COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Web Portal
Pre-Admission Screening Automation
(ePAS)
Users Guide

Version 18.0
Updated: 04/03/2019

HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. Xerox developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandate.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by Xerox. It is health care data, plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.[1]

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.0	07/17/2014	Xerox Web Portal Development Team	Initial Document Creation
2.0	08/15/2014	Xerox Web Portal Development Team	Updated based on DMAS comments and screen changes.
3.0	08/21/2014	Xerox Web Portal Development Team	Updated with Phase II changes
4.0	09/12/2014	Xerox Web Portal Development Team	Updated based on DMAS comments.
5.0	10/14/2014	Xerox Web Portal Development Team	Updated with Phase III changes
6.0	10/24/2014	Xerox Web Portal Development Team	Updated based on DMAS comments and CR#2.
7.0	11/24/2014	Xerox Web Portal Development Team	Updated based on CMAS comments for the CBT.
8.0	12/19/2014	Xerox Web Portal Development Team	Updated based on Release 71.
9.0	03/30/2015	Xerox Web Portal Development Team	Updated based on EWO 2014-328-001-W
10.0	04/20/2015	Xerox Web Portal Development Team	Updated based on DMAS Comments
11.0	04/24/2015	Xerox Web Portal Development Team	Updated based on DMAS Comments
12.0	04/24/2015	Xerox Web Portal Development Team	Updated based on DMAS Comments
13.0	10/21/2015	Xerox Web Portal Development Team	Updated based on EWO 2015-216-001-W: • Increased case summary

			• Print capability on incomplete assessments • Denied assessment tracing
14.0	11/20/2015	Xerox Web Portal Development Team	Pseudo SSN note added
15.0	08/09/2016	Xerox Web Portal Development Team	Updated base on Release 77 – ePAS enhancements
15.1	11/07/2016	Xerox Web Portal Development Team	Updated based on R77 CBT comments that also affect the User Guide.
16.0	08/08/2017	Conduent Web Portal Development Team	Updated based on EWO 2017-137-002-W
17.0	08/23/2017	Conduent Web Portal Development Team	Updated based on EWO 2017-137-002-W CR #1
18.0	04/03/2019	Conduent Web Portal Development Team	Updated based on EWO 2018-351-001-W ePAS Screener Certification

Table of Contents

0.0 Introduction

The Commonwealth of Virginia's Medicaid Web Portal is a web based system that gives providers and their user organizations access to secured provider services.

The Portal extends the business capabilities of Virginia providers by offering user-friendly tools and resources. You will have access to the secured interactive features of the portal including:

- Claims Status Inquiry

- Claim submission of professional, institutional and crossover claims

- Member Eligibility, CoPay Amounts and Service Limits

- Service Authorization Log and Pharmacy Web PA Request

- Provider Payment History

- Provider Profile Maintenance

- Remittance Advice Messages

- Level of Care Review Instrument

- Automated Provider Enrollment

- Pre-Admission Screening

In order to take advantage of the Portal and its functions, users must be part of the security structure.

For the sake of this document, a 'user' is defined as any person that will access and use the Web Portal.

If at any time during the registration process you have questions or issues, please contact the Virginia Medicaid Helpdesk toll free at 866-352-0496.

0.1 Security Structure

The security structure of the Web Portal is provider centric versus user centric.

Security access for the Web Portal is based upon a provider organization. A 'provider organization' is defined as either an individual billing or servicing provider or group provider (and the user community in support of them).

The provider organization can be associated with either a NPI (National Provider Identifier) or an API (Atypical Provider Identifier – assigned by the Commonwealth of Virginia for providers that are not eligible for a NPI, such as a transportation provider).

A unique User ID will need to be established for each provider organization a user supports. Any users added to the organization will have the ability to access services based on the role they are assigned.

0.2 User Roles

There is a three-tiered security structure associated with each provider organization. Additional roles will be provided as new services are added.

Primary Account Holder – A Primary Account Holder is the person who will perform the initial web registration. He/she will establish the security needed for the services accessed.

Each provider organization can have only one Primary Account Holder. To change a Primary Account Holder, the Provider will need to notify Xerox, in writing. Please contact the Virginia Medicaid Help Desk (toll free) at 866-352-0496 for additional information and forms.

Local Departments of Social Services (LDSS) and Local Health District (LHD):

For accessing ePAS, the DMAS contractor, Xerox, will serve as the PAH for community pre-admission screening teams for the initial web registration and establish the security needed for the services to be accessed. This information is supplied by each LDSS and LHD through their state oversight agencies DARS and VDH, respectively to Xerox. Each LDSS and LHD will identify the security access needed (Organizational Administrator or Authorized User) for purposes of the initial web registration.

Acute Care Hospitals: For accessing ePAS, hospitals will continue to identify a PAH for ePAS as with other DMAS interactive features of the Portal.

The Primary Account Holder can:
- Establish Organization Administrators and/or Authorized Users for their organization
- Change roles for any user
- Reset passwords for any user
- Activate and/or deactivate any user
- Unlock any User ID
- Access to all secured provider functionality

Organization Administrator – An Organization Administrator is established by the Primary Account Holder. As described above and to assist LDSS and LHD administrators and staff, Xerox will be assigning the designation of Organizational Administrator to the LDSS and LHD as instructed by the LDSS and LHD via initial Excel Spreadsheet Enrollment form. This process does not apply to hospitals. Hospitals will continue to use their existing procedures to identify organization administrator, if appropriate, for their organization.

With the exception of the LDSS and LHDs, an Organization Administrator is not required for a provider organization - some organizations may only have a Primary Account Holder and associated Authorized Users. A provider

organization can have one-to-many Organization Administrators, if so desired. Organization Administrators tier up to the Primary Account Holder.

The Organization Administrator has the following capabilities associated with only Authorized Users:
- Can establish Authorized Users for their organization
- Can change roles for any Authorized User
- Can reset passwords for any Authorized User
- Can activate and/or deactivate any Authorized User
- Can unlock any Authorized User ID
- Has access to all secured provider functionality

For LDSS and LHD, the Organization Administrator will be responsible for maintaining and updating authorized user accounts within their respective offices. Questions regarding the role of Organization Administrator or maintaining and updating authorized user accounts should be directed to the Virginia Medicaid Helpdesk toll free number at 1-866-352-0496.

Authorized User - The Authorized User is responsible for performing provider support functions.
Authorized Users are not required for a provider organization, but an organization can have one-to-many Authorized Users, if so desired. Authorized Users tier up to the Organization Administrators.

The Authorized User has the following capabilities:
- Has access to all secured provider functionality

Authorized User – Claims – The Authorized User – Claims role is established by either the Primary Account Holder or Organization administrator for performing claims submission on behalf of the provider organization.

The Authorized User - Claims role is not required for a provider organization, but an organization can have one-to-many Authorized User - Claims, if so desired. Authorized User - Claims tier up to the Organization Administrators.

The Authorized User – Claims has the following capabilities:
- Can submit claims through the Claims Direct Data Entry (DDE)
- Has access to all secured provider functionality

Authorized User – Provider – The Authorized User – Provider role is established by either the Primary Account Holder or Organization administrator for performing demographic, disclosure and revalidation updates on behalf of the provider organization, using the Provider Maintenance functionality.

The Authorized User - Provider role is not required for a provider organization, but an organization can have one-to-many Authorized User –

Provider roles, if so desired. The Authorized User - Provider tier up to the Organization Administrators.

The Authorized User – Provider has the following capabilities:

- Can make updates to the provider's demographic information, including:
  - Updates to correspondence information
  - Updates to remittance information
  - Updates to pay-to information
  - Note: updates to service information for most provider types will still be submitted via the enrollment process
  - Updates to disclosure information
  - Revalidation verification (when due)
- Has access to all secured provider functionality

Within the provider organization's security structure, the users within each tier are accessible within the system to all users in the tiers above. All Authorized Users can be accessed and user maintenance performed for them by all Organization Administrators and the Primary Account Holder.

Authorized User – PAS – The Authorized User – PAS role is established by either the Primary Account Holder or Organization Administrator for performing pre-admission screenings on behalf of the provider organization. Note that, as described above, Xerox will serve as the Primary Account Holder for the LDSS and LHD.

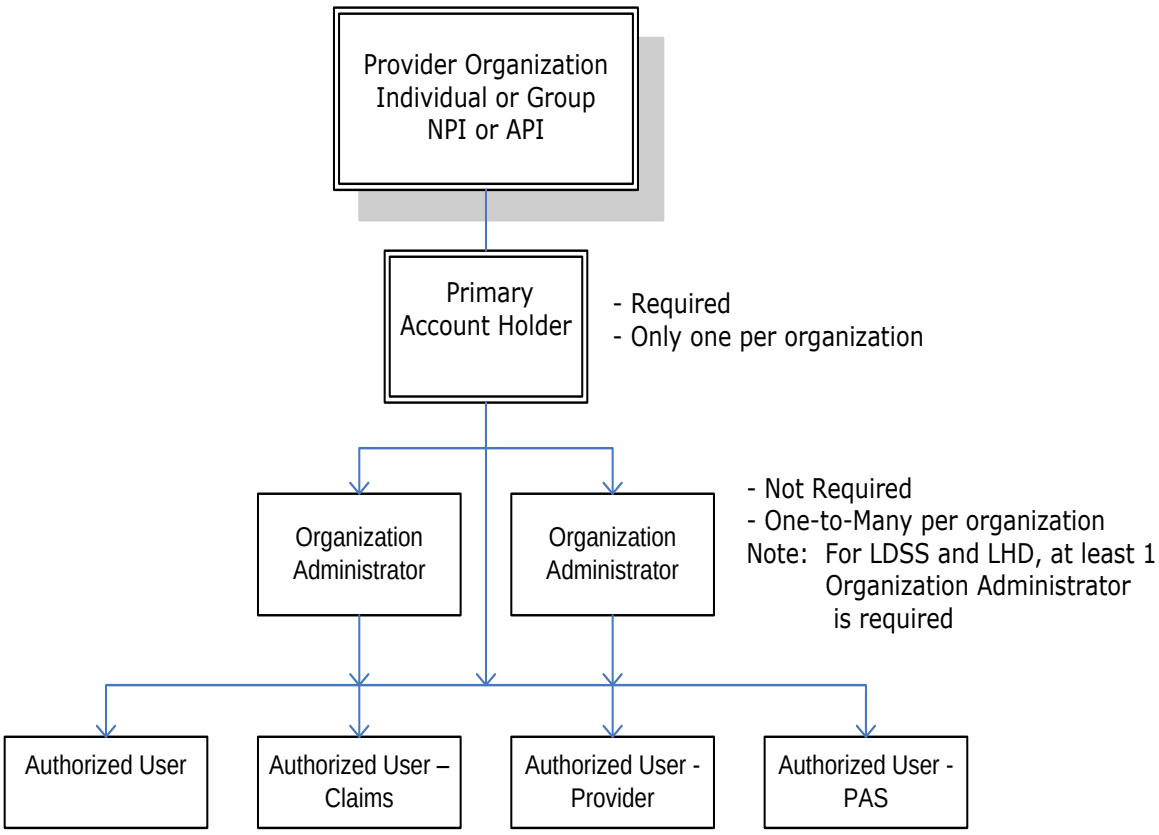
The Authorized User - PAS role is not required for a provider organization, but an organization can have one-to-many Authorized User - PAS, if so desired. Authorized User - PAS tier up to the Organization Administrators.

The Authorized User – PAS has the following capabilities:

- Can submit pre-admission screenings through the Pre-Admission Screening function
- Has access to all secured provider functionality

The following reflects the security structure for each provider organization.

Provider Organization's Security Structure



0.3 Overall Registration Process

The Web Registration process for new provider organizations must be completed by the Primary Account Holder. As described previously, Xerox will serve as the Primary Account Holder for the local departments of social services and local health district for the initial registration process; hospitals will manage the registration process through their organization's designated Primary Account Holder.

The registration process involves the following five steps:

1. Establish a User ID, Password and security profile
2. Request secured access for your organization
3. Successfully complete a one-time verification process of 3 questions
4. Upon receipt of confirmation email, click link within email
5. Sign in to the secured portal

For more details, please see the Provider Registration Users Guide.

1.0 Web Portal Access & Navigation

The Virginia Medicaid Web Portal can be accessed through the following link: www.virginiamedicaid.dmas.virginia.gov

The Web Portal is available daily 24 x 7 with the exception of routine maintenance which will be posted in advance.

The Web Portal currently only supports Internet Explorer browser version 6 and higher. Versions 9 and above may need to utilize the following:

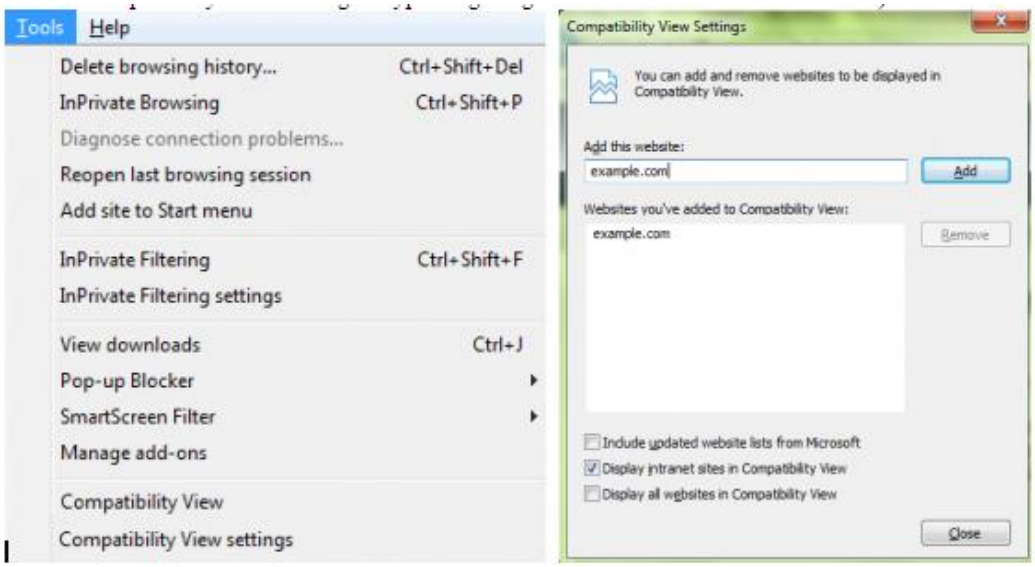
Note for Internet Explorer 9 (or greater) users:

In order to use IE9 (or greater) for the Web Portal the following settings are suggested:

1) Security settings set to Medium-High
    a. Open an IE browser session
    b. Click Tools->Internet Options.
    c. Click the Security Tab
    d. Verify/change to Medium-High
2) Verify Java is installed
    a. Go to www.java.com
    b. Press the option that says 'Do I have Java?'

c. Once the page refreshes, if Java is installed, the Java version will be displayed.
d. If Java is not installed, press the free java download button.

3) Add Virginia.gov to Compatibility View Settings
   a. Open an IE browser session
   b. Click Tools->Compatibility View settings.
   c. Type 'virginia.gov' and click 'Add'.
   d. Click 'Close'



If you have any questions, please contact the Virginia Medicaid helpdesk at 866-352-0496.

The following sections will outline the basic functionality of the portal.

1.1 Medicaid Web Portal – Home Page

The Commonwealth of Virginia Medicaid Web Portal's home page contains various portlets (sections within a portal page) and navigational tabs.

The Web Portal's Home Page is reflected below:

1.1.1 Navigation Tabs

Provider Services – This tab provides access to the following:

- Provider Enrollment – access to provider enrollment applications for downloading
- Provider Manuals – access to provider manuals, service center user manuals, dental manuals and forms
- Provider Forms Search – access to provider related forms
- Medicaid Memos to Providers – Medicaid Memorandums from DMAS to the provider community
- DMAS Provider Services – link to Provider Services on the Department of Medical Assistance Services web site
- DMAS Pharmacy Services – link to Pharmacy Services on the Department of Medical Assistance Services web site

Provider Resources – This tab provides access to the following:

- Provider Manuals – access to provider manuals, service center user manuals, dental manuals and forms
- Provider Links – links to Center of Medicare and Medicaid Services, DMAS and Virginia.gov websites
- Provider Training – access to the provider training library
- Web Registration – access to Registration FAQ, a Registration Quick Reference Guide, this Registration User's Guide and access to the Registration tutorial
- Automated Response System (ARS) – access to the ARS Users Guide, ARS FAQ and ARS tutorials
- Claims Direct Data Entry (DDE) – access to the User's Guide, FAQ and tutorial related to claims entry
- Provider Maintenance – access to the User's Guide, FAQ and tutorial related to the profile maintenance screen enabling you to update various demographic related fields
- Provider Enrollment – access to the User's Guide, FAQ and tutorial related to the provider enrollment screen enabling you to enter provider enrollment applications.
- Search for Provider - search for providers by provider type, location, etc. All providers listed are new and/or active providers
- Provider Screening and Fee Report – For State Medicaid Agencies to be able to check the screening and fees paid by providers for enrollment and revalidation purposes
- Level of Care Eligibility Review Instrument (LOCERI) – access to the User's Guide, FAQ and tutorial related to level of care assessments
- ICD-10 – access to FAQ and testing instructions associated with the implementation of Claims' ICD-10 processing
    - Pre-Admission Screening – access to the Pre-Admission Screening User Guides, Pre-Admission Screening FAQ and Pre-Admission Screening tutorial

EDI Support – This tab provides access to the following:

- EDI Companion Guides – links to the EDI companion guides for support of EDI transactions
- EDI FAQ – Frequently Asked Questions on EDI transactions
- EDI Testing – Guidelines for EDI testing
- EDI Forms and Links – access to EDI forms and links
- EDI HIPAA Changes - access to the HIPAA Operating Rules with regards to ICD-10 processing

Documentation – This tab provides access to the following:

- Provider Forms – access to various forms in support of provider services
- Paper Claim Forms – access to various claims forms for download

EHR Incentive Program - This tab furnishes providers with information regarding the Electronic Health Records provider incentive program

FAQ – This tab provides access to the following:

- ARS FAQ
- Claims DDE FAQ
- Provider Maintenance FAQ
- Provider Enrollment FAQ
- EDI FAQ
- Web Registration FAQ
- VAMMIS File Transfer System FAQ
- Search for Providers FAQ
- Level of Care Review Instrument FAQ
- Pre-Admission Screening FAQ

Provider Enrollment - This tab furnishes providers access to the online provider enrollment applications, once logged in, or a link to the paper versio of the applications.

1.1.2 Home Page Portlets – Physician Primary Care Increase

Physician Primary Care Increase Attestation – this portlet contains information regarding the Physician Primary Care Increase attestation, including reference links, forms for filing, etc.

1.1.3 Home Page Portlets – Web Announcements

Web Announcements – this portlet contains any information that is applicable to all portal users such as maintenance down time, new policies, etc.

1.1.4 Home Page Portlets – Quick Links

Quick Links – this portlet list links to documents or websites that are applicable to the audience viewing this portal page. Quick Links will be located on various portal pages. For consistency and availability to common information, the first six (6) links will always be the same as the navigation tabs:

- Provider Services
- Provider Resources
- EDI Support
- Documentation
- EHR Incentive Program
- FAQ

In addition there are links that are applicable to that portal page.

For the Home Page, the additional quick links are the following:

- **Search for Providers -** search for providers by provider type, location, etc. All providers listed are new and/or active providers
- **Provider Forms Search –** access to provider related forms
- **Web Registration Reference Material** - access to Registration FAQ, a Registration Quick Reference Guide, this Registration User's Guide and access to the Registration tutorial
- **DMAS Web Site** – link to the website for the Department for Medical Assistance Services
- **ICD-10 –** access to FAQ and testing instructions associated with the implementation of Claims' ICD-10 processing
- **DME and Pharmacy Audits** – access to information associated with DME and pharmacy audits and reports

1.1.5 Home Page Portlets – Login

This portlet is used for logging in to the pages needed for secured login. The login choice is based upon the user's role. For registration and access to secured provider functionality, select the 'Provider' role.

1.2 Medicaid Web Portal – Provider Login Page

After selecting the 'Provider' role in the Web Portal Home Page, the provider and the supporting user community are directed to the Provider Login Page.

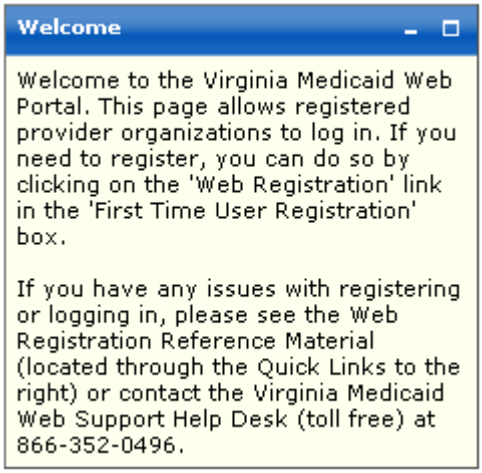
The Provider Login Page is reflected below:

There are three portlets on this page different from the Web Portal Home Page.

