CONSUMER ASSESSMENT TOOL (CAT)

Agency Name:
Provider-Assessor#:
OA/AP#:
Assessment Type:

Applicant Name:
Assessment Date:
Medicaid#:

Client Information

DSDSID:
Street Address:
City:
State:
Zip Code:
Home Phone:
Work Phone:
Cell Phone:
Date of Birth:
Current Age:
Medicaid#:
Medicare#:
Veteran#:
Other Insurance:

Present Location

☐ Same As Above

Facility:
Facility Type:
Street Address:
City:
State:
Zip Code:
Phone:

Demographic Data

Race:
Primary Language:
Gender:
Marital Status:
Education:
Living Arrangement:
Total In Home:
If client does not live alone, indicate number of persons under each category
Client's Spouse:
Client's Parent(s):
Client's Siblings:
Children:
(under age 18, regardless of parentage)
Adult Children:
Other Relatives:
Others:
(ex: friends, roommates)

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
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OA/AP#: **Medicaid#:**

Present (Protocol):

Checked Client's ID.

Showed Assessor's ID.

Read Consumer Assessment Tool/Personal Care Assessment Tool (CAT/PCAT) Brochure to Client.

Left CAT/PCAT Brochure and Personal Care Assistant Brochure With Client.

Assessment Covers Last 7 Days And Considers Other Health, Medical, Or Functional Needs Since Last Assessment And/Or The Previous 12 Months.

Supports:

Legend:

☑ Present At Assessment ☑ Provides Support

☑	☑	Relationship	Name	Phone Numbers	Address
☐	☐			Home: Work:	
☐	☐			Home: Work:	
☐	☐			Home: Work:	
☐	☐			Home: Work:	
☐	☐			Home: Work:	

Services:

Service type	Service Utilization	Provider Name	Days per Week	Times per Day	Amount of Time (Min)
Chore/Waiver					
Instrumental Activities of Daily Living					
Day Habilitation					
Meals On Wheels					
Supported Living					
Transportation					
Adult Day Services					
In Home Supports					
Respite					

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
Provider-Assessor#: **Assessment Date:**
OA/AP#: **Medicaid#:**

Diagnoses:

Other Current DX. & ICD-9 Codes

Other Information/Documents Reviewed

Client has a Mental Health Primary diagnosis

Employment

Is client currently employed?

Are PCA services needed to maintain employment?

PCA/Employment Verification Questions

1. What is the name of your employer?
2. Please submit employment verification to SDS (at minimum, one form of employment verification must be provided):
   - ☐ W-4 form
   - ☐ Most recent tax return
   - ☐ IRS form 1099 (if self employed)
   - ☐ Paystubs last 6 months
3. Has the employment income been reported to the Division of Public Assistance?
4. How long have you been employed?
5. What are your work hours/schedule?
6. What are the specific tasks you do for your job?
7. What specific hands on assistance (within the scope of what PCA services provide) are required to maintain employment?
8. How have you been managing to maintain employment without PCA services?

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name:		**Applicant Name:**	
Provider-Assessor#:		**Assessment Date:**	
OA/AP#:		**Medicaid#:**	

Cognition

Can client draw a clock?	
Can client recall 3 items in 5 minutes?	
Cognition notes:	

Functional assessment

"Touch your hands over your head"	
"Touch your hands behind your back"	
"Place your hands across your chest and stand up"	
"Grip with both hands"	Left Hand:
	Strength:
	Right Hand:
	Strength:
In sitting position - "Touch your feet"	
Functional assessment notes:	

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**

Provider-Assessor#: **Assessment Date:**

OA/AP#: **Medicaid#:**

Medical Providers:
(List all medical and/or dental appointments. Record providers' names, frequency of visits, last visit, and required escort time, if applicable.)

Appointment Type	Is Consent for Release of Information needed?	Days/Year	Escort Time	Provider	Last Visit

Therapies provided by a qualified therapist
(Indicate the number of days per week for each therapy required. Enter 0 if none)

Therapy	Days/Week	Escort Time	Provider	Last Visit
a. Physical therapy				
b. Speech/language therapy				
c. Occupational therapy				
d. Respiratory therapy				
Total # of days of therapy per week				

Prescriptions Requiring PCA Hands-On Assistance:
(The prescription must be dated within one year for it to be considered and must be completed by Physician/PA/ANP)

Prescription Type	Times Per Day	Amount Time (Min)	Days Per Week	Expiration Date
Range of Motion				
Walking Exercise				
Foot Care				

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
Provider-Assessor#: **Assessment Date:**
OA/AP#: **Medicaid#:**

Bed Mobility

Code self-performance during last 7 days (24-28 hours if in hospital) - not including setup with the following codes:

0. Independent - No help or oversight - or - Help/oversight provided only 1 or 2 times during last 7 days.
1. Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - or - Supervision plus nonweight-bearing physical assistance provided only 1 or 2 times during last 7 days.
2. Limited Assistance - Person highly involved in activity; recieved physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3+ times - or - Limited assistance(as just described) plus weight-bearing 1 or 2 times during last 7 days.
3. Extensive Assistance - While person performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   Weight-bearing support
   Full staff/caregiver performance during part (but not all) of last 7 days.
4. Total Dependence - Full staff/caregiver performance of activity during ENTIRE 7 days.
5. Cueing - Spoken instruction or physical guidance which serves as a signal to do an activity are required 7 days a week. Cueing is typically used when caring for individuals who are cognitively impaired.
8. ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS.

Code for most support provided over each 24 hour period during last 7 days (24-48 hours if person is in hospital);code regardless of person's self performance classification using the following codes:

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
5. Cueing - cueing support required 7 days a week
8. Activity did not occur during entire 7 days

Self-Performance Score: Support Score:

a. Bed Mobility (How person moves to and from lying position, turns side to side, and positions body while in bed)

Consumer report

Assessor observation (include type of assistance and assistive devices used, if applicable)

Frequency: Times per day Days per week

Transfers

Self-Performance Score: Support Score:

b. Transfer (How person moves between surfaces - to/from bed, chair, wheelchair, standing position (Exclude to/from bath/toilet))

Consumer report

Assessor observation (include type of assistance and assistive devices used, if applicable)

Frequency: Times per day Days per week

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
Provider-Assessor#: **Assessment Date:**
OA/AP#: **Medicaid#:**

Locomotion

Code self-performance during last 7 days (24-28 hours if in hospital) - not including setup with the following codes:

0. Independent - No help or oversight - or - Help/oversight provided only 1 or 2 times during last 7 days.
1. Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - or - Supervision plus nonweight-bearing physical assistance provided only 1 or 2 times during last 7 days.
2. Limited Assistance - Person highly involved in activity; recieved physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3+ times - or - Limited assistance(as just described) plus weight-bearing 1 or 2 times during last 7 days.
3. Extensive Assistance - While person performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   Weight-bearing support
   Full staff/caregiver performance during part (but not all) of last 7 days.
4. Total Dependence - Full staff/caregiver performance of activity during ENTIRE 7 days.
5. Cueing - Spoken instruction or physical guidance which serves as a signal to do an activity are required 7 days a week. Cueing is typically used when caring for individuals who are cognitively impaired.
8. ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS.

