PERSONAL CARE SERVICES PROGRAM
PRE-ADMISSION SCREENING (PAS) FORM

NOTE: PC Agency use of PC Services PAS is only to be completed in situations where PC RN suspects member is no longer medically eligible for PC Services. PC RN is to complete PAS and enter it into PC UMC web portal. UMC will make final determination about medical eligibility.

Facility/Agency/Person making referral:

Name:____Address: ________________________________

Contact Person: __________________________________

Phone: ________________________________Fax: ________________________________

- o Personal Care: Re-evaluation

I. DEMOGRPAHIC INFORMATION

1 Individual's Full Name	**2. Sex:** ☐Female ☐Male	**3. Medicaid Number**		**4. Medicare Number**
5. Address: (Including Street/Box, City, State & Zip)				**6. Private Insurance**
7. County	**8. Social Security Number**	**9. Birth Date**	**10. Age**	**11. Phone #**
12. Spouse's Name		**13. Address (if different from above)**		
14. Current living arrangements, including formal and informal support (i.e. family, friends, other services)				
15. Name and Address of Provider if Applicable:				

16. Medicaid Waiver Recipient: A.☐ Yes B. ☐ No C. ☐ Aged/Disabled D. ☐ I/DD
17. Has the option of Medicaid Waiver been explained to the applicant? A. ☐ Yes B. ☐ No
18. Check if Applicant has any other of the following:

a. ☐ Guardian
b. ☐ Committee
c. ☐ Medical Power of Attorney Name
d. ☐ Power of Attorney ☐ Other
e. ☐ Durable Power of Attorney
f. ☐ Living Will

Address of the Representative: (Including Street/Box, City, State & Zip)

Phone Number: ________________________________

19. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the physician to Department of Health and Human Resources or its representative.

X____

Signature – Applicant or Person acting for Applicant **Relationship** **Date**

WEST VIRGINIA Department of Health & Human Resources BUREAU FOR MEDICAL SERVICES

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Name:

MEDICAL ASSESSMENT

20. Health Assessment – Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(s) with dates – Date of most recent office visit. (Attach most recent Hospital Discharge and Physical, if available)

21. Normal vital Signs for the Individual:

a. Height b. Weight: c. Blood Pressure d. Temperature e. Pulse f. Respiratory Rate

Check if Abnormal:

a. □ Eyes
b. □ Ears
c. □ Nose
d. □ Throat
e. □ Mouth
f. □ Neck
g. □ Breast
h. □ Lungs
i. □ Heart
j. □ Arteries
k. □ Veins
l. □ Lymph System
m. □ Extremities
n. □ Abdomen
o. □ Hernia(s)
p. □ Genitalia-Male
q. □ Gynecological
r. □ Ano-Rectal
s. □ Musculo-Skeletal
t. □ Skin
u. □ Nervous System
v. □ Allergies (Specify)

Describe Abnormalities and Treatment:

23. Medical Conditions/Symptoms: (Check all that apply and have been diagnosed by a physician and/or treated with prescription medications.)

a. □ Angina-rest
b. □ Angina-exertion
c. □ Dyspnea
d. □ Significant Arthritis
e. □ Paralysis
f. □ Dysphagia
g. □ Aphasia
h. □ Pain
i. □ Diabetes
j. □ Contracture(s)
k. □ Mental Disorder(s)
l. □ Other (Specify)

24. Decubitus: a. □ Yes b. □ No If yes, check the following:

A. Stage B. Size C. Treatment

Location:

a. □ Left Leg
b. □ Left Arm
c. □ Right Leg
d. □ Right Arm
e. □ Left Hip
f. □ Left Buttock
g. □ Right Hip
h. □ Right Buttock

Other: Developed at: a. □ Home b. □ Hospital c. □ Facility

25. Can the individual vacate the building? (Check only one)

a. □ Independently b. □ With Supervision c. □ Mentally Unable d. □ Physically Unable

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26. Indicate individual's ability in the home for each item with the level number 1,2,3, or 4. Nursing care plan must reflect functional abilities of the member in the home.