- Welcome portlet
- First Time User Registration portlet
- Existing User Login portlet

1.2.1 Welcome Portlet

The Welcome portlet is reflected below:



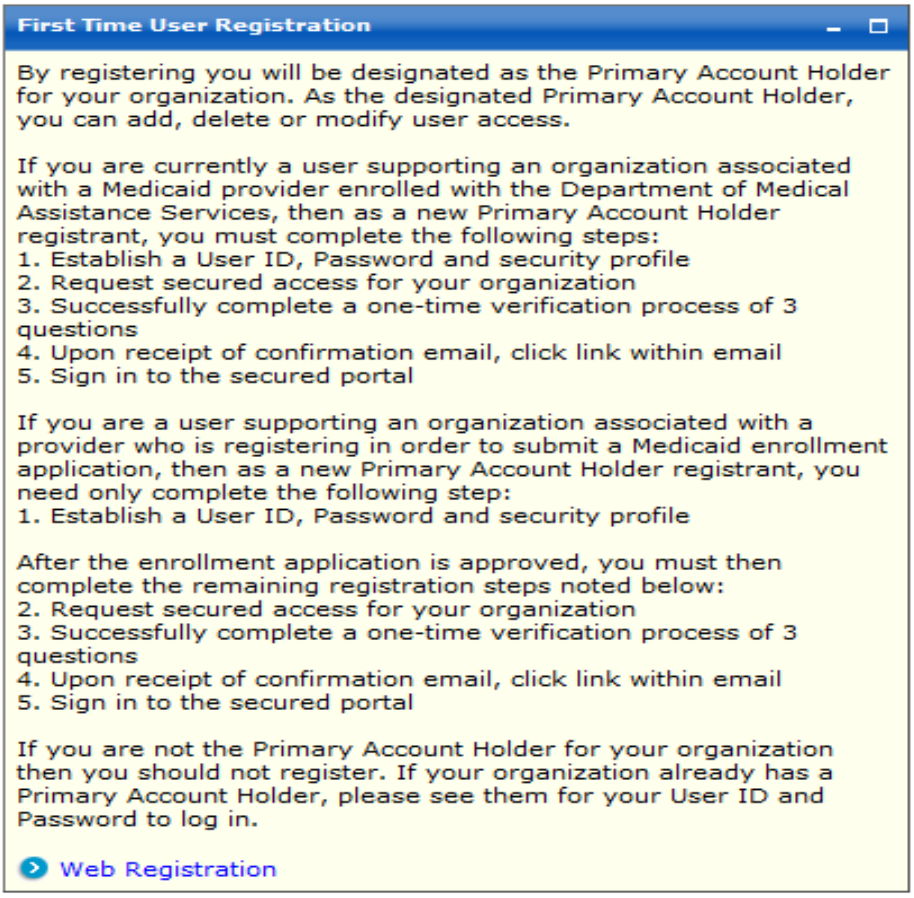
This portlet contains general instructions as well as mechanisms to handling issues or questions:

- Web Registration Reference Material – from the quick links
- Virginia Medicaid Help Desk – toll free number

1.2.2 First Time User Registration Portlet

The First Time User Registration Portlet is reflected in the text block below.

Please note that Xerox will perform the Primary Account Holder functions for local departments of social services (LDSS) and Local Health District (LHD). Xerox will notify each LDSS and LHD staff via e-mail regarding their registration, designation as organizational administrator or authorized user, and the process for logging into ePAS. Local department of social services and local health office staff should skip this section and go directly to section 1.2.3 Existing User Log-in Portlet.



This portlet outlines the steps needed for completing the registration process. Only the user designated as the Primary Account Holder, or Xerox acting as the PAH for LDSS and LHD, should complete the registration process.

Users that are not designated as the Primary Account Holder should contact their Primary Account Holder or Organization Administrator for their User ID and temporary password.

As the Primary Account Holder, not previously registered, you'd select 'Web Registration' link on this portlet.

1.2.3 Existing User Login Portlet

Once you have established your User and Security Profiles, you will have access to the public portal functionality for such things as access to online provider enrollment or requesting secured access to other portal functionality.

The Existing User Login portlet is reflected below:

First Time User? – For users that have not registered for the portal, this link will take you to the start of the registration process.

This portlet is used for applying a registered user's User ID and password. Both are required fields (indicated with a red asterisk *) for the login process.

User ID – this is the User ID created during the registration process when establishing your User Profile (see Registration Users Guide).

Password – this is the Password created during the registration process when establishing your User Profile.

Enter your User ID and Password and click 'Submit'

The Forgot User ID and Forgot Password are addressed in further detail below

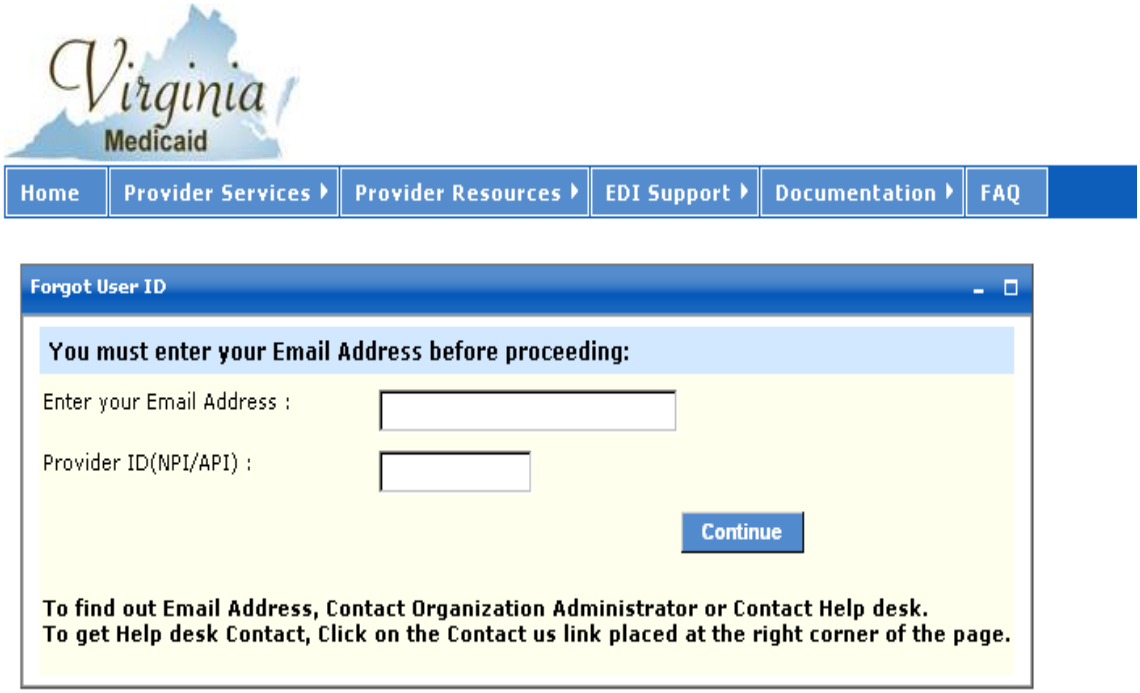
1.3 Forgot User ID

Once you've completed your User and Security Profiles, you are able to leverage the user self -help capabilities of the portal. Authorized Users who forget their User ID can get with their Primary Account Holder or any Organization Administrator associated with this provider organization. For Local department of social services and local health district offices, authorized users should contact the Organization Administrator in their office. They have the capability to look up the User IDs. An Organization Administrator can check with the Primary Account Holder.

All roles have the ability to also request their User ID be emailed to them.

On the Provider Login Page, in the Existing Users Login portlet there is an option for Forgot User ID?

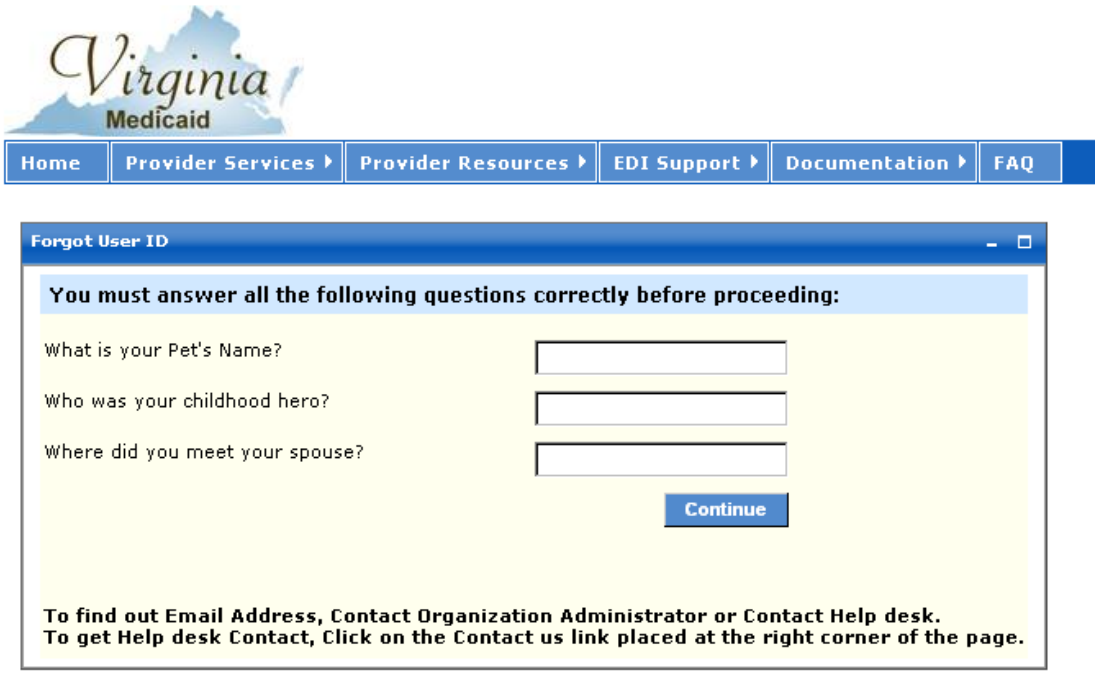
Select 'Forgot User ID?'



Enter your Email Address: - this must be the preferred email that was entered in your User Profile at the time of initial entry (or the last update to your User Profile).

Provider ID (NPI/API): - enter the NPI or API associated with your User ID

Click 'Continue' and you will be routed to the portlet below.

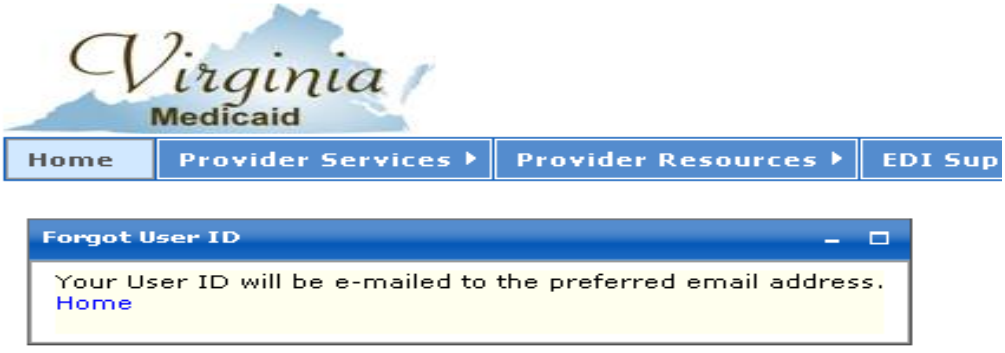


This portlet will display the three questions you chose when establishing your Security Profile.

You must complete all three of these questions, giving the same answers (case sensitive) as you established in your Security Profile.

Upon completing the answers, click 'Continue' to invoke the validation of answers to your Security Profile.

After successful validation you will receive the following portlet:



Your User ID will be emailed to the email address entered in your User Profile.

The following is a sample email with the User ID removed:

Your Forgot User ID request has been processed.

Your User ID is :

Please use this to log in to the Virginia Medicaid Web Portal at https://www.virginiamedicaid.dmas.virginia.gov .Please contact the ACS Web Support Call Center, toll free, at 1-866-352-0496 if you have any questions or problems regarding your web portal registration.

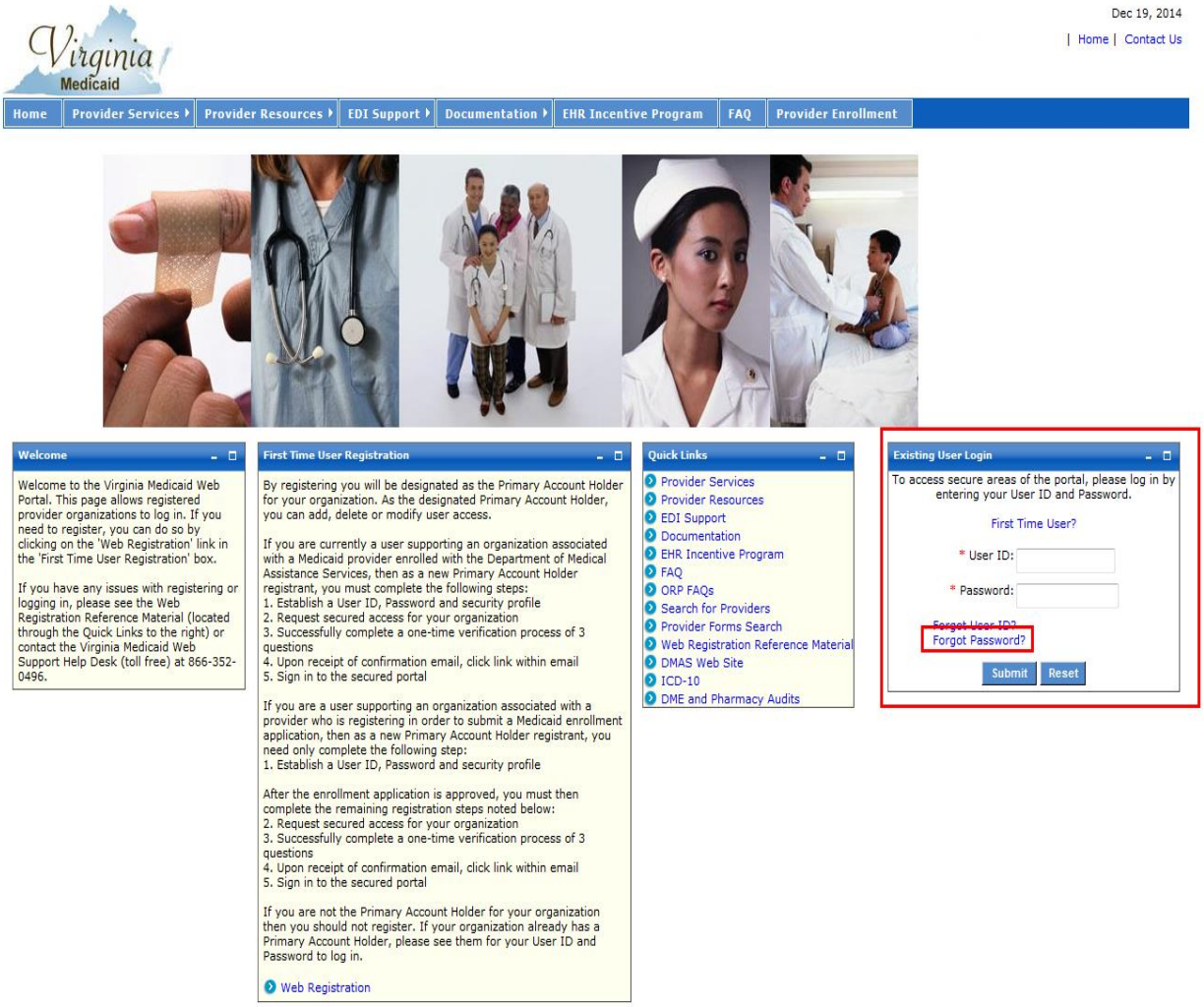
Note: This is an auto-generated email, please do not reply.

1.4 Forgot Password

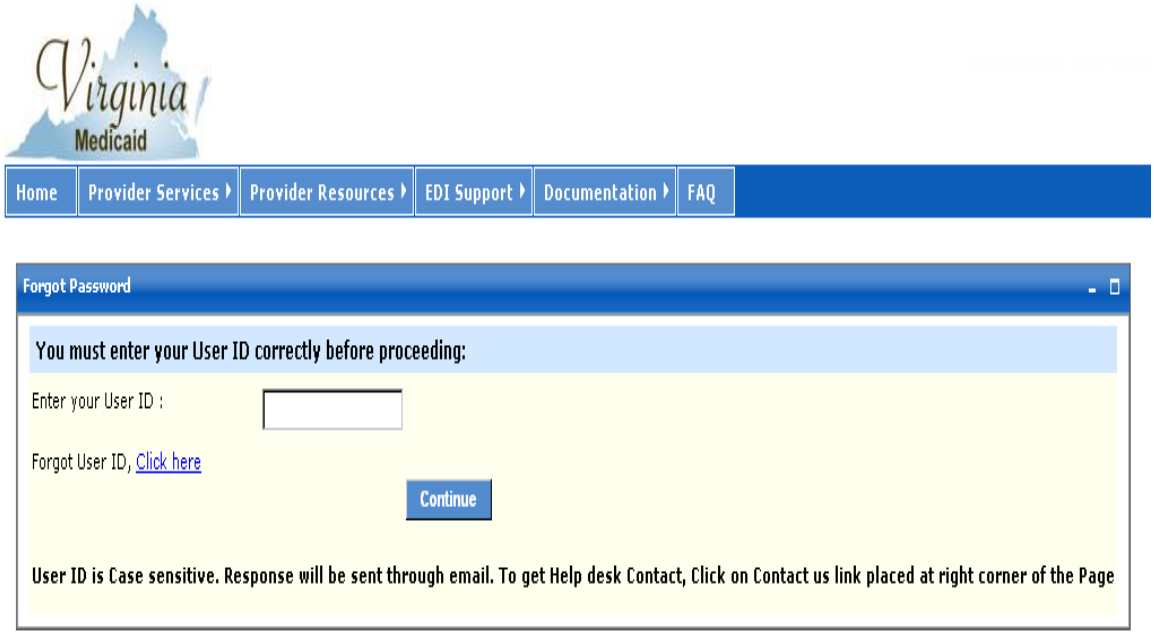
Once you've completed your User and Security Profiles, you are able to leverage the user self-help capabilities of the portal. Authorized Users who forget their password can get with their Primary Account Holder or any Organization Administrator associated with this provider organization. Local Department of Social Services and Local Health District authorized users who forget their password should contact the Organization Administrator in their local office. They have the capability to generate a temporary password. An Organization Administrator can check with the Primary Account Holder.

All roles have the ability to also request their password be emailed to them.

On the Provider Login Page, in the Existing Users Login portlet there is an option for Forgot Password?

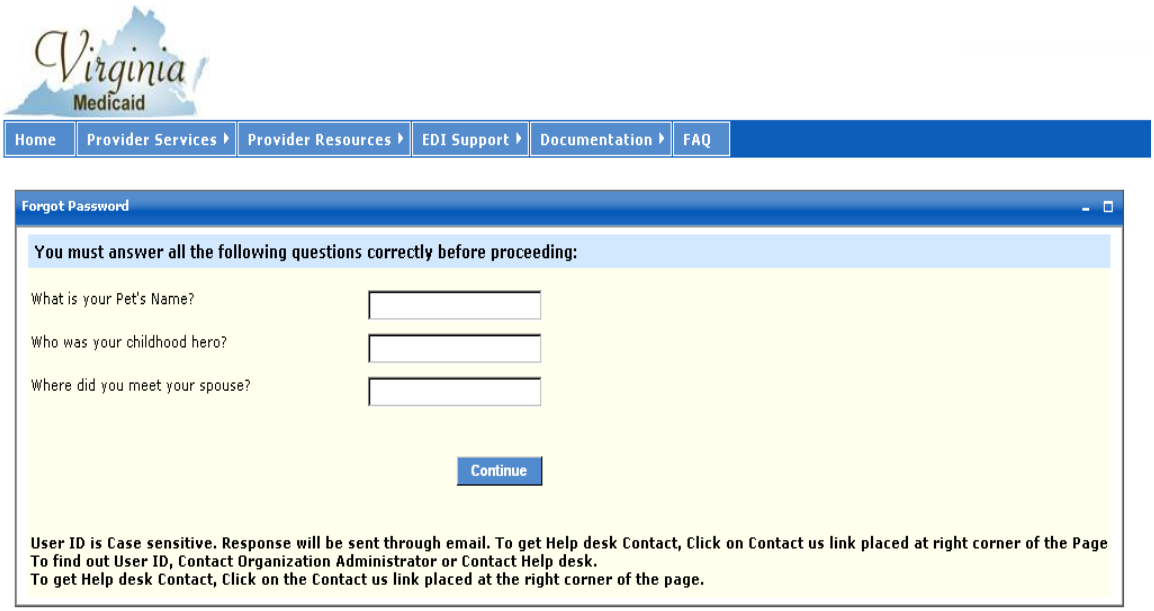


Select 'Forgot Password?'



Enter your User ID: - enter your User ID created in your User Profile

Click 'Continue' and you will be routed to the following portlet:



This portlet will display the three questions you chose when establishing your Security Profile.

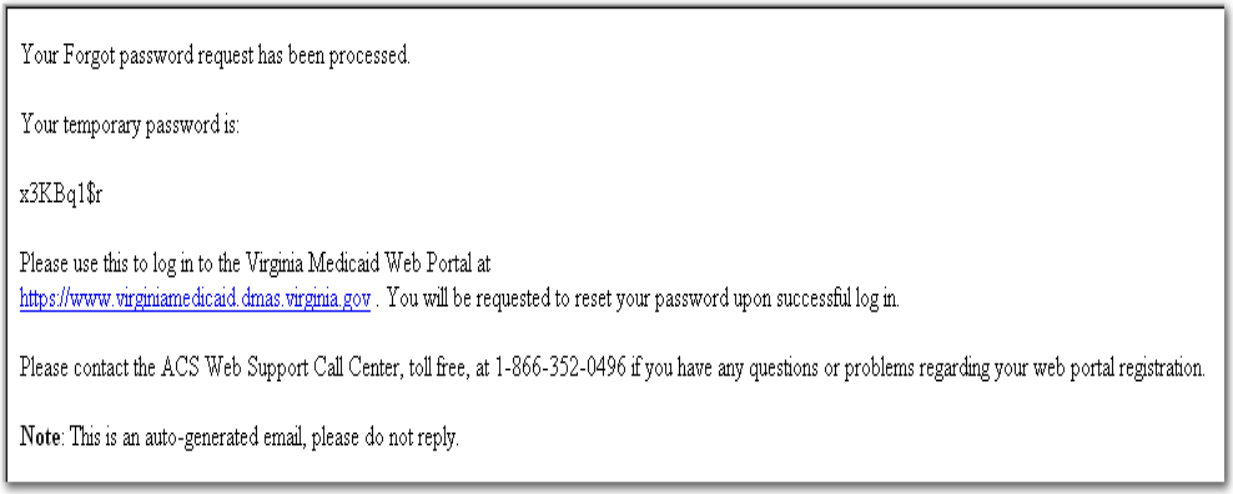
You must complete all three of these questions, giving the same answers (case sensitive) as you established in your Security Profile.