Code for most support provided over each 24 hour period during last 7 days (24-48 hours if person is in hospital);code regardless of person's self performance classification using the following codes:

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
5. Cueing - cueing support required 7 days a week
8. Activity did not occur during entire 7 days

Self-Performance Score: Support Score:

c. Locomotion (How person moves between locations in his/her room and other areas on the same floor. If in wheelchair, self-sufficiency once in chair)

Consumer report

Assessor observation (describe type of assistance, assistive devices used, gait and falls, if applicable)

Frequency: Times per day Days per week

Self-Performance Score:

How a person moves in a multi level house (score zero if single level house)

Frequency: Times per day Days per week

How a person moves outside to access medical appointments

Frequency: Times per day Days per week

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
Provider-Assessor#: **Assessment Date:**
OA/AP#: **Medicaid#:**

Dressing

Code self-performance during last 7 days (24-28 hours if in hospital) - not including setup with the following codes:

0. Independent - No help or oversight - or - Help/oversight provided only 1 or 2 times during last 7 days.
1. Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - or - Supervision plus nonweight-bearing physical assistance provided only 1 or 2 times during last 7 days.
2. Limited Assistance - Person highly involved in activity; recieved physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3+ times - or - Limited assistance(as just described) plus weight-bearing 1 or 2 times during last 7 days.
3. Extensive Assistance - While person performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   Weight-bearing support
   Full staff/caregiver performance during part (but not all) of last 7 days.
4. Total Dependence - Full staff/caregiver performance of activity during ENTIRE 7 days.
5. Cueing - Spoken instruction or physical guidance which serves as a signal to do an activity are required 7 days a week. Cueing is typically used when caring for individuals who are cognitively impaired.
8. ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS.

Code for most support provided over each 24 hour period during last 7 days (24-48 hours if person is in hospital);code regardless of person's self performance classification using the following codes:

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
5. Cueing - cueing support required 7 days a week
8. Activity did not occur during entire 7 days

Self-Performance Score: Support Score:

d. Dressing (How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis)

Consumer report

Assessor observation (describe type of assistance, assistive devices used, fine motor, if applicable)

Frequency: Times per day Days per week

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
Provider-Assessor#: **Assessment Date:**
OA/AP#: **Medicaid#:**

Eating

Code self-performance during last 7 days (24-28 hours if in hospital) - not including setup with the following codes:

0. Independent - No help or oversight - or - Help/oversight provided only 1 or 2 times during last 7 days.
1. Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - or - Supervision plus nonweight-bearing physical assistance provided only 1 or 2 times during last 7 days.
2. Limited Assistance - Person highly involved in activity; recieved physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3+ times - or - Limited assistance(as just described) plus weight-bearing 1 or 2 times during last 7 days.
3. Extensive Assistance - While person performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   Weight-bearing support
   Full staff/caregiver performance during part (but not all) of last 7 days.
4. Total Dependence - Full staff/caregiver performance of activity during ENTIRE 7 days.
5. Cueing - Spoken instruction or physical guidance which serves as a signal to do an activity are required 7 days a week. Cueing is typically used when caring for individuals who are cognitively impaired.
8. ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS.

Code for most support provided over each 24 hour period during last 7 days (24-48 hours if person is in hospital);code regardless of person's self performance classification using the following codes:

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
5. Cueing - cueing support required 7 days a week
8. Activity did not occur during entire 7 days

Self-Performance Score: Support Score:

e. Eating (How person eats and drinks regardless of skill)

Consumer report

Assessor observation (describe type of assistance, assistive devices used, diet, meal preperation, and problems with swallowing/chewing, if applicable)

Frequency: Times per day Days per week

WT (in lbs) pounds Height: inches

Toileting

Self-Performance Score: Support Score:

f. Toilet Use (How persons uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes)

Consumer report

Assessor observation (describe type of assistance, products used, continence, and laundry needs, if applicable)

Frequency: Times per day Days per week

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
Provider-Assessor#: **Assessment Date:**
OA/AP#: **Medicaid#:**

Personal

Code self-performance during last 7 days (24-28 hours if in hospital) - not including setup with the following codes:

0. Independent - No help or oversight - or - Help/oversight provided only 1 or 2 times during last 7 days.
1. Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - or - Supervision plus nonweight-bearing physical assistance provided only 1 or 2 times during last 7 days.
2. Limited Assistance - Person highly involved in activity; recieved physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3+ times - or - Limited assistance(as just described) plus weight-bearing 1 or 2 times during last 7 days.
3. Extensive Assistance - While person performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   Weight-bearing support
   Full staff/caregiver performance during part (but not all) of last 7 days.
4. Total Dependence - Full staff/caregiver performance of activity during ENTIRE 7 days.
5. Cueing - Spoken instruction or physical guidance which serves as a signal to do an activity are required 7 days a week. Cueing is typically used when caring for individuals who are cognitively impaired.
8. ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS.

Code for most support provided over each 24 hour period during last 7 days (24-48 hours if person is in hospital);code regardless of person's self performance classification using the following codes:

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
5. Cueing - cueing support required 7 days a week
8. Activity did not occur during entire 7 days

Self-Performance Score: Support Score:

g. Personal Hygiene (How person maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (Exclude baths and showers))

Consumer report

Assessor observation (describe type of assistance and assistive devices used, if applicable)

Frequency: Times per day Days per week

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
Provider-Assessor#: **Assessment Date:**
OA/AP#: **Medicaid#:**

Bathing

Bathing Self-Performance (Code for most dependent in self performance and support. Bathing Self-Performace codes appear below.)

0. Independent - No help provided
1. Supervision - Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
5. Cueing - Cueing support required 7 days a week
8. Activity did not occur during entire 7 days

Bathing Support Provided - (Code for Most Support Provided Over Each 24 hour Period during last 7 days (24-48 hours if person is in hospital); code regardless of person's self performance classification.)

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
5. Cueing - cueing support required 7 days a week
8. Activity did not occur during entire 7 days

Self-Performance Score: Support Score:

Bathing (How person takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (Exclude washing of back and hair)).