Item	Level 1	Level 2	Level 3	Level 4
a. Eating (Not a meal Prep)	Self/Prompting	Physical Assistance	Total Feed	Tube Feed
b. Bathing	Self/Prompting	Physical Assistance	Total Care	
c. Dressing	Self/Prompting	Physical Assistance	Total Care	
d. Grooming	Self/Prompting	Physical Assistance	Total Care	
e. Cont./Bladder	Continent	Occasional Incontinence	Incontinent	Catheter
f. Cont./Bowel	Continent	Occasional incontinence *less than 3 X per week	Incontinent	Colostomy
g. Orientation	Oriented	Intermittently disoriented	Totally Disoriented	Comatose
h. Transferring	Independent	Supervised/Assistive Device	One Person Assist	Two Person Assist
i. Walking	Independent	Supervised/Assistive Device	One Person Assist	Two Person Assistance
j. Wheeling	No Wheelchair	Wheels Independently	Situational Assistance (Doors, etc.)	Total Assistance
k. Vision	Not Impaired	Impaired/Correctable	Impaired/Not Correctable	Blind
l. Hearing	Not impaired	Impaired/Correctable	Impaired/Not Correctible	Deaf
m. Communication	Not impaired	Impaired/Understandable	Understandable with Aids	Inappropriate/None

27. Professional and technical care needs – check all that apply:

a. □ Physical Therapy	f. □ Ostomy	k. □ Parenteral Fluids
b. □ Speech Therapy	g. □ Suctioning	l. □ Sterile Dressing
c. □ Occupational Therapy	h. □ Tracheostomy	m. □ Irrigations
d. □ Inhalation Therapy	i. □ Ventilator	n. □ Special Skin Care
e. □ Continuous Oxygen	j. □ Dialysis	o. □ Other

28. Individual is capable of administering his/her own medication:
a. □ Yes b. □ With Prompting/Supervision c. □ No

29. Current Medications	Dosage	Frequency

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30. Current Diagnoses – Check all that apply:

a. □ None
b. □ Mental Retardation
c. □ Autism
d. □ Seizure Disorder (Age at onset ( ))
e. □ Cerebral Palsy
f. □ Other Developmental Disability: Specify
g. □ Schizophrenic Disorder
Specify:
h. □ Paranoid Disorder
i. □ Major Affective Disorder
j. □ Schizoaffective Disorder
k. □ Affective Bipolar Disorder
l. □ Tardive Dyskinesia
m. □ Major Depression
n. □ Other related conditions

31. Clinical and Psychosocial Data – Please check any of the following behaviors which the individual has exhibited in the past two years.

a. □ Substance Abuse (Identify)
b. □ Combative
c. □ Withdrawn/Depressed
d. □ Hallucinations
e. □ Delusional
f. □ Disoriented
g. □ Bizarre Behavior
h. □ Bangs Head
i. □ Sets Fires
j. □ Displays inappropriate Social Behavior
k. □ Seriously Impaired Judgment
l. □ Suicidal Thoughts, Ideations/Gestures
m. □ Cannot Communicate Basic Needs
n. □ Talks about his/her Worthlessness
o. □ Unable to Understand Simple Commands
p. □ Physically Dangerous to Self and Others, if unsupervised
q. □ Verbally Abusive
r. □ Demonstrates Severe Challenging Behaviors
s. □ Specialized Training Needs
t. □ Sexually Aggressive

Does the individual have Alzheimer's multi-infarct, senile dementia, or related condition? □ Yes □ No
□ Other (Specify):

II. PHYSICIAN RECOMMENDATION

32. Prognosis: Check one only: a. □ Stable b. □ Improving c. □ Deteriorating d. □ Terminal
Diagnosis:

Rehabilitative Potential – Check one only: a. □ Good b. □ Limited c. □ Poor

33. Other Medical Conditions Requiring Physician Orders:

To the best of my knowledge, the patient's medical and related needs are essentially as indicated above (Must be signed by M.D., D.O, Physician Assistant, or Nurse Practitioner)

Physician's Signature **MD/DO/PA/Nurse Prac.** **Date**	**TYPE OR PRINT** Physician's Name/Address below

34. RN Signature and Date: ______________________________

DISCLAIMER: Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan
NOTE: Information gathered from this form may be utilized for statistical/data collection.