Upon completing the answers, click 'Continue' to invoke the validation of answers to your Security Profile.

After successful validation you will receive the following portlet:

A temporary/one-time use password will be emailed to the email address entered in your User Profile.

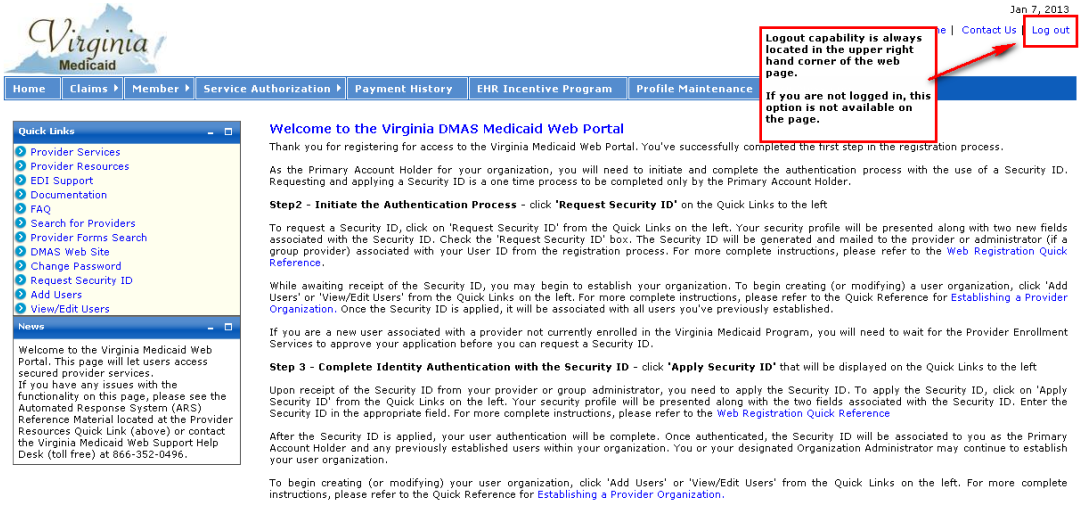
The following is a sample email:



This temporary password will be used for login. You will immediately be taken to your User Profile and will be required to enter another password.

1.5 Log Out

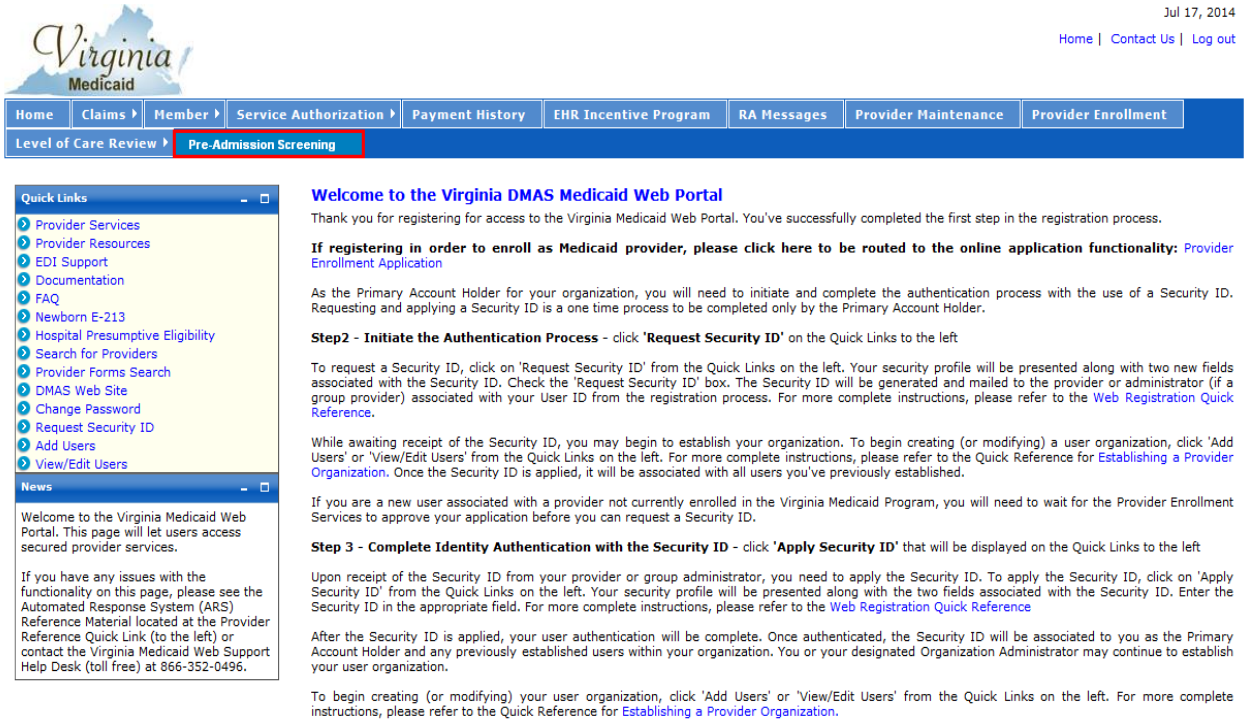
The log out functionality is available on any secured web portal page. The Log Out link is reflected below:



If you are not logged in and are still on public pages, this link is not available as it's not applicable until you've accessed secured portal pages.

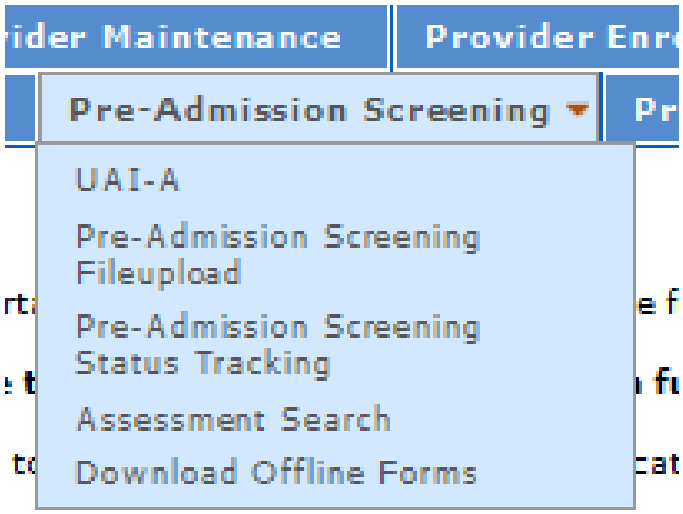
2.0 Accessing the Pre-Admission Screening (ePAS)

Upon successful login you will be directed to the secured Provider Welcome Page.



The Provider Welcome page consists of navigation tabs that are the menu to the various different provider functions. The Pre-Admission Screening tab is the user's access to Pre-Admission Screening (ePAS) functionality.

2.1 Pre-Admission Screening (ePAS) Menu



By hovering over or selecting the Pre-Admission Screening tab you will be directed a series of drop down options:

- **UAI – Part A** – this option will route the users to the pre-admission screening forms. All screenings require the UAI – Part A so this form will be the initiation of the assessment screening. After completion of this form the user will be able to submit the form or navigate to additional forms.

- **Pre-Admission Screening Status Tracking** – this option will route the user to the status tracking screen. All screenings in progress and/or submitted via the portal for the NPI/API organization will be displayed along with their appropriate status. This screen will also allow the user to navigate to status detail, delete incomplete assessments that will not be submitted, recall incomplete forms for update and submission and recall submitted forms for viewing or to save as a new assessment, then update and submit. Print capability will also be available from this screen, via a link, for any submitted and/or processed screening. Please note that the

documents printed from the online ePAS will show the data entered without the lines and margins shown on the paper UAI and other DMAS forms.

- **PAS File Upload** – this option will route the user to a screen where they will be have the ability to attach and upload an assessment file.

  There are two types of uploads the system will accept. If a user has established an xml file of the necessary data, the file can be uploaded from this screen.

  In addition, the following 8 UAI forms are available for offline entry:
  - UAI – Part A
  - UAI – Part B
  - DMAS95 – MI/MR/RC
  - DMAS95 – MI/MR/SUPL
  - DMAS96
  - DMAS97
  - DMAS108
  - DMAS109

  The user can update these offline and when ready for submission to the system, use this screen to upload the offline forms.

  Important: When completing any of the DMAS forms offline, once the data is uploaded to ePAS, the remainder of the form MUST be completed online to avoid duplicate data entry. To the extent feasible, the best practice for working offline is to complete as much of the DMAS form(s) as possible prior to uploading the data to ePAS. The remainder of the data may be entered online by the appropriate LDSS or LHD staff to complete the PAS process.

  Important: When working on-line, no two staff should work in the same assessment on ePAS on the same case at the same time. While ePAS allows for access of a case by both LDSS and LHD staff, ePAS does not permit a "shared document" for multiple users at one time.

  Once uploaded, any user within the NPI/API organization will be able to view the file(s) via the appropriate forms, update, and submit.

- **Assessment Search** – this option will give the user the capability of searching assessments within their NPI/API organization, both submitted and not submitted, via specific search criteria. Once found, the assessment will be available via the assessment forms. If not previously submitted, the assessment can be updated and submitted using the ePAS generated Form ID Number/ATN Reference Number. If previously submitted, the assessment can be saved as a new assessment, updated and submitted, generating a new Form ID Number/ATN Reference Number.

- **Download Offline Forms** – this option will give the user the capability to download the UAI forms in a spreadsheet form for entry offline and eventual upload to the Pre-Admission Screening (ePAS) system. (Please refer to Section 3.14 of this Guide for detail instructions to download offline forms.)

The following sections will detail each of the Pre-Admission Screening (ePAS) options in further detail.

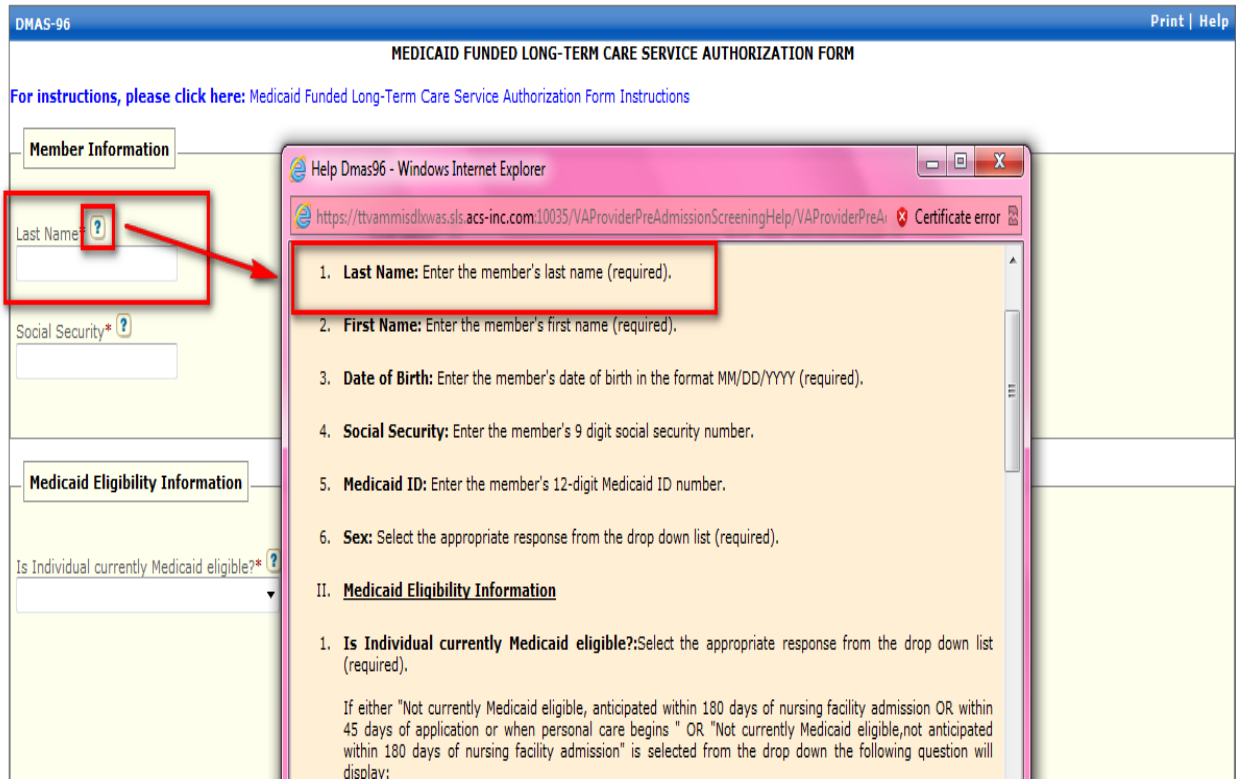
3.0 UAI – Part A (Entry to Assessment Forms)

Select the 'UAI – Part A' option from the Pre-Admission Screening drop down menu.

You will be directed to the Uniform Assessment Instrument – Part A form for selection criteria entry.

Throughout the screen, you will see information icons ( ). If you click any of these icons, the instructions will display, beginning from the point in the instructions relative to the entry field the icon represents.

For instance, if the information icon associated with the 'Assessment Date' is clicked the information page will display with the Assessment Date information at the top of the page, as displayed below.



After completion of the UAI – Part A, you will be given the option of submitting the assessment, continuing with UAI – Part B or electing one for the following additional screening forms:

- DMAS95 – MI/MR/RC
- DMAS95 – MI/MR/SUPL
- DMAS96
- DMAS97

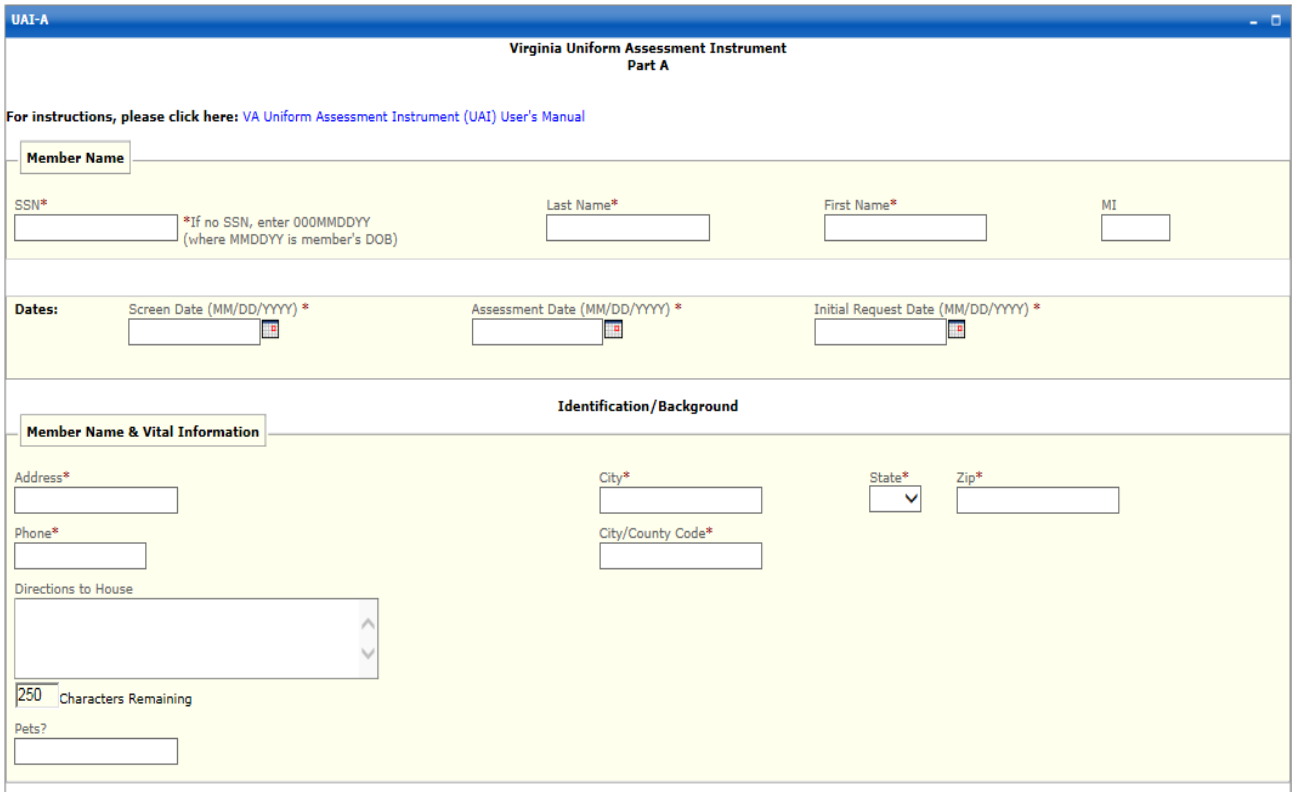
After the completion of each form, you will continue to have the option of submission or electing yet another form for completion.

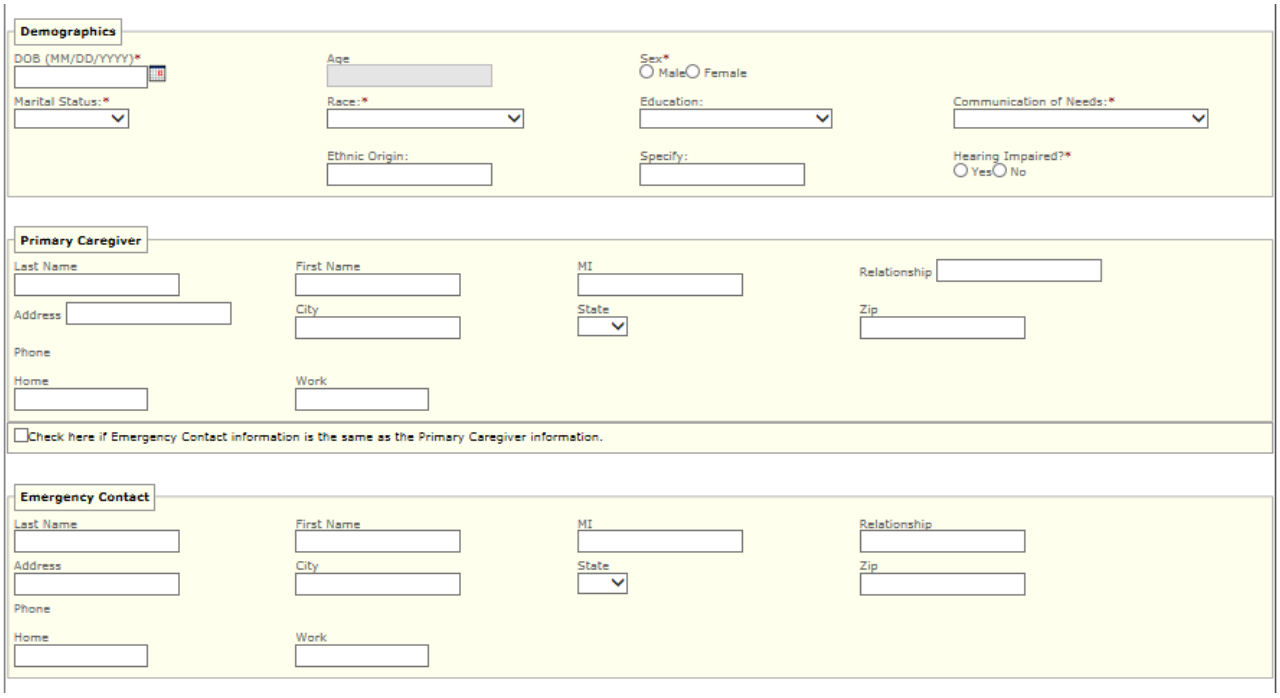
The following sections detail each of the assessment screening forms for aid in completing the necessary data.

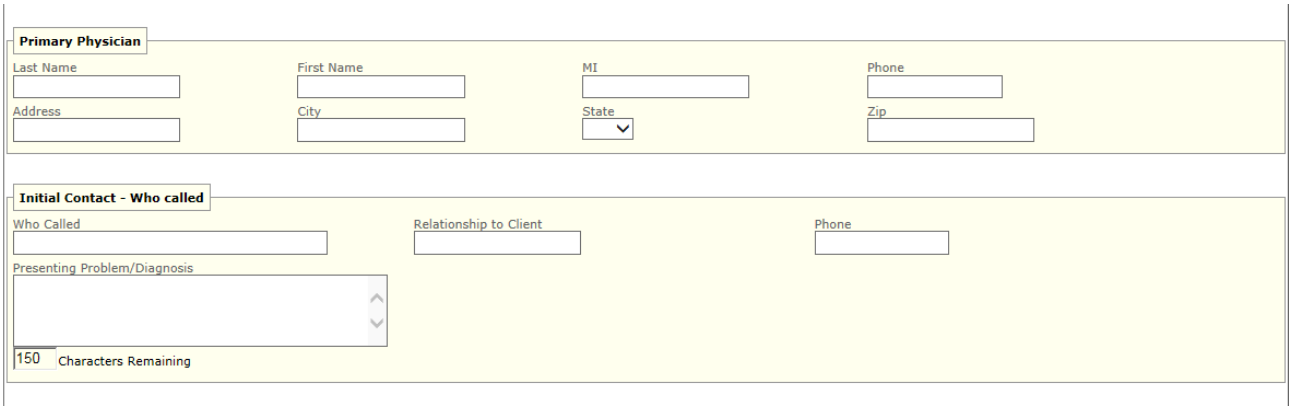
3.1 Uniform Assessment Instrument (UAI) – Part A

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.

The screen sample below has been broken up in parts for display purposes.