Consumer report

Assessor observation (describe type of assistance and assistive devices used, if applicable)

Frequency: Times per day Days per week

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
Provider-Assessor#: **Assessment Date:**
OA/AP#: **Medicaid#:**

Medication
(If a client needs help with medications, please provide the Frequency. If a client does not need help with medications, please enter 0 for Frequency, in both Times per day and Days per week areas.)

Frequency: Times per day Days per week

Findings (Indicate the previous assessment score in each scored area and document what has changed.)

Activities of Daily Living		Self Performace Score	Support Score
Bed Mobility	Previous Score Current Score		
Score Variation Reason(s) For Bed Mobility			
Transfers	Previous Score Current Score		
Score Variation Reason(s) For Transfers			
Locomotion	Previous Score Current Score		
Score Variation Reason(s) For Locomotion			
Dressing	Previous Score Current Score		
Score Variation Reason(s) For Dressing			
Eating	Previous Score Current Score		
Score Variation Reason(s) For Eating			
Toileting	Previous Score Current Score		
Score Variation Reason(s) For Toileting			
Personal	Previous Score Current Score		
Score Variation Reason(s) For Personal			
Bathing	Previous Score Current Score		
Score Variation Reason(s) For Bathing			

Assessment Findings Reviewed with Client and Attendees:

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
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OA/AP#: **Medicaid#:**

Section A: Professional Nursing Services

Use the following codes for section A.1-A.10 (every block should be coded with a response). Personnel will need care that is or otherwise would be performed by or under the supervision of a registered professional nurse.

0. Condition/treatment not present in the last 7 days
1. 1-2 days a week
2. 3-4 days a week
3. 5-6 days a week
4. 7 days a week
5. Once a month
6. At least once every 8 hours/7 days a week (used for Extended PDN only)
7. Twice a month

1. Injections/IV Feeding
Injections/IV feeding for an unstable condition (excluding daily insulin for a person whose diabetes is under control).

a. Intraarterial injection
b. Intramuscular injection
c. Subcutaneous injection
d. Intravenous injection
e. Intravenous feeding (Parental or IV feeding)

2. Feeding Tube
Feeding tube for a new/recent (within 30 days) or an unstable condition.

a. Nasogastric tube
b. Gastrostomy tube
c. Jejunostomy tube
Insertion date:

3. Suctioning/Trach Care

a. Nasopharyngeal suctioning
b. Tracheostomy care for a new/recent (within 30 days) or an unstable condition
Start date:

4. Treatment/Dressings
Treatment and/or application of dressings for one of the following conditions for which the physician has prescribed irrigation, application of medications, or sterile dressings and which requires the skill of an RN.

a. Stage 3 or 4 decubitus ulcers
b. Open surgical site
c. 2nd or 3rd degree burns
d. Stasis ulcer
e. Open lesions other than stasis/pressure ulcers or cuts (including but not limited to fistulas, tube sites and tumor erosions)
f. Other/Explain:

5. Oxygen
Administration of oxygen on a regular and continuing basis when recipient's condition warrants professional observation for a new/recent (within 30 days) condition.

Code
Start date:

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
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OA/AP#: **Medicaid#:**

6. Assessment/Management
Professional nursing assessment, observation and management required for unstable medical conditions. Observation must be needed at least once every 8 hours. Specify condition and code for applicant's need.

Code

Please specify:

7. Catheter
Insertion and maintenance of a urethral or suprapubic catheter as an adjunct to a disease or a medical condition

Code

8. Comatose
Professional care is needed to manage a comatose condition.

Code

9. Ventilator/Respirator
Care is needed to manage ventilator/respirator equipment.

Code

10. Uncontrolled Seizure Disorder
Direct assistance from others is needed for safe management of an uncontrolled seizure disorder.

Code

11. Therapy-Therapies provided by a qualified therapist
Indicate the number of days per week for each therapy required. Enter 0 if none.

a. Physical therapy

b. Speech/language therapy

c. Occupational therapy

d. Respiratory therapy

Total # of days of therapy per week

12. Therapy
Is therapy required at least once a month for any of the following: physical, speech/language, occupational or respiratory therapy?

0-No 1-Yes

13. Assessment/Management
Professional nursing assessment, observation and management of a medical conditions once a month. Specify condition and code for applicant's need.

0-No 1-Yes

Please Specify:

CONSUMER ASSESSMENT TOOL (CAT)

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Provider-Assessor#: **Assessment Date:**
OA/AP#: **Medicaid#:**

Section B: Special Treatments and Therapies

Code for number of days care would be performed by or under the supervision of a registered nurse.

0. Not required
1. 1-2 days a week
2. 3 or more days a week
3. Once a month
4. Twice a month

1. Treatments-Chronic Conditions

Professional nursing care and monitoring for administration of treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders.

a. Medications via tube
b. Tracheostomy care chronic-stable condition
c. Urinary catheter change
d. Urinary catheter irrigation
e. Veni puncture by RN
f. Monthly injections
g. Barrier dressings for Stage 1 or 2 ulcers
h. Chest PT by RN
i. O2 therapy by RN for chronic unstable condition
j. Other, specify:
Code
k. Teach/Train

2. Treatments/Procedures

Code for number of days professional nursing is required.

a. Chemotherapy
b. Radiation Therapy
c. Hemodialysis
d. Peritoneal Dialysis

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
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Section C: Cognition

1. Memory
(Recall of what was learned or known)

0. Memory OK
1. Memory problems

a. Short-term memory – seems/appears to recall after 5 minutes
b. Long-term memory - seems/appears to recall long past

2. Memory/Recall Ability
(Check all that person normally able to recall during last 7 days; 24 - 48 hrs, if in hospital)

a. Current season ☐
b. Location of own room ☐
c. Names/faces ☐
d. Where he/she is ☐
e. None of the above were recalled ☐

3. Cognitive Skills for Daily Decision-Making
Made decisions regarding tasks of daily life

0. Independent - decisions consisent/reasonable
1. Modified independence - some difficulty in new situations only
2. Moderately impaired - decisions poor, cues/supervision required
3. Severely impared - never/rarely made decisions

Code

4A.
Is professional nursing assessment, observation and management required at least 3 days/week to manage all the above cognitive patterns?

0 - No 1 - Yes

If 4A = 1 (Yes), proceed to 5.
If 4A = 0 (No) and person meets the cognitive impairment threshold, then go to section C.4B of the Supplemental Screening Tool.

5.
Is professional nursing assessment, observation and management required once a month to manage all the above cognitive patterns?

0 - No 1 - Yes

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
Provider-Assessor#: **Assessment Date:**
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SECTION C4B: COGNITION
(Enter the code that most accurately describes the person's cognition for last 7 days)

1. Memory For Events:
0. Can recall details and sequences of recent experiences and remember names of meaningful acquaintances.
1. Cannot recall details or sequences of recent events or remember names of meaningful acquaintances.
2. Cannot recall entire events (e.g. recent outings, visits of relatives or friends) or names of close friends or relatives without prompting.
3. Cannot recall entire events or name of spouse or other living partner even with prompting.

