care which is below that of an acute hospital setting, but above that of supervisory level of care.

Member's Information

Name (Last, First, M.I.) _____

Date of Birth _____ Date Pre-PAS Completed _____

Member's Medical Diagnosis Information

Check the diagnosis(es) that the member currently has:

Autism Intellectual Disability Cerebral Palsy Epilepsy (Seizures)

NOTE: Having one of the above diagnoses does not automatically qualify a person for ALTCS.

Member's Independent Living Skill (ILS) Information

Check areas in which the member is currently receiving hands-on assistance from another person:

- Eating/Drinking (may also check this if tube fed)
- Bathing/Showering
- Dressing (does not need to be able to match colors or choose clothing based on the weather)
- Personal Hygiene ((includes hair care (not styling), brushing teeth, washing face and hands, shaving, nail care, menses care and use of deodorant))
- Preparing a simple meal at least 5 times weekly (e.g.,cereal, hot dog, eggs, frozen meals, sandwiches)
- Toileting (i.e., indicating need to use the toilet, wiping, flushing, clothing adjustment)

Check areas in which the member has significant delays:

- Hand Use: uses a raking motion or grasps with whole hand, unable to use fingers independently
- Walking ((unsteady 10-20 feet (with/without devices) alone or with another person; or doesn't walk))
- Understanding and following routines; only knows certain things happen at morning/noon/night

Member's Behavior Information

- Physically attacks other people (not animals) and must be stopped to prevent injury **OR** has caused someone serious injury requiring medical attention in the past year
- Verbally/physically threatens self/others/objects and causes fear at least once weekly, and requires intervention to stop it or prevent it
- Hurts self on purpose repeatedly at least once weekly causing injury and needing intervention to stop or prevent it from happening **OR** has caused him/herself serious injury requiring medical attention in the past year
- Disrupts self or others inappropriately at least once weekly and requires intervention to stop
- Does things over and over and can't seem to stop himself/herself (e.g., rocking, hand flapping)
- Cries, screams, demands attention, teases/pesters others, or has tantrums at least once weekly and needs an intervention to stop

Member's ALTCS Information

If the member has previously applied for ALTCS, what has changed for the member since then that is **NOW** putting the member at risk of, or requiring, an institutional level of care? (Check all that apply)

Hospitalizations/ER Visits
Decline in Function

New Diagnosis
Placements in Facility

Additional/New Treatments
Additional/New Behaviors

If nothing has changed since the last ALTCS application, please discuss with the family that it is not appropriate to submit a new ALTCS referral at this time.

Member's Referral Summary

An ALTCS referral seems appropriate if the member has either:

At least 5 ILS boxes checked

OR a combination of ILS boxes with Behaviors equaling at least 6 boxes total

OR a Moderate or Severe Intellectual Disability with at least any 4 boxes checked.

If member meets criteria above, Date ALTCS Referral sent: _____

Include the Member's current records with this referral to ALTCS:

Most Recent Medical Records (e.g., PCP, specialists)
Most Recent School Records (e.g., IEP, therapy reports, evaluations)
Most Recent Behavioral Health Records
Testing provided for diagnosis(es)
Most Recent DDD ISP

DDD Employee completing this Pre-PAS: _____

DDD Employee Phone #: _____

DDD Fax#: _____

ALTCS Eligibility Outcome: Eligible Ineligible

Date of ALTCS Determination: _____