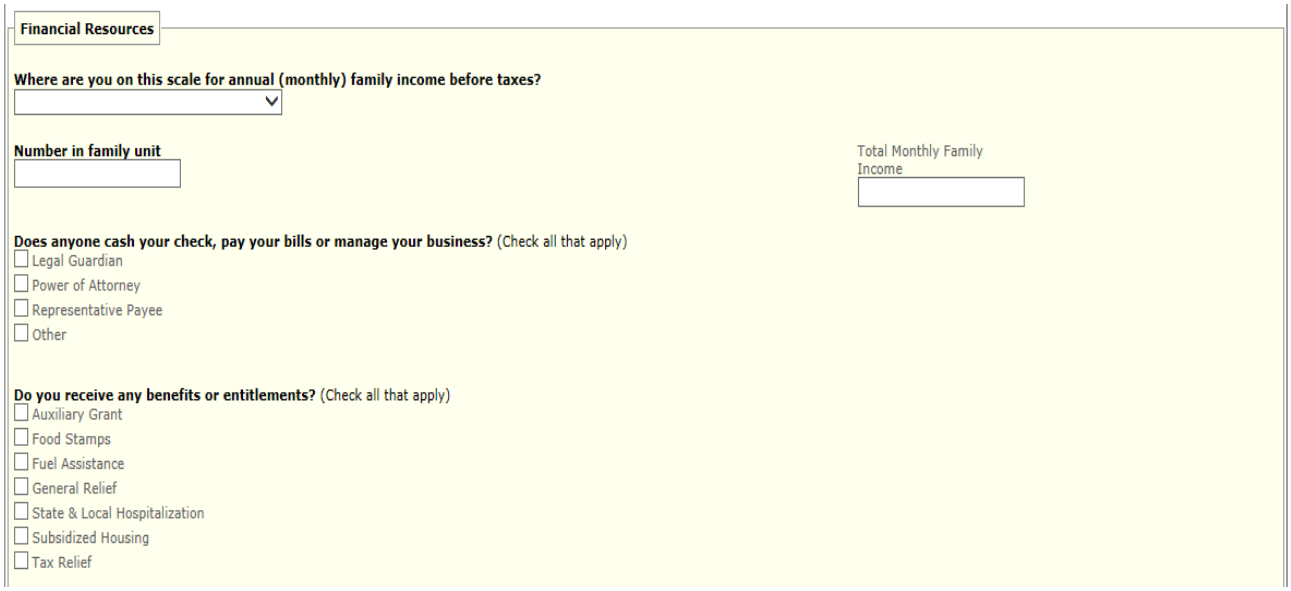

Demographics
DOB (MM/DD/YYYY)*
Age
Sex*
Male
Female
Marital Status:*
Race:*
Education:
Communication of Needs:*
Ethnic Origin:
Specify:
Hearing Impaired?*
Yes
No
Primary Caregiver
Last Name
First Name
MI
Relationship
Address
City
State
Zip
Phone
Home
Work
Check here if Emergency Contact information is the same as the Primary Caregiver information.
Emergency Contact
Last Name
First Name
MI
Relationship
Address
City
State
Zip
Phone
Home
Work


Primary Physician
Last Name
First Name
MI
Phone
Address
City
State
Zip
Initial Contact - Who called
Who Called
Relationship to Client
Phone
Presenting Problem/Diagnosis
150
Characters Remaining

Current Formal Services

Do you currently use any of the following types of services? (Check all services that apply)

- ☐ Adult Day Care
- ☐ Adult Protective
- ☐ Case Management
- ☐ Chore/Companion/Homemaker
- ☐ Congregate Meals/Senior Center
- ☐ Financial Management Counseling
- ☐ Friendly Visitor/Telephone Reassurance
- ☐ Habilitation/Supported Employment
- ☐ Home Delivered Meals
- ☐ Home Health/Rehabilitation
- ☐ Home Repairs/Weatherization
- ☐ Housing
- ☐ Legal
- ☐ Mental Health(Inpatient/Outpatient)
- ☐ Mental Retardation
- ☐ Personal Care
- ☐ Respite
- ☐ Substance Abuse
- ☐ Transportation
- ☐ Vocational Rehabilitation/Counseling
- ☐ Other



Financial Resources

Where are you on this scale for annual (monthly) family income before taxes?

Number in family unit

Total Monthly Family Income

Does anyone cash your check, pay your bills or manage your business? (Check all that apply)

- ☐ Legal Guardian
- ☐ Power of Attorney
- ☐ Representative Payee
- ☐ Other

Do you receive any benefits or entitlements? (Check all that apply)

- ☐ Auxiliary Grant
- ☐ Food Stamps
- ☐ Fuel Assistance
- ☐ General Relief
- ☐ State & Local Hospitalization
- ☐ Subsidized Housing
- ☐ Tax Relief

Do you currently receive income from.....? (Check all that apply)

- ☐ Black Lung
- ☐ Pension
- ☐ Social Security
- ☐ SSI/SSDI
- ☐ VA Benefits
- ☐ Wages/Salary
- ☐ Other

What type of health insurance do you have?* (Check all that apply)

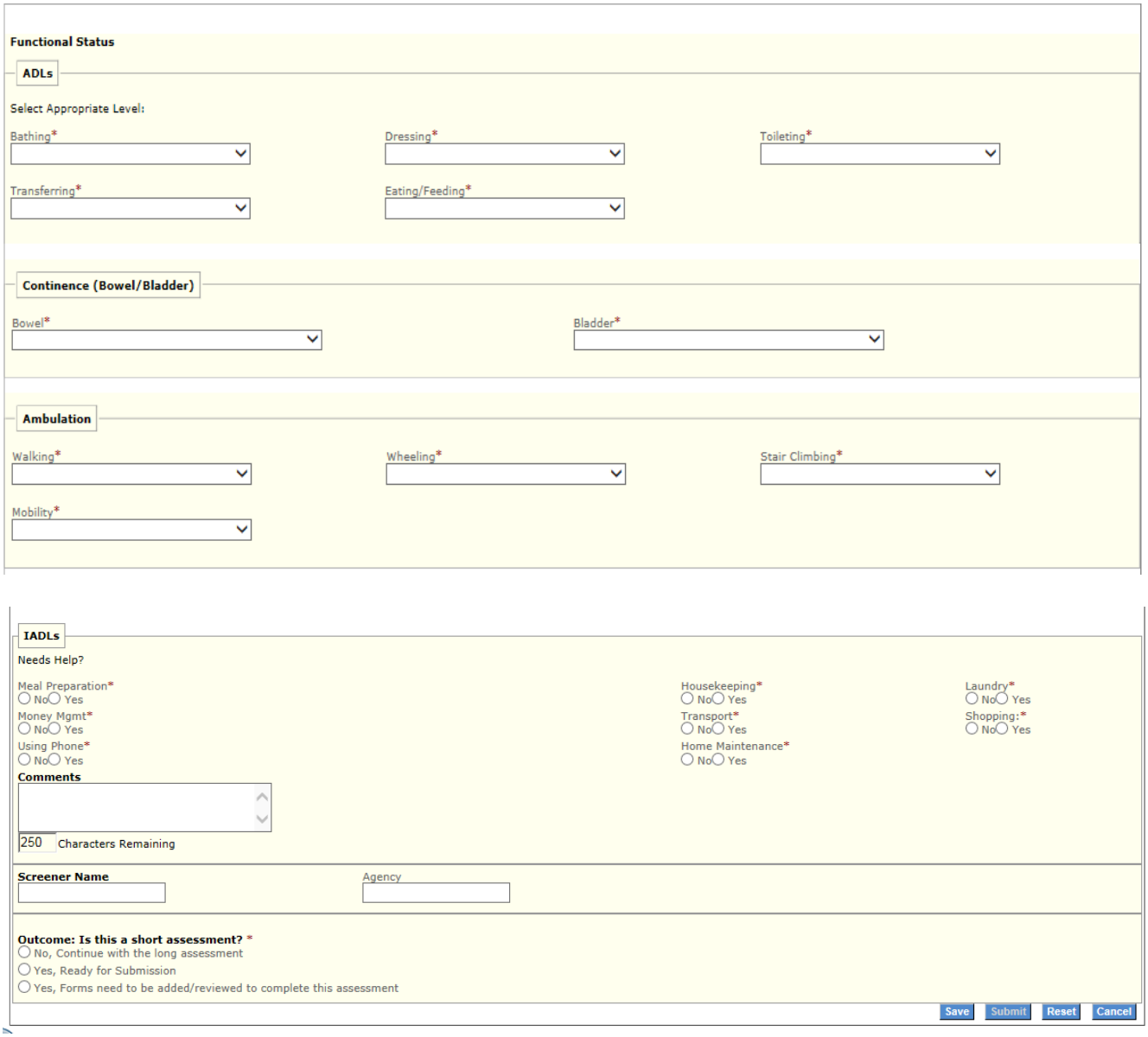
- ☐ Medicare Insured
- ☐ Medicaid Insured
- ☐ Medicaid-Pending
- ☐ Medicaid-QMB/SLMB
- ☐ All Other Public/Private

Physical Environment

Where do you usually live? *

Where you usually live are there any problems? (Check all problems that apply)

- ☐ Barriers to Access
- ☐ Electrical Hazards
- ☐ Fire Hazards/No Smoke Alarm
- ☐ Insufficient Heat/Air Conditioning
- ☐ Insufficient Hot Water/Water
- ☐ Lack of/Poor Toilet Facilities (Inside/Outside)
- ☐ Lack of/Defective Stove, Refrigerator, Freezer
- ☐ Lack of/Defective Washer/Dryer
- ☐ Lack of/Poor Bathing Facilities
- ☐ Structural Problems
- ☐ Telephone Not Accessible
- ☐ Unsafe Neighborhood
- ☐ Unsafe/Poor Lighting
- ☐ Unsanitary Conditions
- ☐ Other



The UAI – Part A has both required and optional fields. The required fields are indicated with a red asterisk (*).

The following is a list of fields on the screen and the necessary information for completing the form.

SSN* - Please enter the member's 9 digit social security number in the format 999999999 or 999-99-999 (dashes optional). This field is required.

Note: If the member does not have a social security number, enter 000MMDDYY where MMDDYY is the member's date of birth.

Once entered, the portal will link to the existing Medicaid information and retrieve the member's last name, first name, middle initial and Medicaid ID (if applicable).

Last Name* - If the member exists within the Medicaid Management Information System (MMIS), this data will be populated and will not be able to be updated.

If the member is not currently with the MMIS, this field will be enterable. Please enter the member's last name. This is a required field.

First Name* - If the member exists within the Medicaid Management Information System (MMIS), this data will be populated and will not be able to be updated.

If the member is not currently with the MMIS, this field will be enterable. Please enter the member's first name. This is a required field.

Middle Initial – If the member exists within the Medicaid Management Information System (MMIS), this data will be populated and will not be able to be updated.

If the member is not currently with the MMIS, this field will be enterable. Please enter the member's middle initial. This is an optional field.

Screen Date* - Please enter the screening date in the format MM/DD/YYYY or utilize the calendar widget. The date cannot be greater than the current date. This is a required field.

Assessment Date* – Please enter the Assessment date. This is required. Please enter the date in the format MM/DD/YYYY or utilize the calendar widget. The date cannot be greater than the current date.

Initial Request Date* – Please enter the date of the initial request for pre-admission screening. Please enter the date in the format MM/DD/YYYY or utilize the calendar widget. The date cannot be greater than the current date.

Identification/Background Section

Member Vital Information

Address* - Please enter the member's building number and street address of residence. This is a required field.

City* - Please enter the member's city of residence. This is a required field.

State* - Please select the member's state of residence from the drop down list. This is a required field.

Zip* - Please enter the member's 5 digit zip code of residence. This is a required field.

Phone* - Please enter the member's phone number including area code. Format must be 9999999999 or 999-999-9999 (dashes are optional). This is a required field.

City/County Code* - Please enter the member's city/county code. Up to three entries are allowed but at least one is required.

Directions to House - Please enter any directions to the member's house that might be of value to the screener. This is an optional field and can be up to 250 characters, including letters, numbers and/or special characters.

Pets? - Please enter whether the member has any pets in the household of residence. This is an optional field.

Demographics Information

Date of Birth* - If the member exists within the Medicaid Management Information System (MMIS), this data will be populated and will not be able to be updated.

If the member is not currently with the MMIS, this field will be enterable. Please enter the member's date of birth in the format MM/DD/YYYY or utilize the calendar widget. The DOB cannot be greater than the current date. This is a required field

Age - This field is display only. It's calculated using the member's date of birth and Assessment Screening Date

Sex* - If the member exists within the Medicaid Management Information System (MMIS), this data will be populated and will not be able to be updated.

If the member is not currently with the MMIS, this field will be enterable. Please select the appropriate button indicating the member's gender. This is a required field.

Marital Status* - Please select the appropriate drop down option indicating the member's marital status. This is a required field.

Race* - Please select the appropriate drop down option indicating the member's race. This is a required field.

> **Ethnic Origin*** – If 'Unknown' is selected from the 'Race' field, the Ethnic Origin entry will display and the entry is required. Please enter the member's ethnic origin using up to 15 characters, including letters, numbers and/or special characters.

Education - Please select the appropriate drop down option indicating the member's level of education. This field is optional.

> **Specify*** – If 'Unknown' is selected from the 'Education' field, the Specify entry will display and the entry is required. Please enter the member's education specifics using up to 15 characters, including letters, numbers and/or special characters.

Communication of Needs*- Please select the appropriate drop down option indicating the member's communication needs. This is a required field.

> **Other Language – Specify*** - If 'Verbally – Other Language' is selected from the 'Communication Needs' field, the Other Language - Specify entry will display and the entry is required. Please enter any other language(s) the member uses for communication using up to 15 characters, including letters, numbers and/or special characters.

Hearing Impaired?* - Please select the appropriate button indicating whether the member is hearing impaired. This is a required field.

Primary Caregiver Information

Last Name - Please enter the last name of the member's primary caregiver. This field is optional.

First Name - Please enter the first name of the member's primary caregiver. This field is optional.

Middle Initial (MI) - Please enter the middle initial of the member's primary caregiver. This field is optional.

Relationship - Please enter the relationship the caregiver has to the member. This field is optional.

Address - Please enter the building number and street address of the primary caregiver's residence. This field is optional.

City - Please enter the city of the primary caregiver's residence. This field is optional.

State - Please select the state abbreviation of the primary caregiver's residence. This field is optional.

Zip - Please enter the 5 digit zip code of the primary caregiver's residence. This field is optional.

Phone - Home - Please enter the caregiver's home phone number including area code. Format must be 9999999999 or 999-999-9999 (dashes are optional). This field is optional.

Phone – Work - Please enter the caregiver's work phone number including area code. Format must be 9999999999 or 999-999-9999 (dashes are optional). This field is optional.

Emergency Contact Information

Note: If Emergency Contact information is the same as the Primary Caregiver, click checkbox to duplicate information.

Last Name - Please enter the last name of the member's emergency contact. This field is optional.

First Name - Please enter the first name of the member's emergency contact. This field is optional.

Middle Initial (MI) - Please enter the middle initial of the member's emergency contact. This field is optional.
Relationship - Please enter the relationship the emergency contact has to the member. This field is optional.

Address - Please enter the building number and street address of the emergency contact's residence. This field is optional.

City - Please enter the city of the emergency contact's residence. This field is optional.

State - Please select the state abbreviation of the emergency contact's residence. This field is optional.

Zip - Please enter the 5 digit zip code of the emergency contact's residence. This field is optional.

Phone - Home - Please enter the emergency contact's home phone number including area code. Format must be 9999999999 or 999-999-9999 (dashes are optional). This field is optional.

Phone – Work - Please enter the emergency contact's work phone number including area code. Format must be 9999999999 or 999-999-9999 (dashes are optional). This field is optional.

Primary Physician Information

Last Name - Please enter the last name of the member's primary physician. This field is optional.

First Name - Please enter the first name of the member's primary physician. This field is optional.

Middle Initial (MI) - Please enter the middle initial of the member's primary physician. This field is optional.

Phone - Please enter the primary physician's phone number including area code. Format must be 9999999999 or 999-999-9999 (dashes are optional). This field is optional.

Address - Please enter the building number and street address of the primary physician's servicing address. This field is optional.

City - Please enter the city of the primary physician's servicing address. This field is optional.

State - Please select the state abbreviation of the primary physician's servicing address. This field is optional.

Zip - Please enter the 5 digit zip code of the primary physician's servicing address. This field is optional.

Initial Contact – Who Called Information

Who Called - Please enter the name of the initial contact. This field is optional.

Relationship - Please enter the relationship the initial contact has to the member. This field is optional.

Phone - Please enter the initial contact's phone number including area code. Format must be 9999999999 or 999-999-9999 (dashes are optional). This field is optional.

Presenting Problem/Diagnosis - Please enter any problems or diagnosis(es) noted at the initial contact using up to 150 characters, including letters, numbers and/or special characters. This field is optional.

Current Formal Services Information

Do you currently use any of the following types of services? – Please check all that apply. This is situationally required field (if applicable).

Service selections:

- Adult Day Care
- Adult Protective
- Case Management
- Chore/Companion/Homemaker
- Congregate Meals/ Senior Center
- Financial Management Counseling
- Friendly Visitor/Telephone Reassurance
- Habitation/ Support Employment
- Home Delivered Meals
- Home Health/Rehabilitation
- Home Repairs/Weatherization
- Housing
- Legal
- Mental Health (Inpatient/Outpatient)
- Mental Retardation
- Personal Care
- Respite
- Substance Abuse
- Transportation
- Vocational Rehabilitation/Counseling
- Other

Provider/Frequency* - For each type of service checked, please note the name of the provider and the frequency the service is used. Please enter up to 20 characters which can include letters, numbers or special characters. This is required for each selection.

Other* - If a type of service selection of 'Other' is checked, please enter what type of other/additional services the member is utilizing Please enter up to 20 characters which can include letters, numbers or special characters. This field is required on an 'Other' selection.

Financial Resources Information

Where are you on this scale for annual (monthly) family income before taxes? - Please select the appropriate drop down option indicating the member's annual family gross income. This field is optional.

Number in family unit - Please enter the number in the member's family. This field is optional.

Total Monthly Family Income - Please enter the member's family's total monthly income. This is an optional field.

Does anyone cash your check, pay your bills or manage your business? – Please check all that apply. This is a situationally required field (if applicable).

Entities listed:
- Legal Guardian
- Power of Attorney
- Representative Payee
- Other

> **Name(s)*** - Please enter the name of each person who assists the member with financial issues. Please enter up to 35 characters which can include letters, numbers or special characters. This field is required for each entity checked.

Do you receive any benefits or entitlements? - Please check all that apply. This is a situationally required field (if applicable).

Benefits/Entitlement listed:
- Auxiliary Grant
- Food Stamps
- Fuel Assistance
- General Relief
- State & Local Hospitalization
- Subsidized Housing
- Tax Relief

Do you currently receive income from ……? - Please check all that apply. This is a situationally required field (if applicable).

Entity options:
- Black Lung
- Pension
- Social Security

- SSI/SSDI
- VA Benefits
- Wages/Salary
- Other

Amount* - Please enter the amount of income received. This field is required for each entity checked.

What types of health insurance do you have?* - Please check all that apply. At least one selection is required.

Health Insurance options:
- Medicare Insured
- Medicaid Insured
- All Other Public/Private

Medicare #* - If 'Medicare Insured' is selected, please enter the member's 10 digit Medicare ID number. This is required if selection is made.

Medicaid #* - If the member exists within the Medicaid Management Information System (MMIS) and has been assigned a Medicaid ID, this data will be populated and will not be able to be updated. If the Medicaid ID is not in the MMIS, no entry can be made.

Pending* – If the member has filed for Medicaid and it's in process, please check.

QMB/SLMB* – If the member is QMB/SLMB eligible, please check.

All Other Public/Private* - If 'All Other Public/Private' is selected, please specify the name of the other insurance or Private Pay.

Physical Environment Information

Where do you usually live?* - Please select the option best reflecting the member's place of residence. This field is required.

Does Anyone Usually Live With You?* - Please select the option indicating whether anyone usually lives with the member. This field is required.

Name of Person(s) in Household* - Please enter the name of anyone living within the member's household. This field will display and is required if the following condition is met:

- Member's residence is one of the following:
  - House Own
  - House Rent
  - House Other
  - Apartment
  - Rented Room

  AND

- Member does not live alone

Name of Provider (Place)* - Please enter the name of the provider facility where the member currently resides. This field will display and is required if the member's residence is one of the following:
- Adult Care Residence
- Adult Foster
- Nursing Facility
- Mental Health/Retardation Facility
- Other

Admission Date* - Please enter the date of admission where the member currently resides. Please enter the date in the MM/DD/YYYY format or utilize the calendar widget. This field will display and is required if the member's residence is one of the following:
- Adult Care Residence
- Adult Foster
- Nursing Facility
- Mental Health/Retardation Facility
- Other

Provider NPI (if applicable) - Please enter the 10 digit numeric NPI of the provider facility where the member currently resides. This field will display and is requested (if applicable), if the member's residence is one of the following:
- Adult Care Residence
- Adult Foster
- Nursing Facility
- Mental Health/Retardation Facility
- Other

Where you usually live are there any problems? - Please check all that apply. This is a situationally required field (if applicable).

Residential problems listed:
- Barriers to Access
- Electrical Hazards
- Fire Hazards/No Smoke Alarm
- Insufficient Heat/Air Conditioning

- Insufficient Hot Water/Water
- Lack of/Poor Toilet Facilities (Inside/Outside)
- Lack of/Defective Stove, Refrigerator, Freezer
- Lack of/Defective Washer/Dryer
- Lack of/Poor Bathing Facilities
- Structural Problems
- Telephone Not Accessible
- Unsafe Neighborhood
- Unsafe/Poor Lighting
- Unsanitary Conditions
- Other

Describe Problems* - Please enter a description of the problem(s) associated with the member's usual residence. Please enter up to 250 characters, which can include letters, numbers and/or special characters. This field is required if any problem is checked.

Functional Status Information

ADLs (Select appropriate level)

Bathing* - Please select the member's appropriate level from the drop down options. This is a required field.