2. Memory And Use Of Information:
0. Does not have difficulty remembering and using information. Does not require directions or reminding from others.
1. Has minimal difficulty remembering and using information. Requires direction and reminding from others one to three times per day. Can follow simple written instructions.
3. Has difficulty remembering and using information. Requires direction and reminding from others four or more times per day. Cannot follow written instructions.
4. Cannot remember or use information. Requires continual verbal reminding.

3. Global Confusion:
0. Appropriately responsive to environment.
1. Nocturnal confusion on awakening.
2. Periodic confucion during daytime.
3. Nearly always confused.

4. Spatial Orientation:
0. Oriented, able to find and keep his/her bearings.
1. Spatial confusion when driving or riding in local community.
2. Gets lost when walking neighborhood.
3. Gets lost in own home or present environment.

5. Verbal Communication:
0. Speaks normally.
1. Minor difficulty with speech or word-finding difficulties.
2. Able to carry out only simple conversations.
3. Unable to speak coherently or make needs known.

C.4B Total Cognitive Score

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
Provider-Assessor#: **Assessment Date:**
OA/AP#: **Medicaid#:**

Section D: Problem Behavior

1.

Column A Codes: Code for the frequency of behavior in last 7 days
0. Behavior not exhibited in last 7 days
1. Behavior of this type occured 1 to 3 days in last 7 days
2. Behavior of this type occured 4 to 6 days, but less than daily
3. Behavior of this type occured daily

Column B Codes: Alterability of behavior symptoms
0. Not Present or easily altered
1. Behavior not easily altered

	Column A (Frequency)	Column B (Problem Behavior)
a. Wandering (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. Verbally Abusive (others threatened, screamed at, cursed at)		
c. Physically Abusive (others were hit, shoved, scratched, sexually abused)		
d. Socially Inappropriate/Disruptive Behavior (made disruptive sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. Resists Care (resisted taking medications/injections, ADL assistance or eating)		

2a.
Is professional nursing assessment, observation and management required at least 3 days/week to manage the behavior problems - items a-d?

0 - No 1 - Yes

If 2a = 1 (Yes) proceed to 3.
If 2a = 0 (No) **and** person meets the behavior impairment threshold, then go to page 3A and complete Section D.2B of the Supplemental Screening Tool.

3.
Is professional nursing assessment, observation and management required once a month to manage the above behavior problems?

0 - No 1 - Yes

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
Provider-Assessor#: **Assessment Date:**
OA/AP#: **Medicaid#:**

SECTION D2B: BEHAVIOR
Enter the code that most accurately describes the person's behavior for last 7 days.

1. Sleep Patterns:
0. Unchanged from "normal" for the consumer.
1. Sleeps noticeably more or less than "normal".
3. Restless, nightmares, disturbed sleep, increased awakenings.
4. Up wandering for all or most of the night, inability to sleep.

2. Wandering:
0. Does not wander.
1. Does not wander. Is chair bound or bed bound.
2. Wanders within the facility or residence and may wander outside, but does not jepordize health and safety.
3. Wanders within the facility or residence. May wander outside, health and safety may be jeopardized. Does not have history of getting lost and is not combative about returning.
4. Wanders outside and leaves grounds. Has consistent history of leaving grounds, getting lost or being combative about returning. Requires a treatment plan that may include the use of psychotropic drugs for management and safety.

3. Behavioral Demands On Others:
0. Attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions.
1. Attitudes, habits and emotional states limit the individual's type of living arrangement and companions.
3. Attitudes, disturbances and emotional states create consistent difficulties that are modifiable to manageable levels. The consumer's behavior can be changed to reach the desired outcome through respite, in-home services, or exiting facility staffing.
4. Attitudes, disturbances and emotional states create consistent difficulties that are not modifiable to manageable levels. The consumer's behavior cannot be changed to reach the desired outcome through respite, in-home services, or existing facility staffing even given training for the caregiver.

4. Danger To Self And Others
0. Is not disruptive or aggressive, and is not dangerous.
1. Is not capable of harming self or others because of mobility limitations (is bed bound or chair bound).
2. Is sometimes (1 to 3 times in last 7 days) disruptive or aggressive, either physically or verbally, or is sometimes extremely agitated or anxious, even after proper evaluation and treatment.
3. Is frequently (4 or more time during the last 7 days) disruptive or aggressive, or is frequently extremely agitated or anxious; and professional judgment is required to determine when to administer prescribed medication.
5. Is dangerous or physically abusive, and even with proper evaluation and treatment may require physician's orders for appropriate intervention.

5. Awareness of Needs/Judgment:
0. Understands those needs that must be met to maintain self care.
1. Sometimes (1 to 3 times in last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
2. Frequently (4 or more time during the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
3. Does not understand those needs that must be met for self care and will not cooperate even though given direction or explanation.

D.2B total Behavior Score

CONSUMER ASSESSMENT TOOL (CAT)

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Section E: Physical Functioning / Structural Problems

1.

ADL Self-Performance (Code for Performance during last 7 days (24-28 hrs if in hospital) - not including setup.)

0. Independent - No help or oversight - or - Help/oversight provided only 1 or 2 times during last 7 days.
1. Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - or - Supervision plus nonweight-bearing physical assistance provided only 1 or 2 times during last 7 days.
2. Limited Assistance - Person highly involved in activity; recieved physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3+ times - or - Limited assistance(as just described) plus weight-bearing 1 or 2 times during last 7 days.
3. Extensive Assistance - While person performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   Weight-bearing support
   Full staff/caregiver performance during part (but not all) of last 7 days.
4. Total Dependence - Full staff/caregiver performance of activity during ENTIRE 7 days.
5. Cueing - Spoken instruction or physical guidance which serves as a signal to do an activity are required 7 days a week. Cueing is typically used when caring for individuals who are cognitively impaired.
8. ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS.

ADL Support Provided - (Code for Most Support Provided Over Each 24 hour Period during last 7 days (24-48 hours if person is in hospital); code regardless of person's self performance classification.)

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
5. Cueing - cueing support required 7 days a week
8. Activity did not occur during entire 7 days

	Column A (Self-Performance)	Column B (Support Provided)
a. Bed Mobility (How person moves to and from lying position, turns side to side, and positions body while in bed)		
b. Transfer (How person moves between surfaces - to/from bed, chair, wheelchair, standing position (Exclude to/from bath/toilet))		
c. Locomotion (How person moves between locations in his/her room and other areas on the same floor. If in wheelchair, self-sufficiency once in chair)		
d. Dressing (How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis)		
e. Eating (How person eats and drinks regardless of skill)		
f. Toilet Use (How persons uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes)		
g. Personal Hygiene (How person maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (Exclude baths and showers))		

3. Walking

	Column A (Self-Performance)	Column B (Support Provided)
a. How person walks for exercise only		
b. How person walks around own room		
c. How person walks within home		
d. How person walks outside		

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4. Bathing
(How person takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (Exclude washing of back and hair)).