Dressing* - Please select the member's appropriate level from the drop down options. This is a required field.

Toileting* - Please select the member's appropriate level from the drop down options. This is a required field.

Transferring* - Please select the member's appropriate level from the drop down options. This is a required field.

Eating/Feeding* - Please select the member's appropriate level from the drop down options. This is a required field.

Continence (Bowel/Bladder)

Bowel* - Please select the member's appropriate level from the drop down options. This is a required field.

Bladder* - Please select the member's appropriate level from the drop down options. This is a required field.

IADLs

Meal Preparation* - Please select the appropriate yes/no response indicating whether the member needs assistance. This is a required field.

Housekeeping* - Please select the appropriate yes/no response indicating whether the member needs assistance. This is a required field.

Laundry* - Please select the appropriate yes/no response indicating whether the member needs assistance. This is a required field.

Money Mgmt* - Please select the appropriate yes/no response indicating whether the member needs assistance. This is a required field.

Transport* - Please select the appropriate yes/no response indicating whether the member needs assistance. This is a required field.

Shopping* - Please select the appropriate yes/no response indicating whether the member needs assistance. This is a required field.

Using Phone* - Please select the appropriate yes/no response indicating whether the member needs assistance. This is a required field.

Home Maintenance* - Please select the appropriate yes/no response indicating whether the member needs assistance. This is a required field.

Ambulation

Walking* - Please select the member's appropriate level from the drop down options. This is a required field.

Wheeling* - Please select the member's appropriate level from the drop down options. This is a required field.

Stair Climbing* - Please select the member's appropriate level from the drop down options. This is a required field.

Mobility* - Please select the member's appropriate level from the drop down options. This is a required field.

Comments – Please enter any additional comments or information that would help in the screening process. This is an optional field.

Screener Name - Please enter the name of the person completing the screening. This field is optional.

Agency – Please enter the name of the agency the screener is employed by. This is an optional field.

Outcome: Is this a short assessment?* – Please select the appropriate assessment option. One of the following is required:

- No, Continue with the long assessment
  - Selecting this option will open up the UAI – Part B button for selection. When the UAI – Part B button is clicked, it will trigger the form edits for the UAI – Part A form and if successful, open up the UAI – Part B form for entry.
- Yes, Ready for Submission
  - Selecting this option will enable the 'Submit' button so the form can submitted for processing.
- Yes, Additional Forms Needed Before Submission
  - Selecting this option will enable a section of buttons indicating additional forms that the user may need to complete as part of this screening. When one of these buttons is clicked, it will trigger the form edits for the UAI – Part A form and if successful, open up the requested form for entry

Additional Forms: (Display the following links if additional forms are requested in outcome) – This section displays if 'Yes, Additional Forms Needed Before Submission' is selected.

Additional Forms available:
- DMAS95 – MI/MR/RC
- DMAS95 – MI/MR/SUPL
- DMAS96
- DMAS97

Note: Access to the UAI – Part B form is via Outcome option 'No, Continue with the long assessment'

Navigation Buttons

Save - this will save any data entered. The user will be given the option to save and continue the form entry or save and come back in later and recall the assessment from the Assessment Tracking Summary via the 'Recall' link.

Please note that completing one form and progressing to another does an auto-save to ensure the capture of any data entered.

Submit (if displayed) - will trigger the form edits for the UAI – Part A form and if successful display a submission successful screen or will display error messages that need to be resolved before submission.

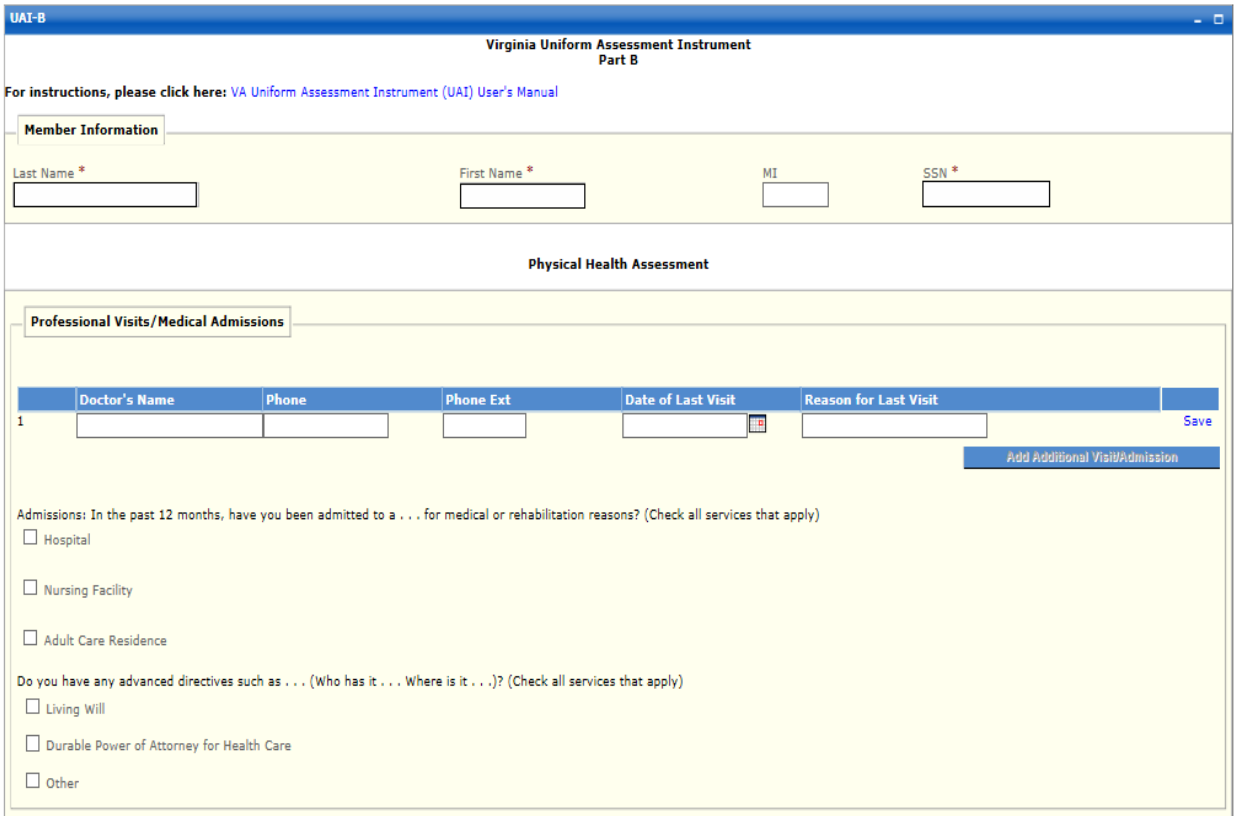
Reset – hitting this button will remove any data entered on the form and set the page back as it appeared upon initial entry. No data entered will be saved.

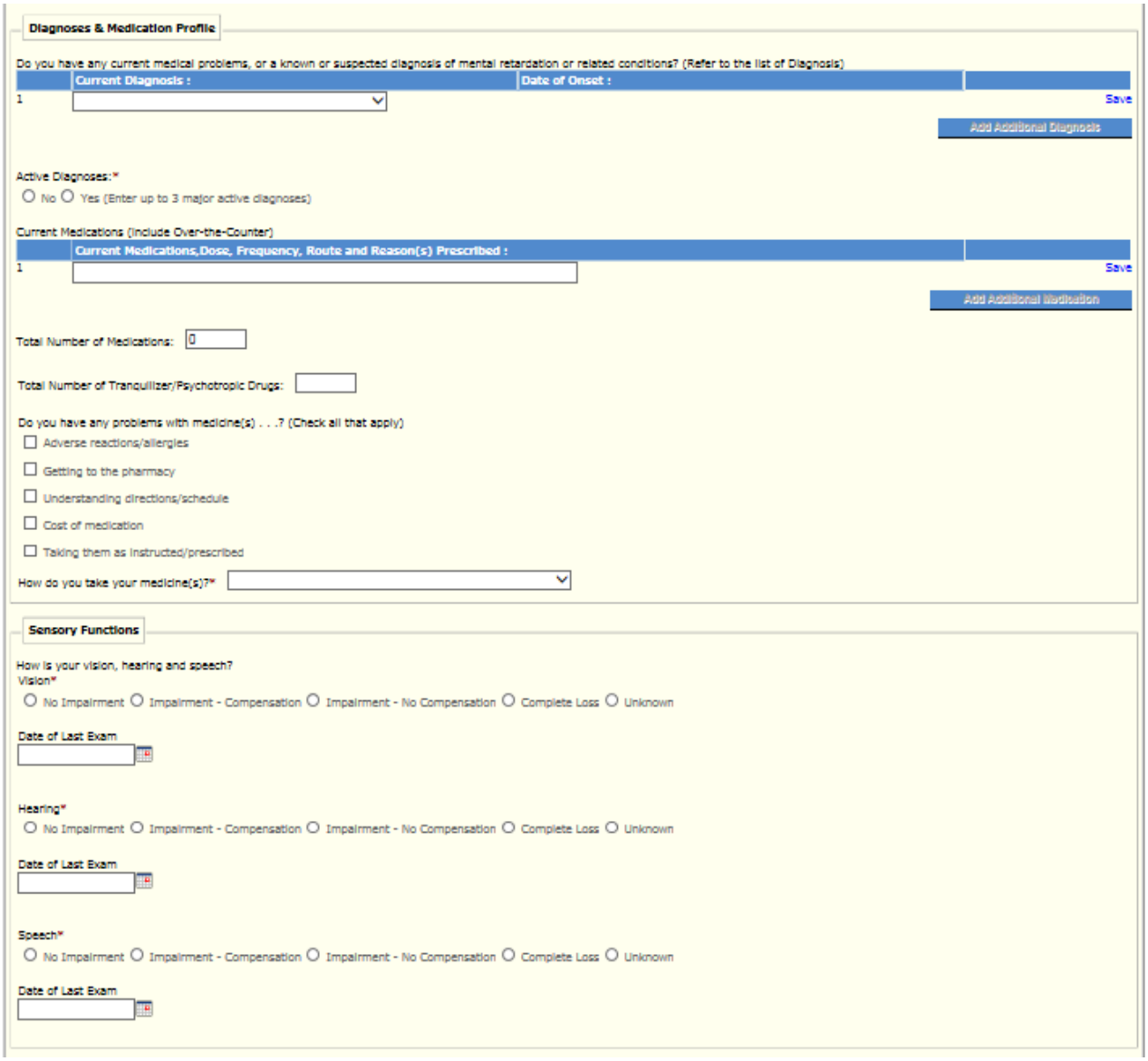
Cancel – hitting this button will disregard any data entered on the form and navigate the user back to the secured portal screen for a different navigation tab selection. No data entered will be saved.

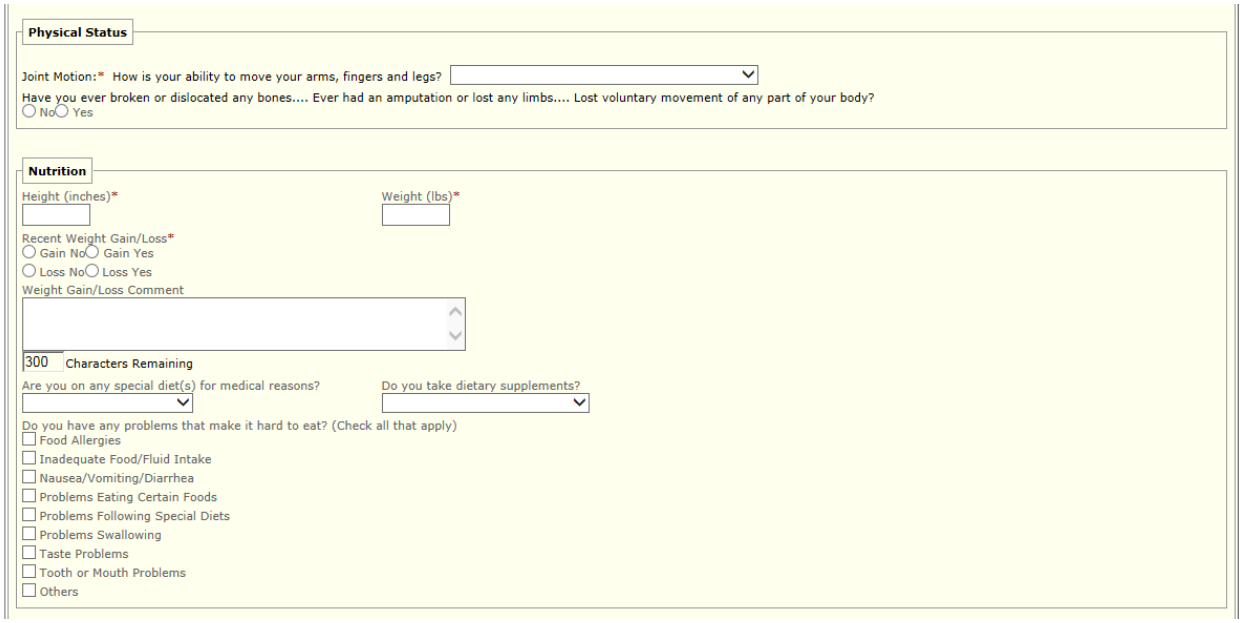
3.2 Uniform Assessment Instrument (UAI) – Part B

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity. **There is no "auto-save" on a time out."**

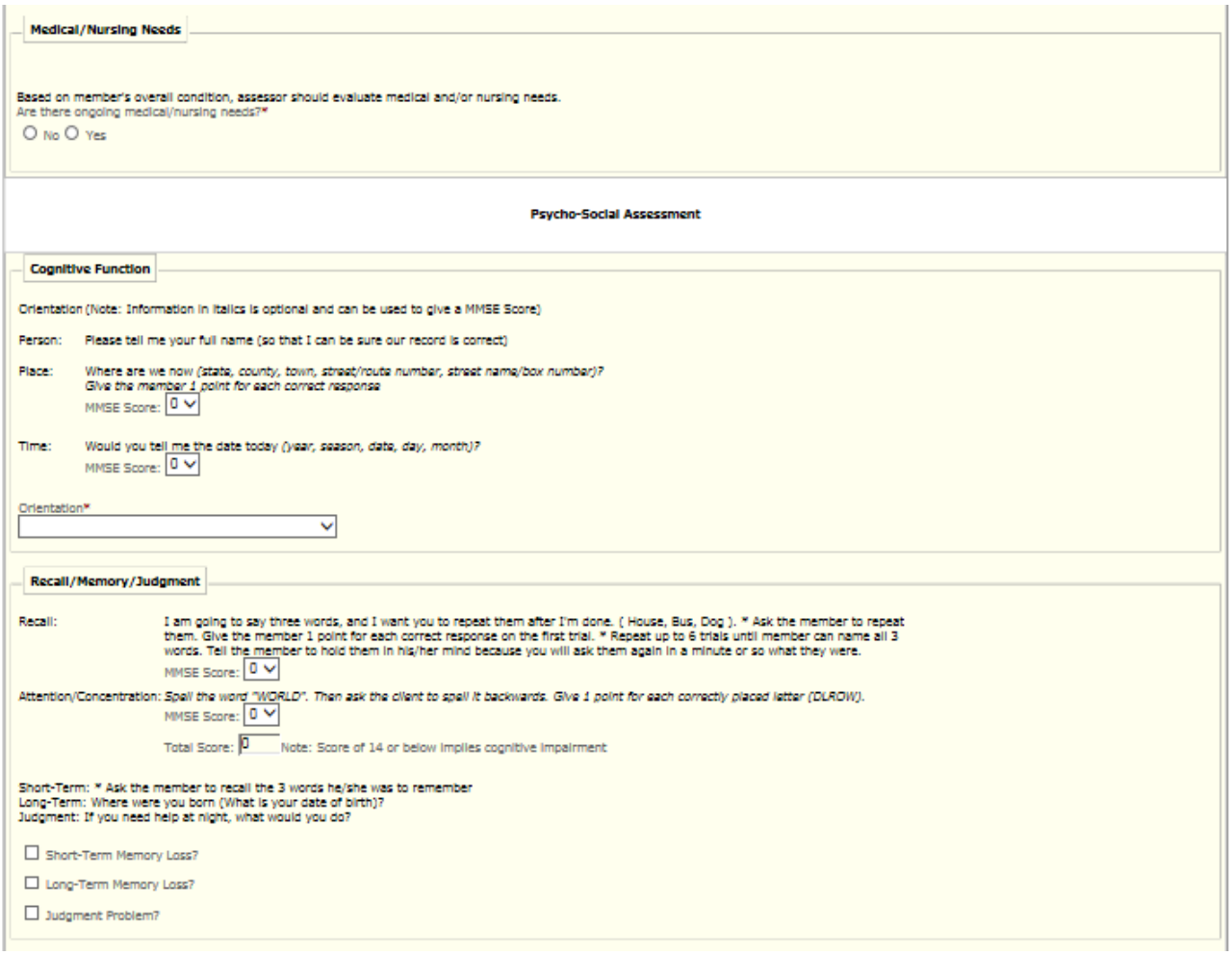
The screen sample below has been broken up in parts display purposes.




Diagnoses & Medication Profile
Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions? (Refer to the list of Diagnosis)
Current Diagnosis :
Date of Onset :
1
Save
Add Additional Diagnosis
Active Diagnoses:*
No Yes (Enter up to 3 major active diagnoses)
Current Medications (Include Over-the-Counter)
Current Medications,Dose, Frequency, Route and Reason(s) Prescribed :
1
Save
Add Additional Medication
Total Number of Medications: 0
Total Number of Tranquilizer/Psychotropic Drugs:
Do you have any problems with medicine(s) . . .? (Check all that apply)
Adverse reactions/allergies
Getting to the pharmacy
Understanding directions/schedule
Cost of medication
Taking them as instructed/prescribed
How do you take your medicine(s)?*
Sensory Functions
How is your vision, hearing and speech?
Vision*
No Impairment Impairment - Compensation Impairment - No Compensation Complete Loss Unknown
Date of Last Exam
Hearing*
No Impairment Impairment - Compensation Impairment - No Compensation Complete Loss Unknown
Date of Last Exam
Speech*
No Impairment Impairment - Compensation Impairment - No Compensation Complete Loss Unknown
Date of Last Exam


Physical Status
Joint Motion:* How is your ability to move your arms, fingers and legs?
Have you ever broken or dislocated any bones.... Ever had an amputation or lost any limbs.... Lost voluntary movement of any part of your body?
No Yes
Nutrition
Height (inches)*
Weight (lbs)*
Recent Weight Gain/Loss*
Gain No Gain Yes
Loss No Loss Yes
Weight Gain/Loss Comment
300 Characters Remaining
Are you on any special diet(s) for medical reasons?
Do you take dietary supplements?
Do you have any problems that make it hard to eat? (Check all that apply)
Food Allergies
Inadequate Food/Fluid Intake
Nausea/Vomiting/Diarrhea
Problems Eating Certain Foods
Problems Following Special Diets
Problems Swallowing
Taste Problems
Tooth or Mouth Problems
Others


Current Medical Services
Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as . . . . ? (Check all services that apply)
Occupational
Physical
Reality/Remotivation
Respiratory
Speech
Other
Do you have any pressure ulcers?*
No Yes
Special Medical Procedures: Do you receive any special nursing care, such as . . . ? (Check all services that apply)
Bowel/Bladder Training
Dialysis
Dressing/Wound Care
Eyecare
Glucose/Blood Sugar
Injections/IV Therapy
Oxygen
Radiation/Chemotherapy
Restraints
ROM Exercise
Trach Care/Suctioning
Ventilator
Other



Medical/Nursing Needs

Based on member's overall condition, assessor should evaluate medical and/or nursing needs.
Are there ongoing medical/nursing needs?*
No Yes

Psycho-Social Assessment

Cognitive Function

Orientation (Note: Information in italics is optional and can be used to give a MMSE Score)

Person: Please tell me your full name (so that I can be sure our record is correct)

Place: Where are we now *(state, county, town, street/route number, street name/box number)?*
Give the member 1 point for each correct response
MMSE Score: 0

Time: Would you tell me the date today *()year, season, date, day, month)?*
MMSE Score: 0

Orientation*

Recall/Memory/Judgment

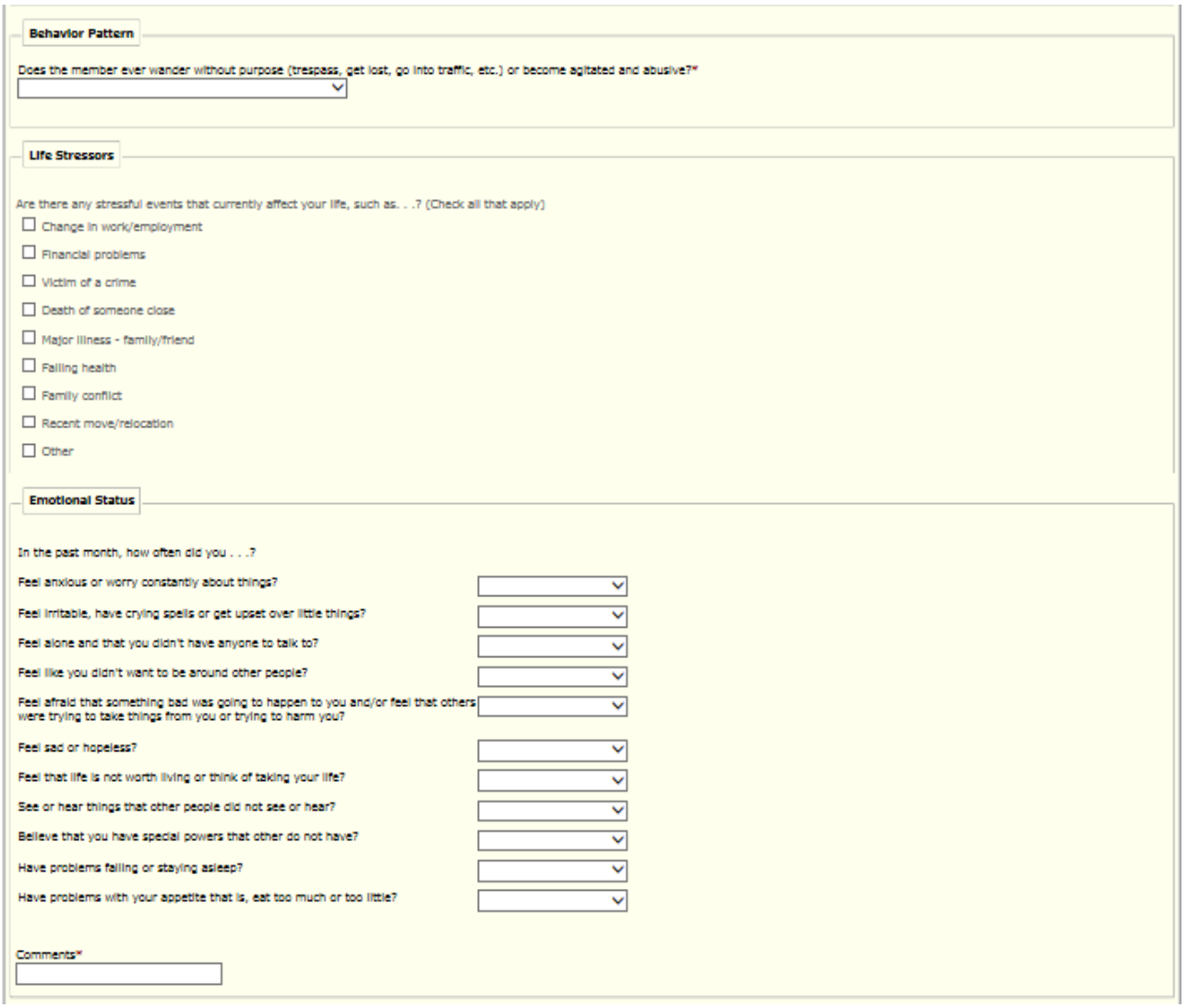
Recall: I am going to say three words, and I want you to repeat them after I'm done. (House, Bus, Dog). * Ask the member to repeat them. Give the member 1 point for each correct response on the first trial. * Repeat up to 6 trials until member can name all 3 words. Tell the member to hold them in his/her mind because you will ask them again in a minute or so what they were.
MMSE Score: 0

Attention/Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*
MMSE Score: 0

Total Score: 0 Note: Score of 14 or below implies cognitive impairment

Short-Term: * Ask the member to recall the 3 words he/she was to remember
Long-Term: Where were you born (What is your date of birth)?
Judgment: If you need help at night, what would you do?

Short-Term Memory Loss?
Long-Term Memory Loss?
Judgment Problem?



Behavior Pattern

Does the member ever wander without purpose (trespass, get lost, go into traffic, etc.) or become agitated and abusive?*

Life Stressors

Are there any stressful events that currently affect your life, such as. . .? (Check all that apply)

- ☐ Change in work/employment
- ☐ Financial problems
- ☐ Victim of a crime
- ☐ Death of someone close
- ☐ Major illness - family/friend
- ☐ Failing health
- ☐ Family conflict
- ☐ Recent move/relocation
- ☐ Other

Emotional Status

In the past month, how often did you . . .?

Feel anxious or worry constantly about things?

Feel irritable, have crying spells or get upset over little things?

Feel alone and that you didn't have anyone to talk to?

Feel like you didn't want to be around other people?

Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?

Feel sad or hopeless?

Feel that life is not worth living or think of taking your life?

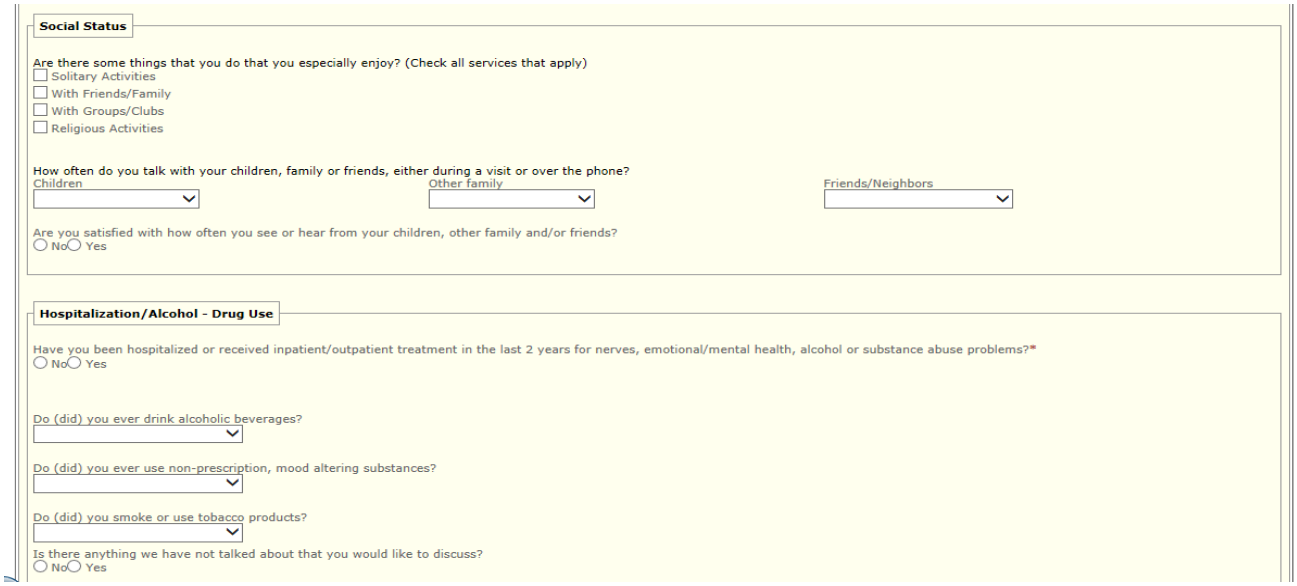
See or hear things that other people did not see or hear?

Believe that you have special powers that other do not have?

Have problems falling or staying asleep?

Have problems with your appetite that is, eat too much or too little?

Comments*



Social Status

Are there some things that you do that you especially enjoy? (Check all services that apply)

- ☐ Solitary Activities
- ☐ With Friends/Family
- ☐ With Groups/Clubs
- ☐ Religious Activities

How often do you talk with your children, family or friends, either during a visit or over the phone?

Children | Other family | Friends/Neighbors

Are you satisfied with how often you see or hear from your children, other family and/or friends?

○ No ○ Yes

Hospitalization/Alcohol - Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?*

○ No ○ Yes

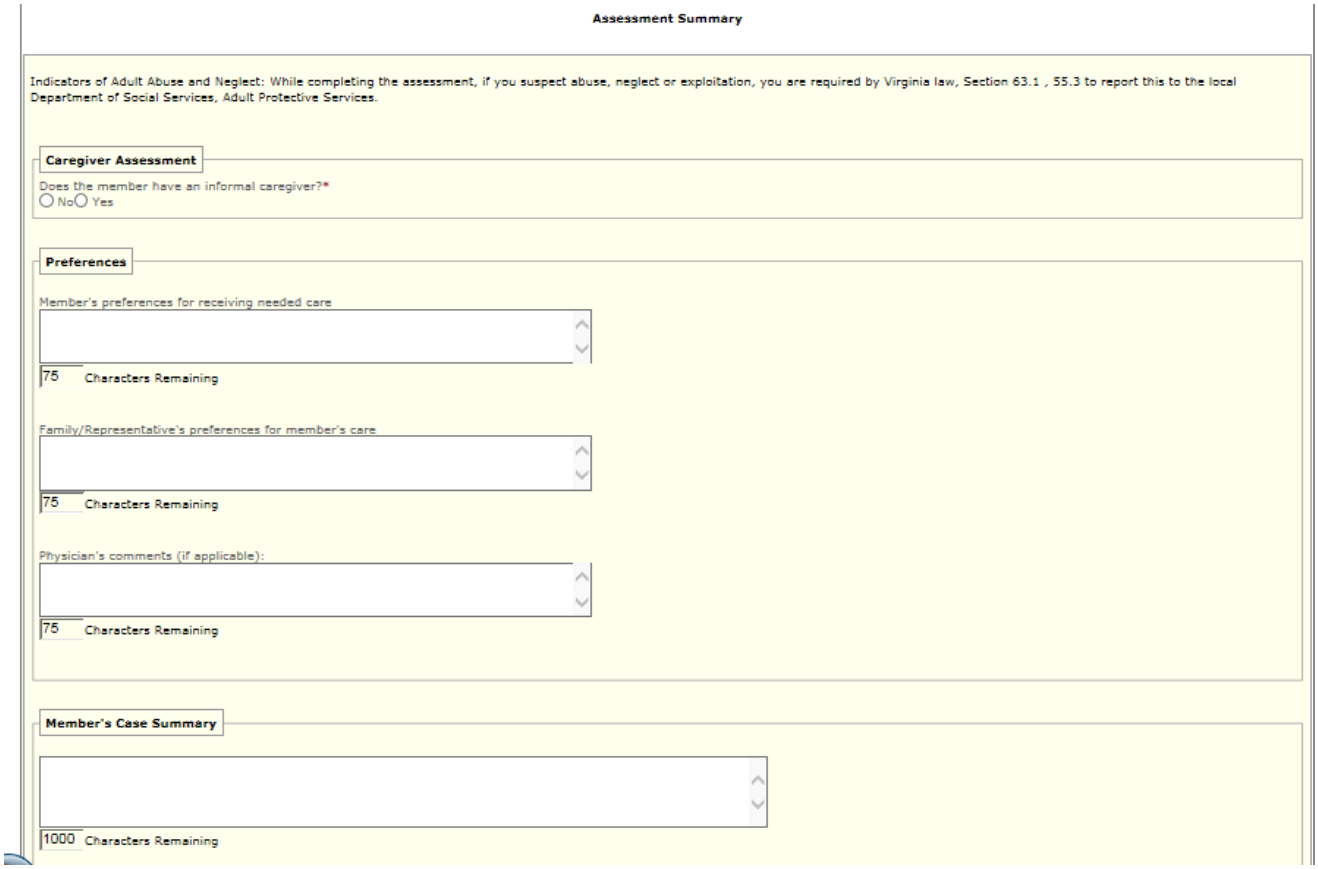
Do (did) you ever drink alcoholic beverages?

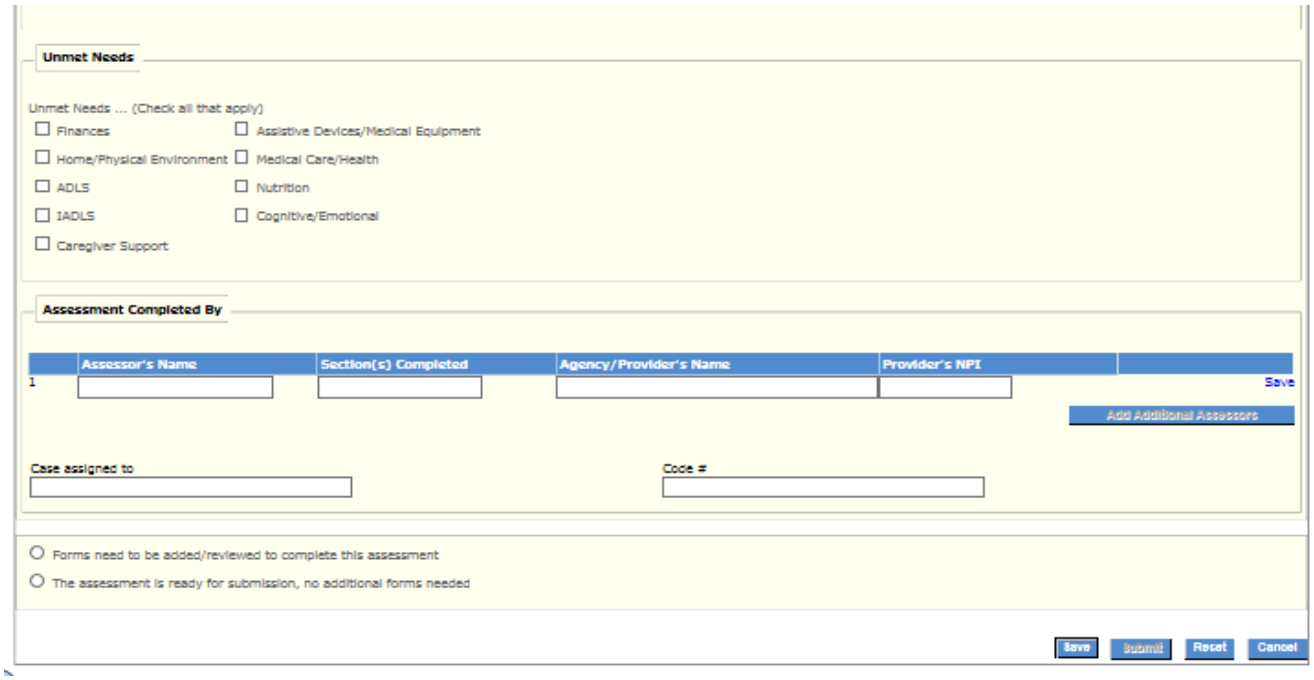
Do (did) you ever use non-prescription, mood altering substances?

Do (did) you smoke or use tobacco products?

Is there anything we have not talked about that you would like to discuss?

○ No ○ Yes


Assessment Summary
Indicators of Adult Abuse and Neglect: While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 , 55.3 to report this to the local Department of Social Services, Adult Protective Services.
Caregiver Assessment
Does the member have an informal caregiver?*
No Yes
Preferences
Member's preferences for receiving needed care
75 Characters Remaining
Family/Representative's preferences for member's care
75 Characters Remaining
Physician's comments (if applicable):
75 Characters Remaining
Member's Case Summary
1000 Characters Remaining


Unmet Needs
Unmet Needs ... (Check all that apply)
Finances
Assistive Devices/Medical Equipment
Home/Physical Environment
Medical Care/Health
ADLS
Nutrition
IADLS
Cognitive/Emotional
Caregiver Support
Assessment Completed By
Assessor's Name
Section(s) Completed
Agency/Provider's Name
Provider's NPI
1
Save
Add Additional Assessors
Case assigned to
Code #
Forms need to be added/reviewed to complete this assessment
The assessment is ready for submission, no additional forms needed
Save
Submit
Reset
Cancel

The UAI – Part B has both required and optional fields. The required fields are indicated with a red asterisk (*)

The following is a list of fields on the screen and the necessary information for completing the form.

Member Information Section

Last Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

First Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Middle Initial (MI) – This field is optional and will be auto-populated from the information entered on the UAI-A form.

SSN* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Physical Health Assessment

Professional Visits/Medical Admissions

Provider's Name* - Please enter the provider's first and last name. This is a required field.

Provider's Phone* - Please enter the provider's phone number, including area code, in the format 9999999999 or 999-999-9999 (dashes are optional).

Provider's Phone Ext - Please enter the provider's phone extension, if applicable.

Date of Last Visit* - Please enter the date the provider last visited this member in the format MM/DD/YYYY or utilize the calendar widget. This field is required and can't be greater than the current date.

Reason for Last Visit* - Please enter the reason for the provider's last visit to this member. Please enter up to 20 characters, which can include letters, numbers and/or special characters. This field is required.

Add Additional Visit/Admission (button) - You can enter up to 3 Professional Visits/Medical Admissions provider sections. In order to add additional sections, click the 'save' link to save the existing data and then

click the 'Add Additional Visit/Admission' button. This will open up additional fields for entry.

Admissions: In the past 12 months, have you been admitted to a . . . for medical or rehabilitation reasons? – Please check any/all facilities member has been admitted to in the past 12 months. This question is situationally required (if applicable).

Facility options:
- Hospital
- Nursing Facility
- Adult Care Residence

> **Name of Place*** - For each of the facility options selected, this field will display and is required. Please enter the name of the admitted facility.
>
> **Admit Date*** - For each of the facility options selected, this field will display and is required. Please enter the date of admission in the facility in the format MM/DD/YYYY or utilize the calendar widget.
>
> **Length of Stay/Reason*** - For each of the facility options selected, this field will display and is required. Please enter the length of the stay and the admission reason using up to 25 characters which can include letters, numbers or special characters.

Do you have any advanced directives such as . . . (Who has it . . . Where is it . . .)? Please check any/all advanced directives the member has. This question is situationally required (if applicable).

Advanced directive options:
- Living Will
- Durable Power of Attorney for Health Care
- Other

> **Who/Location*** - For each of the advanced directive options selected, this field will display and is required. Please enter the name of the person who has custody of the document and location of it using up to 25 characters which can include letters, numbers or special characters.

Diagnoses & Medication Profile

Do you have any current medical problems, or a known suspected diagnosis of mental retardation or related conditions, such as?

Current Diagnosis – Please choose the appropriate option from the drop down list. This field is situationally required (if applicable).

Date of Onset* - For any diagnosis selection, this field will display and is required. Please enter the date of the onset associated with the diagnosis in the format MM/DD/YYYY or utilize the calendar widget.

Add Additional Diagnosis (button) – if additional diagnosis are applicable, click the 'Save' link to save the existing data and then click this button to open up another Current Diagnosis list and with a diagnosis selection, the Date of Onset field. You can enter up to a maximum of 5 diagnosis/date of onset combinations.

Enter Codes for 3 Major, Active Diagnoses* – Please select appropriate response indicating whether the member has any active diagnoses. This field is required.

Diagnosis 1, 2, 3* - If the 'Active Diagnoses' button is selected, three diagnosis fields will display and are available for entry. Please enter the member's active diagnosis/diagnoses. At least one diagnosis is required.

Additional Diagnosis Information – If additional diagnosis information is needed, it can be entered in this text box, up to 300 characters. This field is optional.

Current Medications (include Over-the-Counter)

Current Medications – Please enter any of the member's current medications (prescribed and over-the-counter). This is a situationally required field (if applicable).

Dose, Frequency, Route* - If an entry is made in 'Current Medications' this field will display and will be required. Please enter the dose, frequency and route of the medication.

Reason(s) Prescribed* - If an entry is made in 'Current Medications' this field will display and is required. Please enter the reason(s) the medication is required/needed using up to 150 characters, which can include letters, numbers and/or special characters.

Add Additional Medications (button) – If additional medications sections are needed, click the 'Save' link to save the existing data and then click this button to open up another section. You can enter up to 30 medication sections.

Total Number of Medications - This is a calculated field displaying the total number of medication lines added (or zero if no entry was made).

Total Number of Tranquilizer/Psychotropic Drugs* - If 'Total Number of Medications' is greater than zero, entry is required. Please enter the number of tranquilizer/psychotropic drugs included in the 'Total Number of Medications' count.

Do you have any problems with medicine(s) . . .? - If 'Total Number of Medications' is greater than zero, entry is situationally required (if applicable). Please check all that apply.

How do you take your medicine(s)?* - If 'Total Number of Medications' is greater than zero, this will display and is required. Please select the appropriate option from the drop down list.

Describe Help* - If the answer to 'How do you take your medicine(s)' is anything **other than** 'Without Assistance', this field will display and is required. Please describe the help the member requires with medicine administration using up to 20 characters which can include letters, numbers or special characters.

Name of Helper* - If the answer to 'How do you take your medicine(s)' is anything **other than** 'Without Assistance', this field will display and is required. Please enter the name of the person that assists the member with medicine administration using up to 20 characters which can include letters, numbers or special characters.

Sensory Functions

How is your vision, hearing and speech?

Vision* - Please select the appropriate button indicating the member's vision assessment. This is a required field.

Date of Last Exam* - Please enter the date of the member's last vision exam in the format MM/DD/YYYY or utilize the calendar widget. This is a required field and cannot be greater than the current date.

Record Date of Onset* - If 'Vision' selection is anything **other than** 'No impairment' this field will display and is required. Please enter the date the member's vision impairment started in the format MM/DD/YYYY or utilize the calendar widget.

Type of Impairment* - If 'Vision' selection is either of the 'Impairment' options this field will display and is required. Please enter the type of vision impairment.

Hearing* - Please select the appropriate button indicating the member's hearing assessment. This is a required field.

Date of Last Exam* - Please enter the date of the member's last hearing exam in the format MM/DD/YYYY or utilize the calendar widget. This is a required field and cannot be greater than the current date.

> **Record Date of Onset*** - If 'Hearing' selection is anything **other than** 'No impairment' this field will display and is required. Please enter the date the member's hearing impairment started in the format MM/DD/YYYY or utilize the calendar widget.
>
> **Type of Impairment*** - If 'Hearing' selection is either of the 'Impairment' options this field will display and is required. Please enter the type of hearing impairment.

Speech* - Please select the appropriate button indicating the member's speech assessment. This is a required field.

Date of Last Exam* - Please enter the date of the member's last speech exam in the format MM/DD/YYYY or utilize the calendar widget. This is a required field and cannot be greater than the current date.

> **Record Date of Onset*** - If 'Speech' selection is anything **other than** 'No impairment' this field will display and is required. Please enter the date the member's speech impairment started in the format MM/DD/YYYY or utilize the calendar widget.
>
> **Type of Impairment*** - If 'Speech' selection is either of the 'Impairment' options this field will display and is required. Please enter the type of speech impairment.

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?* - Please select the appropriate option from the drop down list. This field is required.

Have you ever broken or dislocated any bones… Ever had an amputation or lost any limbs… Lost voluntary movement of any part of your body? * - Please select the appropriate yes/no response. This field is required.

> **Fractures/Dislocation*** - If the answer to whether the member has ever broken or dislocated any bones, lost any limbs or lost voluntary movement is 'yes', then this field will display and is required. Please select the appropriate option from the drop down list.

Previous Rehab Program?* - If the selection from the 'Fractures/Dislocations' is anything **other than** 'None' this field will display and is required. Please select the appropriate response.

Missing Limbs* - If the answer to whether the member has ever broken or dislocated any bones, lost any limbs or lost voluntary movement is 'yes', then this field will display and is required. Please select the appropriate option from the drop down list.