Bathing Self-Performance (Code for most dependent in self performance and support. Bathing Self-Performace codes appear below.)

0. Independent - No help provided
1. Supervision - Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
5. Cueing - Cueing support required 7 days a week
8. Activity did not occur during entire 7 days

Bathing Support Provided - (Code for Most Support Provided Over Each 24 hour Period during last 7 days (24-48 hours if person is in hospital); code regardless of person's self performance classification.)

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
5. Cueing - cueing support required 7 days a week
8. Activity did not occur during entire 7 days

	Column A (Self-Performance)	Column B (Support Provided)
Code		

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Section F: Medications List

List all medications given during the last 7 days. Include medications used regularly less than weekly as part of the person's treatment regimen

1. List the medication name and the dosage

2. RA (Route of Administration). Use the appropriate code from the following list

1 = by mouth (PO)	3 = intramuscular (M)	5 = subcutaneous (SubQ)	7 = topical	9 = enternal tube
2 = sublingual (SL)	4 = intravenous (IV)	6 = rectally	8 = inhalation	

3. FREQ (Frequency): Use the appropriate frequency code to show the number of times per day that the meditation was given.

PR = (PRN) as necessary	6H = (q6h) every 6 hours	3D = (TID) 3 times daily	3W = 3 times every week	1M = (Qmonth) once every month
1H = (qh) every hour	8H = (q8h) every 8 hours	4D = (QID) 4 times daily	QO = every other day	2M = twice every month
2H = (q2h) every 2 hours	1D = (qd or hs) once daily	5D = 5 times daily	4W = 4 times every week	C = continuos
3H = (q3h) every 3 hours	2D = BID 2 times daily,	1W = (Q week) once every week	5W = 5 times every week	O = other
4H = (qrh) every 4 hours	(includes every 12 hours)	2W = twice every week	6W = 6 times every week	

4. PRN-n (prn-number of doses): If the frequency code is "PR", record the number of times during the past 7 days that each PRN medication was given. Do not use this column for scheduled medications.

5. OTC Drugs

1. Medication Name	Dosage	Units	2. RA	3. Freq	4. PRN

Section G: Medication

1a. Preparation / Administration

Did person prepare and administer his/her own medications In the last 7 days?

0. Person prepared and administered **All** of his/her own medications.
1. Person prepared and administered **Some** of his/her own medications.
2. Person prepared and administered **None** of his/her own medications.
3. Person **had no** medications in the last 7 days.
4. Person did not prepare but did self-administer all medications.
5. Facility prepares and administers medications.
6. Person requires administration of medications due to severe and disabling illness.

1b. Compliance

Person's level of compliance with medications prescribed by a physician/phychiatrist in the last 7 days

0. Person always compliant.
1. Person compliant some of the time (80% of time or more often) **OR** compliant with some medications.
2. Person rarely or never compliant.
3. Person had no medications during last 7 days.
4. Person requires monitoring of medications due to severe and disabling illness.

1c. Self-Administration

- ☐ a. Insulin
- ☐ b. Oxygen
- ☐ c. Nebulizers
- ☐ d. Nitropatch
- ☐ e. Glucoscan
- ☐ f. OTC Meds
- ☐ g. Other
  Specify
- ☐ h. None

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Section H: Diagnoses

Diagnoses: Check only those diagnoses that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nurse monitoring, or risk of death. (Do not list inactive diagnoses.) **If none apply, check xx, None of the Above**

Endocrine/Metabolic/Nutritional

- ☐ a. Diabetes mellitus
- ☐ b. Hyperthyroidism
- ☐ c. Hypothyroidism

Heart/Circulation

- ☐ d. Arteriosclerotic heart disease - ASHD
- ☐ e. Cardiac dysrhythmia
- ☐ f. Congestive heart failure
- ☐ g. Deep vein thrombosis
- ☐ h. Hypertension
- ☐ i. Hypotension
- ☐ j. Peripheral vascular disease
- ☐ k.Other cardiovascular disease

Musculoskeletal

- ☐ l. Arthritis
- ☐ m. Hip fracture
- ☐ n. Missing limb (e.g. amputation)
- ☐ o. Osteoporosis
- ☐ p. Pathological bone fracture

Neurological

- ☐ q. Alzheimer's disease
- ☐ r. Aphasia
- ☐ s. Cerebral palsy
- ☐ t. Cerebrovascular accident (stroke)
- ☐ u. Dementia other than Alzheimer's
- ☐ v. Hemiplegia / hemiparesis
- ☐ w. Multiple sclerosis
- ☐ x. Paraplegia
- ☐ y. Parkinson's disease
- ☐ z. Quadriplegia
- ☐ aa. Seizure disorder
- ☐ bb. Transient ischemic attack (TIA)
- ☐ cc. Traumatic brain injury

Psychiatric/Mood

- ☐ dd. Anxiety disorder
- ☐ ee. Depression
- ☐ ff. Manic Depression (Bipolar Disease)
- ☐ gg. Schizophrenia

Pulmonary

- ☐ hh. Asthma
- ☐ ii.Emphysema / COPD
  - ☐ ii.a. Bronchitis
  - ☐ ii.b. Pneumonia

Sensory

- ☐ jj. Cataracts
- ☐ kk. Diabetic retinopathy
- ☐ ll. Glaucoma
- ☐ mm. Macular degeneration

Other

- ☐ nn. Allergies (specify)
- ☐ oo. Anemia
- ☐ pp. Cancer
- ☐ qq. Renal failure
- ☐ rr. Tuberculosis
- ☐ ss. HIV
- ☐ tt. Mental retardation (e.g., Down's syndrome, autism, or other condition related to MR or DD)
- ☐ uu. Substance abuse (alcohol or drug)
- ☐ vv. Other psychiatric diagnosis, (e.g. paranoia, phobias, personality disorder)
- ☐ ww. Explicit terminal prognosis
- ☐ xx. None of the Above

2. Other Current DX. & ICD-9 Codes

- ☐ **3. 2 or more hospitalizations r/t primary / secondary diagnosis**
- ☐ **3a. NF placement in the past 12 months r/t primary / secondary diagnosis**
- ☐ **3b. 5 or more ER visits r/t primary / secondary diagnosis**

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Section I: Communication / Hearing Patterns

1. Hearing
(With hearing appliance, if used)

(Choose only one)