Previous Rehab Program?* - If the selection from the 'Missing Limbs' is anything **other than** 'None' this field will display and is required. Please select the appropriate response.

Paralysis/Paresis* - If the answer to whether the member has ever broken or dislocated any bones, lost any limbs or lost voluntary movement is 'yes', then this field will display and is required. Please select the appropriate option from the drop down list.

Describe* - If the 'Paralysis/Paresis' selection is anything **other than** 'None', this will field will display and is required. Please enter a description of the member's paralysis/paresis.

Previous Rehab Program?* - If the selection from the 'Paralysis/Paresis' selection is anything **other than** 'None' this field will display and is required. Please select the appropriate response.

Nutrition

Height (inches)* - Please enter the member's height in inches. This field is required.

Weight (lbs)* - Please enter the member's weight in pounds. This field is required.

Recent Weight Gain/Loss* - Please select the appropriate yes/no response. This field is required.

Describe* - If member has had recent weight gain/loss, this field will display and is required. Please enter a description/reason for any recent weight change using up to 20 characters which can include letters, numbers or special characters.

Weight Gain/ Loss Comment - If additional weight gain/loss information is needed, it can be entered in this text box, up to 300 characters. This field is optional.

Are you on any special diet(s) for medical reasons? - Please select the appropriate option from the drop down list. This field is optional.

Do you take dietary supplements? - Please select the appropriate option from the drop down list. This field is optional.

Do you have any problems that make it hard to eat? – Please check any problems the member has that make it difficult to eat. This field is situationally required (if applicable).

> **Specify*** - If 'Other' is checked, this field will display and is required. Please enter the specifics about the problem the member has that makes it difficult to eat using up to 150 characters which can include letters, numbers or special characters.

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as . . . . ? – Please check all services the member utilizes. This field is situationally required (if applicable).

Rehabilitation Therapies List:
- Occupational
- Physical
- Reality/Remotivation
- Respiratory
- Speech
- Other

> **Frequency*** - For each rehabilitation therapy checked, this field will display and is required. Please enter the frequency the member utilizes the checked therapy using up to 75 characters which can include letters, numbers or special characters.

Do you have any pressure ulcers?* - Please select the appropriate yes/no response. This field is required.

> **Stage*** - If member has pressure ulcers, this field will display and is required. Please select the appropriate option from the drop down list.
>
> **Location/Size*** - If member has pressure ulcers, this field will display and is required. Please note the location and size of the member's

ulcer(s) using up to 15 characters which can include letters, numbers or special characters.

Special Medical Procedures: Do you receive any special nursing care, such as . . . ? – Please check all services the member utilizes. This field is situationally required (if applicable).

Special Medical Procedures List:
- Bowel/Bladder Training
- Dialysis
- Dressing/Wound Care
- Eye care
- Glucose/Blood Sugar
- Injections/IV Therapy
- Oxygen
- Radiation/Chemotherapy
- ROM Exercise
- Trach Care/Suctioning
- Ventilator
- Other

Site, Type, Frequency* - For each medical procedure checked, this field will display and is required. Please enter the site, type and frequency the member requires the procedure using up to 15 characters which can include letters, numbers or special characters.

Medical/Nursing Needs

Note: Based on the member's overall condition, assessor should evaluate medical and/or nursing needs

Are there ongoing medical/nursing needs?* - Please select the appropriate yes/no response. This is a required field.

Comments * - If the member has ongoing medical/nursing needs, this field will display and is required. Please describe ongoing medical/nursing needs:
- Evidence of medical instability
- Need for observation/assessment to prevent destabilization
- Complexity created by multiple medical conditions
- Why member's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis

Physician's Name/Title* - If the member has ongoing medical/nursing needs, this field will display and either the Physician's Name and/or Other's Name is required.

Date* - If the member has ongoing medical/nursing needs, this field will display and is required. Please enter the date the comments were entered in the format MM/DD/YYYY or utilize the calendar widget.

Other's Name/Title* - If the member has ongoing medical/nursing needs, this field will display and either the Physician's Name and/or Other's Name is required.

Date* - If the member has ongoing medical/nursing needs, this field will display and is required. Please enter the date the comments were entered in the format MM/DD/YYYY or utilize the calendar widget.

Psycho-Social Assessment

Cognitive Function

Orientation

(Note: Information in italics is optional and can be used to give a MMSE Score)

Person: Please tell me your full name (so that I can be sure our record is correct)

Place: Where are we now (*state, county, town, street/route number, street name/box number)?*

Give the member 1 point for each correct response

MMSE Score* - Please select the appropriate option from the drop down list. This is a required field

Time: Would you tell me the date today (*year, season, day, month)*?

MMSE Score* - Please select the appropriate option from the drop down list. This is a required field

Orientation* - Please select the appropriate option from the drop down list. This is a required field.

Spheres affected* - For any selected option **other than** 'Oriented', this field will display and is required. Please enter the affected spheres associated with your selection using up to 25 characters which can include letters, numbers or special characters.

Recall/Memory/Judgment

Recall: I am going to say three words, and I want you to repeat them after I'm done. (House, Bus, Dog). Ask the member to repeat them. *Give the member 1 point for each correct response on the first trial.* Repeat up to 6 trials until member can name all 3 words. Tell the member to hold them in his/her mind because you will ask them again in a minute or so what they were.

MMSE Score* - Please select the appropriate option from the drop down list. This is a required field

Attention/Concentration: *Spell the 'WORLD'. Then ask the member to spell it backwards. Give 1 point for each correctly placed letter (DLROW)*

MMSE Score* - Please select the appropriate option from the drop down list. This is a required field.

Total MMSE Score – This is a calculated field totalling all MMSE scores within the Cognitive Function section.

Note: Score of 14 or below implies cognitive impairment

Short-Term: Ask the member to recall the 3 words he/she was to remember
Long-Term: Where were you born (What is your date of birth)?
Judgment: If you need help at night, what would you do?

Judgment – Check all judgment options that apply. This field is situationally required (if applicable).

Judgment List:
- Short-Term Memory Loss?
- Long-Term Memory Loss?
- Judgment Problem?

Behavior Pattern

Does the member ever wander without purpose (trespass, get lost, go into traffic, etc.) or become agitated and abusive?* – Please select the appropriate option from the drop down list. This field is required.

> **Type of inappropriate behavior:*** - If response to the previous question is anything **other than** 'Appropriate' this field will display and is required. Please describe the type of behavior the member exhibits.

Source of Information:* - If response to the previous question is anything **other than** 'Appropriate' this field will display and is required. Please describe the source of information regarding the member's behavior.

Life Stressors

Are there any stressful events that currently affect your life, such as. . .? – Please check any life stressors the member is dealing with. This field is situationally required (if applicable).

Life Stressors List:
- Change in work/employment
- Financial problems
- Victim of a crime
- Death of someone close
- Major illness – family/friend
- Failing health
- Family conflict
- Recent move/relocation
- Other

Specify* - If 'Other' is checked from the Life Stressors, this field will display and is required. Please specify the life stressor the member is dealing with using up to 50 characters which can include letters, numbers or special characters.

Emotional Status

In the past month, how often did you . . .?

Feel anxious or worry constantly about things? * - Please select the appropriate option from the drop down list. This field is required.

Feel irritable, have crying spells or get upset over little things? * - Please select the appropriate option from the drop down list. This field is required.

Feel alone and that you didn't have anyone to talk to? * - Please select the appropriate option from the drop down list. This field is required.

Feel like you didn't want to be around other people? * - Please select the appropriate option from the drop down list. This field is required.

Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you? * - Please select the appropriate option from the drop down list. This field is required.

Feel sad or hopeless? * - Please select the appropriate option from the drop down list. This field is required.

Feel that life is not worth living or think of taking your life? * - Please select the appropriate option from the drop down list. This field is required.

See or hear things that other people did not see or hear? * - Please select the appropriate option from the drop down list. This field is required.

Believe that you have special powers that other do not have? * - Please select the appropriate option from the drop down list. This field is required.

Have problems falling or staying asleep? * - Please select the appropriate option from the drop down list. This field is required.

Have problems with your appetite that is, eat too much or too little? * - Please select the appropriate option from the drop down list. This field is required.

Comments * - Please enter any additional comments related to the member's emotional status using up to 25 characters which can include letters, numbers or special characters. This field is required.

Social Status

Are there some things that you do that you especially enjoy? – Please check all things that the member enjoys? This is a situationally required field (if applicable).

Things You Enjoy List:
- Solitary Activities
- With Friends/Family
- With Groups/Clubs
- Religious Activities

> **Describe*** - For any option checked from the list of things the member enjoys, this field will display and is required. Please describe what the member enjoys about the checked activity using up to 25 characters which can include letters, numbers or special characters.

How often do you talk with your children, family or friends, either during a visit or over the phone?

Children - Please select the appropriate option from the drop down list. This field is optional.

Other Family - Please select the appropriate option from the drop down list. This field is optional.

Friends/Neighbors - Please select the appropriate option from the drop down list. This field is optional.

Are you satisfied with how often you see or hear from your children, other family and/or friends? - Please select the appropriate yes/no response. This field is optional.

Hospitalization/Alcohol – Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems? * - Please select the appropriate yes/no response. This is a required field.

> **Name of Place*** - If the member has been hospitalized or received treatment in the last 2 years, this field will display and is required. Please enter the name of the place where the member was hospitalized or received treatment using up to 30 characters which can include letters, numbers or special characters.
>
> **Admit Date*** - If the member has been hospitalized or received treatment in the last 2 years, this field will display and is required. Please enter the date the member was hospitalized or received treatment in the format MM/DD/YYYY or utilize the calendar widget.
>
> **Length of Stay/Reason*** - If the member has been hospitalized or received treatment in the last 2 years, this field will display and is required. Please enter the length of the member's stay and the reason for the hospitalization or treatment using up to 30 characters which can include letters, numbers or special characters.

Add Additional Places (button) – You can enter up to a total of 3 hospitalization/treatment segments. If additional segments are needed, please click this button to open up additional fields for entry.

Do (did) you ever drink alcoholic beverages? - Please select the appropriate option from the drop down list. This field is optional.

How much* - If the member is 'Currently' drinking alcoholic beverages, this field will display and is required. Please enter the amount of alcohol the member consumes.

How often*- If the member is 'Currently' drinking alcoholic beverages, this field will display and is required. Please enter how often the member consumes alcohol.

Do (did) you ever use non-prescription, mood altering substances? Please select the appropriate option from the drop down list. This field is optional.

How much* - If the member is 'Currently' using non-prescription or mood altering substances, this field will display and is required. Please enter the amount of non-prescription, mood altering substances the member uses.

How often*- If the member is 'Currently' using non-prescription or mood altering substances, this field will display and is required. Please enter how often the member use non-prescription, mood altering substances.

Have you, or someone close to you ever been concerned about your use of alcohol/other mood altering substances?* - Please select the appropriate yes/no response. This field is required.

Describe concerns* - If the answer to the previous question is 'yes' this field will display and is required. Please describe the concerns expressed.

Do (did) you ever use alcohol/other mood-altering substances with .... – If the member has used alcohol/other substances, please check if it was with any of the following. This field is situationally required (if applicable).

Combination List:
- Prescription drugs?
- OTC medicine?
- Other substances?

Describe what and how often:* - If any combination is selected from above, this field will display and is required. Please describe what and how often the combination was used using up to 40 characters which can include letters, numbers or special characters.

Do (did) you ever use alcohol/other mood-altering substances to help you .... – Please select any reason for using alcohol or other substances. This field is situationally required (if applicable)

Reasons List:
- Sleep?
- Relax?
- Get more energy?
- Relieve worries?
- Relieve physical pain?

Describe what and how often: * - If any reason is checked, this field will display and is required. Please describe what and how often the member used alcohol/substances to help using up to 40 characters which can include letters, numbers or special characters.

Do (did) you smoke or use tobacco products? - Please select the appropriate option from the drop down list. This field is optional.

How much* - If the member is 'Currently' smoking or using tobacco products, this field will display and is required. Please enter the amount of tobacco products the member uses.

How often*- If the member is 'Currently' smoking or using tobacco products, this field will display and is required. Please enter how often the member smokes or uses tobacco products.

Is there anything we have not talked about that you would like to discuss? Please enter the appropriate yes/no response. This field is optional.

Comments: * - If the member has something not previously talked about they would like to discuss, this field will display and is required. Please enter any relevant comments using up to 100 characters which can include letters, numbers or special characters.

Assessment Summary

Indicators of Adult Abuse and Neglect: While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 – 55.3 to report this to the local Department of Social Services, Adult Protective Services.

Caregiver Assessment

Does the member have an informal caregiver* - Please select the appropriate yes/no response. This is a required field.

Where does the caregiver live?* - If the member has an informal caregiver this field will display and is required. Please select the appropriate option from the drop down list.

Is the caregiver's help* - If the member has an informal caregiver this field will display and is required. Please select the appropriate option for the drop down list.

Has providing care to the member become a burden for the caregiver?* - If the member has an informal caregiver this field will display and is required. Please select the appropriate option from the drop down list.

Describe any problems with continued caregiving - If the member has an informal caregiver this field will display. Please enter any problems with continued caregiving using up to 100 characters which can include letters, numbers or special characters. This field is situationally required (if applicable).

Preferences

Member's preferences for receiving needed care - Please enter any preferences the member has for receiving care using up to 75 characters which can include letters, numbers or special characters. This field is optional.

Family/Representative's preferences for member's care - Please enter any preferences the member's family/representative has for receiving care using up to 75 characters which can include letters, numbers or special characters. This field is optional.

Physician's comments – Please enter any physician's comments using up to 75 characters which can include letters, numbers or special characters. This field is situationally required (if applicable).

Member's Case Summary

Case Summary – Enter any relevant comments regarding the member's case summary using up to 1000 characters which can include letters, numbers or special characters. This field is optional.

Unmet Needs

Unmet Needs – Please check any need that is not being met. This field is situationally required (if applicable).

Unmet Needs List:
- Finances
- Assistive Devices/Medical Equipment
- Home/Physical Environment
- Medical Care/Health
- ADLS
- Nutrition
- IADLS
- Cognitive/Emotional
- Caregiver Support

Assessment Completed By:

Assessor's Name* - Please enter the name of the assessor conducting the screening. This is a required field.

Section(s) Completed* - Please note the section(s) completed by the assessor using up to15 characters which can include letters, numbers or special characters. This is a required field.

Agency/Provider's Name* - Please enter the agency/provider the assessor is employed by. This is a required field.

Provider's NPI* - Please enter the 10 digit NPI of the agency/provider the assessor is employed by. This is a required field.

Add Additional Assessors (button) – Up to a total of 6 assessor sections can be submitted. Please click this button to open additional assessment fields for entry.

Case assigned to – Please enter the name of the casework this member is assigned to. This field is situationally required (if applicable).

Code # - Please enter the code number associated with the case this member is assigned to. This field is situationally required (if applicable).

The assessment is ready for submission, no additional forms needed. – If selected, the 'Submit button will display. When the button is hit, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, all forms entered for this assessment will be submitted. Either this option or the following option is required.

Additional forms are needed to complete this assessment. – If selected a set of buttons will display representing each of the assessment forms for selection. Once a button for another form is clicked, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, you will be routed to the selected form. Either this option or the previous option is required.

Additional Forms Available:
- UAI – Part A
- UAI – Part B
- DMAS-95 MI/MR/RC
- DMAS-95 MI/MR/SUPL
- DMAS-96
- DMAS-97

Navigation Buttons

Save - this will save any data entered. The user will be given the option to save and continue the form entry or save and come back in later and recall the assessment from the Assessment Tracking Summary via the 'Recall' link.

Please note that completing one form and progressing to another does an auto-save to ensure the capture of any data entered.

Submit (if displayed) - will trigger the form edits for the UAI – Part B form and if successful display a submission successful screen or will display error messages that need to be resolved before submission.

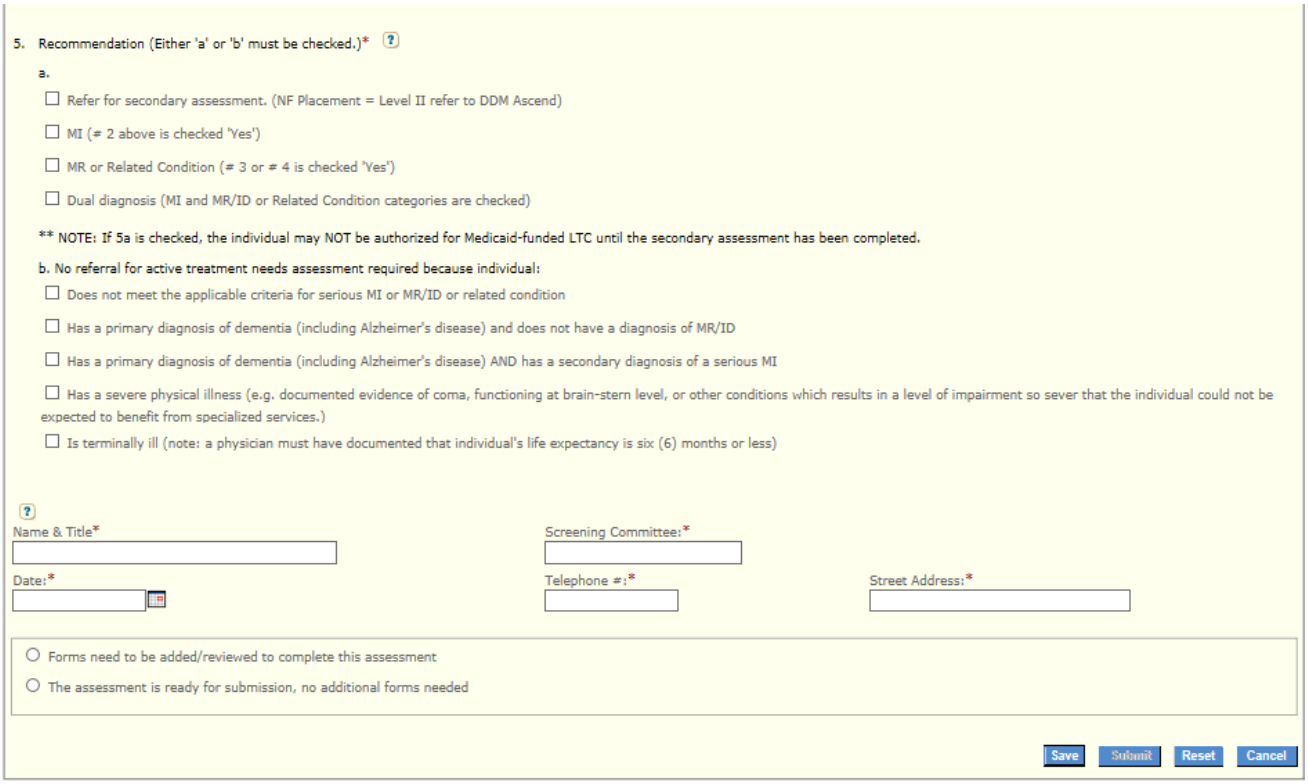
Reset – hitting this button will remove any data entered on the form and set the page back as it appeared upon initial entry. No data entered will be saved.

Cancel – hitting this button will disregard any data entered on the form and navigate the user back to the secured portal screen for a different navigation tab selection. No data entered will be saved.

3.3 DMAS95 – MI/MR/RC

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.

The screen sample below has been broken up in parts display purposes.



The DMAS95 – MI/MR/RC has both required and optional fields. The required fields are indicated with a red asterisk (*)

The following is a list of fields on the screen and the necessary information for completing the form.

A. This section is to be completed by the Pre-admission Screening Committee. This form applies to NF Admissions ONLY.

Last Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

First Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Date of Birth* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Date PAS Request Received* - Please enter the date that a request for a secondary assessment was made in the MM/DD/YYYY format or utilize the calendar widget. This is a required field.

Social Security No* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Medicaid # - This is a situationally required field and if it exists on the UAI-A then it will be auto-populated. If not, then no entry will be allowed.

Responsible CSB* - Please enter the Community Services Board in the locality in which the individual resides. This is a required field.

1. Does the individual meet nursing facility criteria?* - Please indicate whether the individual meets nursing facility criteria as described in the Virginia Medicaid Pre-Admission Screening Manual. Please select the appropriate yes/no response. This is a required field.

> **Yes** – complete screening
>
> **No** - If the individual does NOT meet nursing facility criteria, do not complete Level 1 screening and do not refer for a secondary assessment. If criteria are not met, the individual cannot be admitted to Long-Term Care Services.

a. Can a safe and appropriate plan of care be developed to meet all medical/nursing/custodial care needs?* - Please select the appropriate yes/no response. This is a required field.

> **Yes** - this form must be completed AND the DMAS-96 form LTC service authorization must be completed.
>
> **No** – continue completing this form.

2. Does the individual have a current serious mental illness (MI)?* - Select 'yes' (that the individual has a current diagnosis of serious MI) only if 2 a, b, and c all have a selection of 'yes'. Indicate the diagnosis if 'yes' is selected. If 'no' is selected for a, b or c, **do not refer for** Level II for MI. Please select the appropriate yes/no response. This is a required field.

a. Is this major mental disorder diagnosable under DSM-IV (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability)?* - Select 'yes' if the individual has a major mental disorder diagnosable under DSM-III-R (e.g. schizophrenia (including disorganized, catatonic, and paranoid types), mood (including bipolar disorder (mixed manic, depressed, seasonal, NOS), major depression (single episode/recurrent, chronic, melancholic or seasonal), depressive disorder

MOS, cyclothymia, dysthymia (primary/secondary or early/late onset). Paranoid (including delusional, erotomanic, grandiose, jealous, persecurtory, somatic, unspecified, or induced psychotic disorder), panic or other sever anxiety disorder (including panic disorder with agoraphobia, agoraphobia with or without history of panic disorder, social phobia general wed anxiety disorder, obsessive compulsive disorder, past-traumatic stress disorder), somatoform disorder (includes somatization disorder, conversion disorder somatoform pain disorder, hypochondriasis, body dysmorphic disorder, undifferentiated somatoform disorder NOS). Personality disorder (includes paranoid, schizoid, sehizotypal, histrionic, narcissistic, antisocial, borderline, avoidant, dependent, obsessive compulsive , passive aggressive, and NOS), other psychotic disorder (includes schizophreniform disorder schtizoaffective disorder (bipolar/depressive), brief reactive psychosis, atypical NOS) or other mental disorder that may lead to a chronic disability). Please select the appropriate yes/no response. This is a required field.

b. Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace; and adaptation to change?* - Select 'yes' if the individual has a mental disorder that has resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning concentration, persistence, and pact, arid adaptation to change. Please select the appropriate yes/no response. This is a required field.

c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder?* - Select 'yes' if the individual's treatment history indicates that he or she has experienced (1) psychiatric treatment more intense than outpatient care more than once in the past 2 years or (2) within the last 2 years, an episode of significant disruption to the normal living situation due to the mental disorder. Please select the appropriate yes/no response. This is a required field.