0. Hears adequately - normal talk, TV, phone
1. Minimal Difficulty when not in quiet setting
2. Hears in Special Situations only - speaker has to adjust tonal quality and speak distinctly
3. Highly Impaired absence of useful hearing

2. Communication Devices/Techniques
(Check all that apply during last 7 days)

- ☐ a. Hearing aid, present and used
- ☐ b. Hearing aid, present and not used regularly
- ☐ c. Other receptive communication techniques used (e.g., lip reading)
- ☐ d. None of the Above

3. Making Self Understood
(Expressing information content-however able)

(Choose only one)

0. Understood
1. Usually understood - difficulty finding words or finishing thoughts
2. Sometimes understood - ability is limited to making concrete requests
3. Rarely / Never understood

4. Ability to Understand Others
(Understanding information content-however able)

(Choose only one)

0. Understands
1. Usually understands - may miss some part/intent of message
2. Sometimes understands - responds adequately to simple, direct communication
3. Rarely/Never understands

Section J: Vision Patterns

1. Vision
(Ability to see in adequate light & with glasses if used)

(Chose only one)

0. Adequate - sees fine detail, including regular print in newspapers/books
1. Impaired - sees large print, but not regular print in newspapers/books
2. Moderately impaired - limited vision; not able to see newspaper headlines, but can identify objects
3. Highly impaired - object identification in question, but eyes appear to follow objects
4. Severely impaired - no vision or sees only light, colors, or shapes; eyes do not appear to follow objects

2. Visual appliances

0 - No 1 - Yes

a. Glasses, contact lenses
b. Artificial eye

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Section K: Nutritional Status

1. Weight(optional if info is not available)
Record weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard practice (e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes)

WT (in lbs)

2. Weight Change(optional if info is not available)

(Chose only one)

0. No weight change
1. Unintended weight gain - 5% or more in last 30 days or 10% or more in last 180 days.
2. Unintended weight loss - 5% or more in last 30 days or 10% or more in last 180 days.

3. Nutritional Problems or Approaches(check all that apply)

- ☐ a. Chewing or swallowing
- ☐ b. Complains about the taste of many foods
- ☐ c. Regular or repetitive complaints of hunger
- ☐ d. Leaves 25% or more of food uneaten at most meals
- ☐ e. Therapeutic diet
- ☐ f. Mechanically altered (or pureed) diet
- ☐ g. Noncompliance with diet
- ☐ h. Food Allergies
  Specify:
- ☐ i. Restrictions
  Specify:
- ☐ j. None of the Above

Section L: Continence in Last 14 Days

1. Bladder Continence
Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants) with appliances if used (e.g., pads or incontinence program employed) in last 14 days.

(Choose only one)

0. Continent - complete control
1. Usually Continent - incontinent episodes once a week or less
2. Occasionally incontinent - 2 or more times a week but not daily
3. Frequently incontinent - tended to be incontinent daily, some control present
4. Incontinent - bladder incontinent all (or almost all) of the time

2. Bowel Continence

(Choose only one)

0. Continent - complete control
1. Usually Continent - Bowel incontinent episodes less than weekly
2. Occasionally incontinent - bowel incontinent episode once a week
3. Frequently incontinent - bowel incontinent episodes 2 to 3 times per week
4. Incontinent - Bowel incontinent all (or almost all) of the time

3. Appliances / Programs

- ☐ a. External (condom) catheter
- ☐ b. Indwelling catheter
- ☐ c. Pads / briefs
- ☐ d. Ostomy present
- ☐ e. Scheduled toileting / other program
- ☐ f. None of the Above

Section M: Balance

1. Accidents (Check all that apply)

- ☐ a. Fell in past 30 days
- ☐ b. Fell in past 31-180 days
- ☐ c. Hip fracture in last 180 days
- ☐ d. Other fracture in last 180 days
- ☐ e. None of the Above

2. Danger of Fall (Check all that apply)

- ☐ a. Has unsteady gait
- ☐ b. Has balance problems when standing
- ☐ c. Limits activities because person or family fearful of person falling
- ☐ d. None of the Above

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Section N: Oral/Dental Status

1. Oral Status and Disease Prevention (Check all that apply)

- ☐ a. Has dentures or removable bridge
- ☐ b. Some/all natural teeth lost - does not have or does not use dentures (or partial)
- ☐ c. Broken, loose, or carious teeth
- ☐ d. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes
- ☐ e. None of the Above

Section O: Skin Conditions

1. Skin problems (Check all that apply)

- ☐ a. Abrasions / scrapes
- ☐ b. Burns
- ☐ c. Bruises
- ☐ d. Rashes, itchiness, body lice, scabies
- ☐ e. Open sores or lesions
- ☐ f. None of the Above

2. Pressure Ulcers

Presence of an ulcer anywhere on the body? This would include an area of persistent skin redness (Stage 1), partial loss of skin layers (Stage 2), deep craters in the skin (Stage 3), and breaks in the skin exposing muscle or bone, (Stage 4).

0 - No 1 - Yes

3. Foot Problems

0 - No 1 - Yes

a. Person or someone else inspects feet on a regular basis?

b. One or more foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, onychomycosis?

Section P: Environmental Assessment

1. NF, RCF, Hospital

If person resides in a facility such as a NF, RCF, or hospital, check here and proceed to Section Q ☐

2. Home Environment

Check any of the following that makes home environment hazardous or uninhabitable. If none apply, check None of Above. If temporarily in institution, base assessment on home visit

- ☐ a. Lighting including adequacy of lighting, exposed wiring
- ☐ b. Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)
- ☐ c. Bathroom and toiletroom environment(e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)
- ☐ d. Kitchen environment (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs
- ☐ e. Heating and cooling
- ☐ f. Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)
- ☐ g. Access to home (e.g., difficulty entering/leaving home)
- ☐ h. None of the above

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Section Q: Mood

1. Indicators of Depression, Anxiety, Sad Mood

Code for behavior in last 30 days irrespective of the assumed cause with the following codes

0. Indicator not exhibited
1. Indicator of this type exhibited up to 5 days a week
2. Indicator of this type exhibited daily or almost daily (6,7 days a week)

Verbal Expressions of Distress

a. Person made negative statements - e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die"

b. Repetitive questions - e.g., "Where do I go? What do I do?"

c. Repetitive verbalizations, e.g., calling out for help., ("God help me")

d. Persistent anger with self or others - e.g., easily annoyed; anger at placement in nursing home; anger at care received

e. Self-deprecation - e.g., "I am nothing; I am of no use to anyone."

f. Expressions of what appear to be unrealistic fears - e.g., fear of being abandoned, left alone, being with others.

g. Recurrent statements that something terrible is about to happen - e.g., believes he or she is about to die, have a heart attack.

h. Repetitive health complaints - e.g., persistently seeks medical attention, obsessive concern with body functions.

i. Repetitive anxious complaints/concerns (non-health related) - e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues.

Sleep-Cycle Issues

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern

Loss of Interest

l. Sad, pained, worried facial expressions - e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements - e.g., pacing, hand-wringing, restlessness, fidgeting, picking.

o. Withdrawl from activities of interest - e.g., no interest in longstanding activities or being with family/friends.

p. Reduced social interaction.

2. Mood Persistence

One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer-up," console or reassure the person over the last 7 days.

0. No mood indicators
1. Indicators present, easily altered
2. Indicators present, not easily altered

3. Mood

Person's current mood status compared to person's status 180 days ago.

0. No change
1. Improved
2. Declined

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Section R: Instrumental Activities of Daily Living

1. Daily Instrumental Activities

Code for level of independence based on person's involvement in the activity in the last 7 days

IADL Self-Performance Codes:

0. Independent: (with/without assisstive devices) - No help provided.
1. Independent with difficulty: Person performed task, but did so with difficulty or took a great amount of time to do it.
2. Assisstance / done with help: Person involved in activity but help (including supervision, reminders, and/or physical "hands-on" help) was provided.
3. Dependent / done by others: Full performance of the activity was done by others. The person was not involved at all each time the activity was performed.
8. Activity did not occur.

IADLS Support Codes:

0. No support provided.
1. Supervision / cueing provided.
2. Set-up help only.
3. Physical assisstance was provided.
4. Total dependence - the person was not involved at all when the activity was performed.
8. Activity did not occur.

	Column A (Self Performance)	Column B (Support)
a. Meal Preparation: Prepared breakfast and light meals.		
b. Main Meal Preparation: Prepared or received main meal _____ times per week.		
c. Telephone: Used telephone as necessary, e.g., able to contact people in an emergency.		
d. Light Housework: Did light housework such as dishes, dusting (on daily basis), making own bed.		

2. Other Instrumental Activities of Daily Living

Code for level of independence based on person's involvement in the activity in the last 14 days

	Column A (Self Performance)	Column B (Support)
a. Managing Finances: Managed own finances, including banking, handling checkbook, paying bills.		
Override: Client has not managed their own finances but is cognitively able to.	☐	
b. Routine Housework: Did routine housework such as vacuuming, cleaning floors, trash removal, cleaning bathroom, as needed.		
c. Grocery Shopping: Did grocery shopping as needed (excluding transportation).		

d. Laundry: Indicate In Home ☐ Out Home ☐

3. Transportation

Check all that apply for level of independence based on person's involvement in the activity in the last 30 days

☐ a. Person drove self or used public transportation independently to get medical, dental appointments, necessary engagements, or other activities.

☐ b. Person needed arrangement for transportation to medical, dental appointments, necessary engagements, or other activities.

☐ c. Person needed transportation to medical, dental appointments, necessary engagements, or other activities.

☐ d. Person needed escort to medical, dental appointments, necessary engagements, or other activities.

☐ e. Activity did not occur.

4. Primary Modes Of Transportation

Code for the primary mode of locomotion for (a) indoors or (b) outdoors for the following list:

0. No assistive device,
1. Cane,
2. Walker/crutch,
3. Scooter,
4. Wheelchair,
5. Activity did not occur

(a) Indoors

(b) Outdoors

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Section S: Assistive Devices

1. Daily Instrumental Activities

Code for level of independence based on person's involvement in the activity in the last 7 days

0. Does not need
1. Does not have needed device (refer to physician for DME)
2. Has device in home and is independent with use
3. Has device in home and needs assistance with use

1. Bath Bench
2. Braces/AFOs
3. Cane
4. Commode
5. Elevated Toilet
6. Gait Belt
7. Grab Bars
8. Hand Held Shower
9. Hospital Bed
10. Lifeline
11. Lift/Hoyer
12. Stair glide
13. Wheelchair
14. Walker
15. Other
16. Other

Section T: Advanced Directives

0 - No 1 - Yes

1. Informed of Advanced Directives
2. Living Will
0. Comfort One

Section U: Mailing Address: (If different from CAT client location data)

Physical Address:
2121 Gutter Way
Anchorage, AK 99503

☐ Select as Mailing Address

Current Address:
,

☐ Select as Mailing Address

Mailing Address
Address, line 2
City **State** AK **Zip**

Section V: Split Service Plan

0 - No 1 - Yes

Split Service Plan

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Section W: Current Formal and Informal Supports

0 - No 1 - Yes

1. Day Habilitation
2. Assisted Living
3. Care Coordination

Name: Phone Number: Address:

4. Chore/Waiver
5. Church
6. Equipment/Supplies
7. Family
8. Friends
9. Foster Care
10. Home Health
11. Hospital/Medical
12. Meals
13. Medications (mediset, prefilled syringes)
14. Personal Care Assistant(s)

Name: Phone Number: Address:

15. Back Up Personal Care Assistant(s)

Name: Phone Number: Address:

16. Respite
17. Skilled Nursing
18.Transportation

Section X: Legal Representative(s)

0 - No 1 - Yes

1. An unpaid care provider involved in the day-to-day care of the recipient
2. Manage and evaluate the recipient's care as it occurs in the recipient's home
3. Complete recipient training
4. Make, understand, and assume responsibility for choices regarding the recipients activities of daily living
5. Designate a Consumer-Directed agency for services
6. Cooperate with the Division or its designee
7. Specify training requirements of the PCA
8. Schedule, train, supervise, and terminate the employment of personal care assistant
9. Power of Attorney (Durable, regular or special)

Name: Phone Number: Address:

10. Legal Guardian(s)

Name: Phone Number: Address:

CONSUMER ASSESSMENT TOOL (CAT)

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NF. 1.

a. In Section A, Nursing Services, items 1-8, did you code any of the responses with a 4 (i.e, services needed 7 days/wk)?
b. In Section A, items 9 (Ventilator/Respirator) did you code this response with a 2,3 or 4 (treatment needed at least 3 days/wk)?
c. In Section A, item 10 (Uncontrolled seizure), did you code this response with a 1, 2, 3, or 4 (care needed at least once/wk)?
d. In Section A, item 11 (Therapies), was the total number of days of therapy 5 or more days/wk?
e. In Section E, (Physical Functioning/Structural Problems), were 3 or more shaded ADLs coded with a 3 (extensive assistance) or 4 (dependent) in self performance?

*If the answer to any of these questions is "Yes", then the person will be found medically eligible for NF level of care and will be scored a 3 or presumed to have a score of 3 or more.

NF. 2.

a. In Section A, Nursing Services, items 1-8, how many were coded with a 2 or 3 (service needed 3-6 days/week)?
b. In Section A, item 11 (Therapies), was the total number of days of therapy 3 or 4 days/week? 0 - No 1 - Yes
c. In Section B, items 1a-1e and 1g-1j (excluding 1f, monthly injection), did you code any of the responses with a 2? 0 - No 1 - Yes
d. In Section B, items 2a-2d, did you code any of the responses with a 2? 0 - No 1 - Yes

Compute the nursing services score from 2a-2d and enter it here. **Total:**

NF. 3.

a. Is Section C1a (short-term memory), coded with a "1"?
b. In section C2 (memory recall) are 1 or 2 boxes checked in C2a-C2d or is C2e. None of the Above checked? 0 - No 1 - Yes
c. Is Section C3 coded with a 2 or 3? 0 - No 1 - Yes
d. [Is Section C4A coded with a 1] OR [in Section E, is at least one shaded ADL coded with a 2, 3, or 4 in self-performance and a 2 or 3 in support AND C4B (from page 3A Supplemental Screening Tool) is 13 or more]? 0 - No 1 - Yes

*If **all** the answers to the above questions are "yes," then score this section with a "1".* **Score:**

NF. 4.

a. In Section D, are one or more of the behaviors from items a-d (wandering, verbally abusive, physically abusive, socially inappropriate behavior) coded with a 2 or 3?
b. [Is Section D2A coded with a 1] OR [in Section E, is at least one shaded ADL coded with a 2, 3 or 4 in self-performance and a 2 or 3 in support AND D2B (from page 3A Supplemental Screening Tool) is 14 or more]? 0 - No 1 - Yes

If the answer to both questions is yes, then score this section with a "1". **Score:**

NF. 5.

Compute the total nursing score from questions 2, 3 and 4. If the total nursing score is a 1 or more, proceed. Otherwise person appears not to be medically eligible for NF level of care. **Total Nursing:**

NF. 6.

In Section E(Physical Functioning/Structural Problems), how many "shaded" ADL's were coded with a 2, 3 or 4 in self-performance AND required a one or more physical assist in support (support coded as 2 or 3)? **Total ADL Needs:**

NF. 7. Total nursing and ADL Needs Score (NF.5 + NF.6)

If the Total Nursing and ADL Needs Score is 3 or more, the person appears to be medically eligible for NF level of care. Otherwise, person appears not to be medically eligible **Total:**

Signature of Assessor: **Date:**

CONSUMER ASSESSMENT TOOL (CAT)

Agency Name: **Applicant Name:**
Provider-Assessor#: **Assessment Date:**
OA/AP#: **Medicaid#:**

Medicaid Personal Care Services Eligibility

PCA.1.A In Section E, are any of the following 6 ADLs: transfer, locomotion, eating, toilet use, dressing, or bathing coded with 2, 3, or 4 in Self-Performance AND 2, 3, or 4 in Support?

If PCA.1.A is answered "Yes", recipient appears to be functionally eligible for Personal Care Assistant Services. Please proceed to the Cognitive Capacity For Consumer-Directed Model section.

If PCA.1.A is answered "No", please proceed to the PCA1.B question.

PCA.1.B In Section R, are any of the following 6 IADLs: meal preparation, main meal preparation, light housework, routine housework, grocery shopping, or laundry coded with 1, 2, or 3 in Self-Performance?

If PCA.1.B is answered "Yes", recipient appears to be functionally eligible for Personal Care Assistant Services. Please proceed to Cognitive Capacity For Consumer-Directed Model section.

If PCA.1.A and PCA.1.B are both answered as "No", recipient is not functionally eligible for Personal Care Assistant Services; - STOP- do not continue or complete a service plan.

Cognitive Capacity For Consumer-Directed Model

Ability to Self-direct Indicators:

1. Decision Making skills (Section C.3) = 0 or 1
2. Making Self Understood (Section I.3) = 0, 1 or 2
3. Ability to Understand Others (Section I.4) = 0, 1, 0r 2
4. Managing Finances (Section R.2.a)
   a. in Self Performance = 0 or 1
   b.in Support = 0 or 2

CC.1 If all the answers to the above questions are "Yes" then score this section with a "1" Recipient appears to have cognitive capacity to self-direct their care.

If CC.1 is <u>not</u> scored with a "1" <u>AND</u> recipient's legal representative listed in Section X.9 and/or X.10 requests to manage Consumer-Directed Model; continue below:

Ability for Legal Representative Management Indicators:

CC.2 In Section X, Legal Representative(s), total scores for questions 1-8.

CC.3 In Section X, Legal Representative(s), total scores for questions 9 & 10.

CC.4 If CC.2 is scored with an 8 AND CC.3 is scored with a 1 or greater, score this section with a "1".

If CC.4 is scored with a "1", the recipient's legal representative, used in CC.3 scoring, is eligible to manage the recipient's Personal Care Attendant Services under the Consumer-Directed Model; continue below:

Consumer-Directed PCA Services Model Eligibility

CDPCA.1 If PCA.1.A answer is No, AND Section D.1a, b, c, e and 2a are all scored with a "0", AND PCA.1.D is scored with a "1", AND Section W.15 is scored with a "1", AND CC.1 is scored with a "1"; then score this section with a "1".

CDPCA.2 If PCA.1.D is scored with a "1", AND Section W.15 is scored with a "1", AND CC.1 is not scored with a "1", AND CC.4 is scored with a "1", then score this section with a "1".

If CDPCA.1 is scored with a "1", the recipient appears to be functionally eligible to self-direct under the Consumer-Directed Model for Personal Care Assistant Services.

If CDPCA.1 is not scored with a "1", AND CDPCA.2 is scored with a "1", the recipient's legal representative as indicated in Section X.9 and/or X.10, appears to be eligible to direct the recipient's Personal Care Services under the Consumer-Directed Model for Personal Care Assistant Services.

CDPCA.1 If PCA.1.A and/or PCA.1.B is "Yes", AND Section D.1a, b, c, e and 2a are all scored with a "0", AND Section W.15 is scored with "1", AND CC.1 is scored with a "1", then score this section with a "1"

CDPCA.2 If PCA.1.A and/or PCA.1.B is "Yes", AND Section W.15 is scored with a "1", And CC.1 is not scored with a "1", AND CC.4 is scored with a "1", then score this section with a "1"

If CDPCA.1 is scored with a "1", the recipient appears to be functionally eligible to self-direct under the Consumer-Directed Model for Personal Care Assistant Services.

If CDPCA.1 is not scored with a "1", AND CDPCA.2 is scored with a "1", the recipient's legal representative as indicated in Section X.9 and/or X.10, appears to be eligible to direct the recipient's Personal Care Services under the Consumer-Directed Model for Personal Care Assistant Services.