3. Does the individual have a diagnosis of mental retardation (MR)/intellectual disability (ID) which was manifested before age 18?* - Select 'yes' if the individual has a level of retardation or disability (mild, moderate, severe, or profound) as described in the American Association on Mental Retardation's Manual on Classification In Mental Retardation (1983) that was manifested before age 18. Please select the appropriate yes/no response. This is a required field.

4. Does the individual have a related condition?* - Select 'yes' only if each item in 4 a –d is selected. If 'no' is selected, do not refer for Level II

PAS for related conditions. Please select the appropriate yes/no response. This is a required field.

a. Is the condition attributable to any other condition (e.g. cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina bifida), other than MI, found to be closely related to MR/ID because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of MR/ID persons and requires treatment of services similar to those for these persons?* Select 'yes' if the condition is attributable to any other condition (e.g. cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina bifida), other than MI, found to be closely related to MR because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of MR/ID persons and requires treatment or services similar to those for these persons.
Please select the appropriate yes/no response. This is a required field.

b. Has the condition manifested before age 22?* - Please select the appropriate yes/no response. This is a required field.

c. Is the condition likely to continue indefinitely?* - Please select the appropriate yes/no response. This is a required field.

d. Has the condition resulted in substantial limitations in 3 or more of the following areas of major life activity; self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living?* - Select 'yes' if the condition has resulted in substantial limitations in 3 or more of the following areas of major life activity self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living. Please select the appropriate yes/no response. This is a required field.

> **Applicable Areas* –** If 4d is 'yes' the following list will display. Please check all applicable areas. At least one entry is required.
>
> Applicable Areas List:
> - Self-care understanding and use of language
> - Learning
> - Mobility
> - Self-direction
> - Capacity for independent living

5. Recommendation* - Either 'a' or 'b' is required and must be checked.

a. Refer for secondary assessment. - Please check if Question 2 has a 'yes' selection AND/OR either Question 3 or 4 has a selection of 'yes'. Indicate whether referral is for MI, MR or RC, the date the package is

referred to the appropriate secondary screener, and where and to the package is sent. An individual for whom 5a has been selected may NOT be admitted to a LTC Services until the secondary assessment is completed.

MI – Please check if # 2 above is checked 'yes'

MR or Related Condition – Please check if # 3 or # 4 is checked 'yes'

Dual diagnosis – Please check if MI and MR/ID or Related Condition categories are checked.

** *Note*: If 5a is checked, the individual may NOT be authorized for Medicaid-funded LTC until the secondary assessment has been completed.

b. No referral for active treatment needs assessment required because individual ….– Select this 'no referral needed' category ONLY if there is documented evidence from the list below. Please check all that apply.

- Does not meet the 'applicable criteria' for MI, MR or a related condition
- Has a primary diagnosis of dementia (including Alzheimer's disease). If there is a diagnosis of MR this category does not apply
- Has a primary diagnosis of dementia (including Alzheimer's disease) AND a secondary diagnosis of MI
- Has a severe physical illness (e.g. documented evidence of coma, functioning at brain-stem level, or other diagnoses which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services). If the answer determines than an illness not listed here is so severe that the individual could not be expected to benefit from specialized services, documentation describing the severe illness must be submitted for review.
- Is terminally ill (Note: a physician must have documented that individual's life expectancy is less than 6 months)

Note: **When a screening has not been performed prior to an individual's admission to a nursing facility in a timely manner, Federal Financial Participation (FFP) is available only for services furnished after the screening has been performed.**

Name * - Please enter Assessor's first name, middle initial and last name. This is a required field.

Title * - Please enter assessor's professional title using up to 20 characters which can include letters, numbers or special characters. This is a required field.

Screening Committee* - Please enter the name/locality of screening committee using up to 20 characters which can include letters, numbers or special characters. This is a required field.

Date – This field will auto-populate with the current date. No entry is needed.

Telephone #* - Please enter the assessor's phone number including area code. Format must be 9999999999 or 999-999-9999 (dashes are optional). This is a required field.

Street Address* - Please enter the assessors street address, city, state and 5 digit zip code. This is a required field.

The assessment is ready for submission, no additional forms needed. – If selected, the 'Submit button will display. When the button is hit, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, all forms entered for this assessment will be submitted. Either this option or the following option is required.

Additional forms are needed to complete this assessment. – If selected a set of buttons will display representing each of the assessment forms for selection. Once a button for another form is clicked, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, you will be routed to the selected form. Either this option or the previous option is required.

Additional Forms Available:
- UAI – Part A
- UAI – Part B
- DMAS-95 MI/MR/RC
- DMAS-95 MI/MR/SUPL
- DMAS-96
- DMAS-97

Release Form (button) – This button will also display with the additional forms. If this form was accidently selected and is really not needed, clicking this button will remove any data entered, remove the form and return the user to the previous screen.

Navigation Buttons

Save - this will save any data entered. The user will be given the option to save and continue the form entry or save and come back in later and recall the assessment from the Assessment Tracking Summary via the 'Recall' link.

Please note that completing one form and progressing to another does an auto-save to ensure the capture of any data entered.

Submit (if displayed) - will trigger the form edits for the DMAS-95 MI/MR/RC form and if successful display a submission successful screen or will display error messages that need to be resolved before submission.

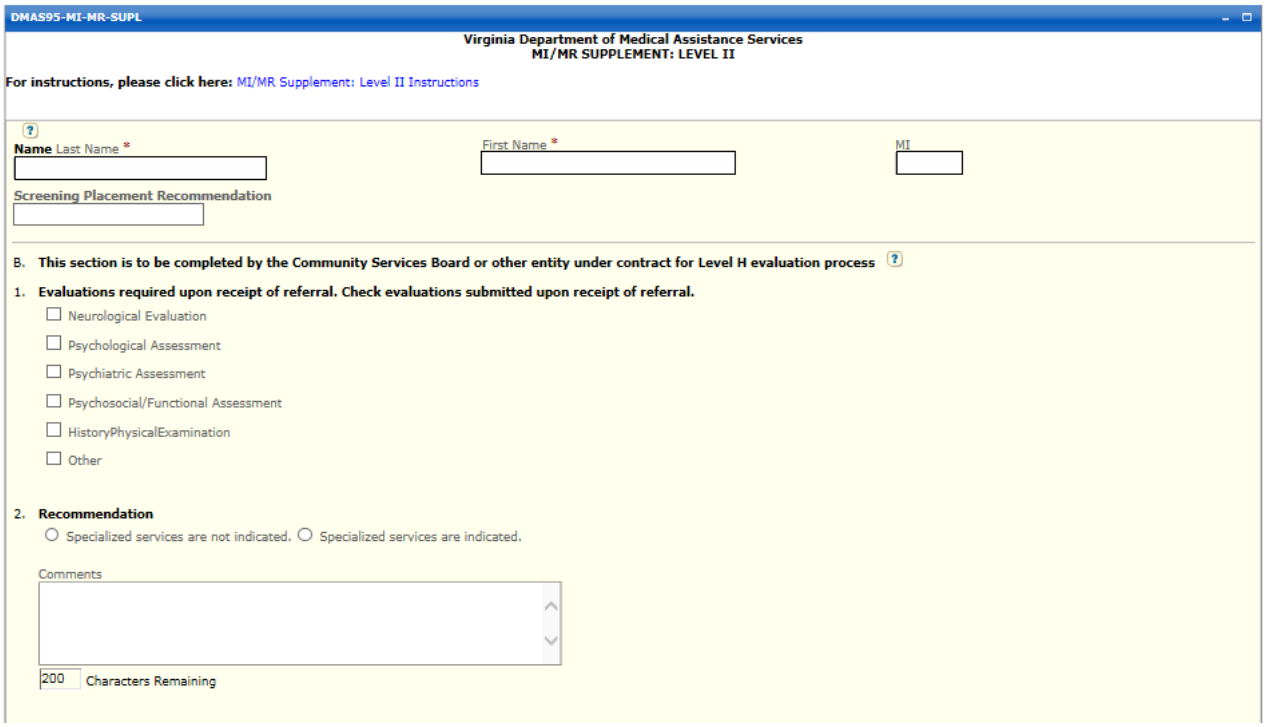
Reset – hitting this button will remove any data entered on the form and set the page back as it appeared upon initial entry. No data entered will be saved.

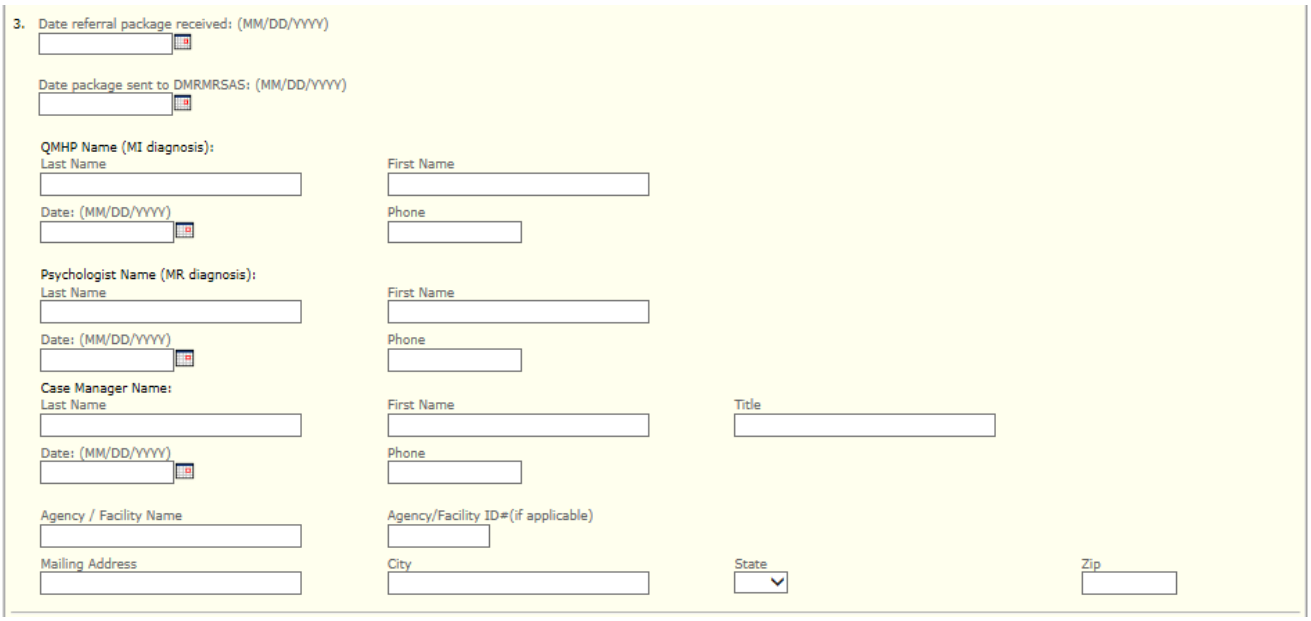
Cancel – hitting this button will disregard any data entered on the form and navigate the user back to the secured portal screen for a different navigation tab selection. No data entered will be saved.

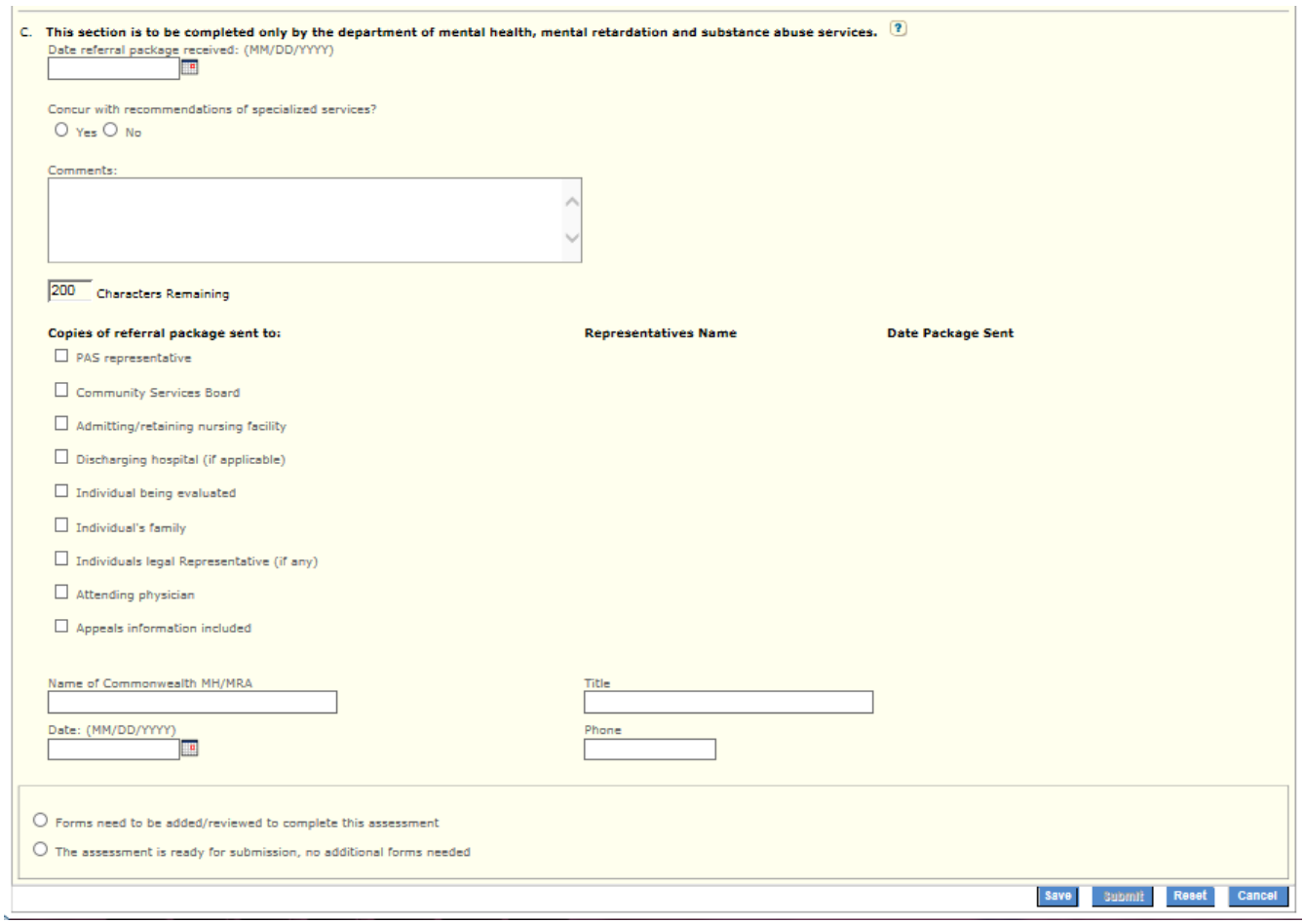
3.4 DMAS95 – MI/MR/SUPL

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.

The screen sample below has been broken up in parts display purposes.







The DMAS95 – MI/MR/SUPL has both required and optional fields. The required fields are indicated with a red asterisk (*)

The following is a list of fields on the screen and the necessary information for completing the form.

Last Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

First Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Middle Initial (MI) - This field is optional and will be auto-populated from the information entered on the UAI-A form.

Screening Placement Recommendation* - Please enter the screening placement recommendation for this member using up to 20 characters which can include letters, numbers or special characters. This is a required field

B. This section is to be completed by the Community Services Board or other entity under contract for Level II evaluation process

1. **Evaluations required upon receipt of referral. Check evaluations submitted upon receipt of referral. * -** Please check any evaluation(s) submitted when this referral was received. At least one is required.
   - Neurological Evaluation
   - Psychological Assessment
   - Psychiatric Assessment
   - Psychosocial/Functional Assessment
   - History and Physical Examination
   - Other

   (Please specify)* – If 'Other' was checked for evaluations submitted, this field will display and is required. Please specify what additional evaluations were completed/submitted using up to 20 characters which can include letters, numbers or special characters.

2. **Recommendation* -** Please select the appropriate response indicating whether specialized services are indicated or not. This is a required field.

   Comments – Please enter any recommendation comments relevant to this member's evaluation using up to 200 characters which can include letters, numbers or special characters. This field is optional.

3. **Date referral package received*** – Enter the date the referral package was received. Please enter the date in MM/DD/YYYY format or utilize the calendar widget. This is a required field.

   Date package sent to the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMRMRSAS)* - Please enter the date the referral package was sent to DMHMRSAS. Please enter the date in MM/DD/YYYY format or utilize the calendar widget. This is a required field.

   QMHP Name (MI diagnosis) – Please enter the last and first name of the Qualified Mental Health Professional that determined the MI diagnosis. Either the QMHP or Psychologist information is required.

   Date – Please enter the date the QMHP determined the MI diagnosis. Please enter the date in the MM/DD/YYYY format or utilize the calendar widget. If a QMHP Name is entered, this field is required.

Phone – Please enter the phone number of the QMHP that determined the MI diagnosis. Please include area code and enter the phone number in the 999-999-9999 (dashes are optional) or 9999999999 format. If a QMHP Name is entered, this field is required.

Psychologist Name (MR diagnosis) – Please enter the last and first name of the Psychologist that determined the MR diagnosis. Either the QMHP or Psychologist information is required.

Date – Please enter the date the Psychologist determined the MR diagnosis. Please enter the date in the MM/DD/YYYY format or utilize the calendar widget. If a Psychologist Name is entered, this field is required.

Phone – Please enter the phone number of the Psychologist that determined the MR diagnosis. Please include area code and enter the phone number in the 999-999-9999 (dashes are optional) or 9999999999 format. If a Psychologist Name is entered, this field is required.

Case Manager Name* – Please enter the last and first name of the Case Manager. This field is required.

Case Manager's Title* – Please enter the title of the Case Manager. This field is required.

Date* – Please enter the date of the Case Manager's review. Please enter the date in the MM/DD/YYYY format or utilize the calendar widget. This is a required field.

Phone* – Please enter the phone number of Case Manager. Please include area code and enter the phone number in the 999-999-9999 (dashes are optional) or 9999999999 format. This is a required field.

Agency/Facility Name* – Please enter the name of the agency or facility. This field is required.

Agency/Facility ID # – Please enter the Agency/Facility's NPI/API. This field is situationally required (if applicable).

Mailing Address – Please enter the street address, city, state and 5 digit zip code of the Agency/Facility's correspondence address.

C. This section is to be completed only by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Date referral package received* – Please enter the date the referral package was received by DMHMRSAS. Please enter the date in MM/DD/YYYY format. This is a required field.

Concur with recommendations of specialized services?* - Please select appropriate yes/no response. This is a required field.

Comments: Please enter any comments relevant to this member's evaluation using up to 200 characters which can include letters, numbers or special characters. This entry is optional.

Copies of referral package sent to:* - Please check any entity receiving copies of the referral package. At least one option is required. For any selection made, also enter the name of the representative from the selected entity, as well as the date the package was sent in the format MM/DD/YYYY. For any selection made, the representative's name and the date sent are required.

Referral Package List:

- PAS representative
- Community Services Board
- Admitting/retaining nursing facility
- Discharging hospital (if applicable)
- Individual being evaluated
- Individual's family
- Individuals legal Representative (if any
- Attending physician
- Appeals information included

Name* - For any selection made, this field will display and is required. Please enter the name of the representative from the selected entity using up to 40 characters which can include letters, numbers or special characters.

Date* - For any selection made, this field will display and is required. Please enter the date the package was sent in the format MM/DD/YYYY or utilize the calendar widget.

Name of Commonwealth MH/MRA* – Please enter the name of the Mental Health/Mental Retardation Assessor (MH/MRA). This field is required.

Title* – Please enter the title of the MH/MRA. This field is required.

Date* - Please enter the date of the MH/MRA's review. Please enter the date in the MM/DD/YYYY format or utilize the calendar widget. This is a required field.

Phone* - Please enter the phone number of the MH/MRA. Please include area code and enter the phone number in the 999-999-9999 (dashes are optional) or 9999999999 format. This is a required field.

The assessment is ready for submission, no additional forms needed. – If selected, the 'Submit button will display. When the button is hit, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, all forms entered for this assessment will be submitted. Either this option or the following option is required.

Additional forms are needed to complete this assessment. – If selected a set of buttons will display representing each of the assessment forms for selection. Once a button for another form is clicked, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, you will be routed to the selected form. Either this option or the previous option is required.

Additional Forms Available:
- UAI – Part A
- UAI – Part B
- DMAS-95 MI/MR/RC
- DMAS-95 MI/MR/SUPL
- DMAS-96
- DMAS-97

Release Form (button) – This button will also display with the additional forms. If this form was accidently selected and is really not needed, clicking this button will remove any data entered, remove the form and return the user to the previous screen.

Navigation Buttons

Save - this will save any data entered. The user will be given the option to save and continue the form entry or save and come back in later and recall the assessment from the Assessment Tracking Summary via the 'Recall' link.

Please note that completing one form and progressing to another does an auto-save to ensure the capture of any data entered.

Submit (if displayed) - will trigger the form edits for the DMAS-95 MI/MR/SUPL form and if successful display a submission successful screen or will display error messages that need to be resolved before submission.

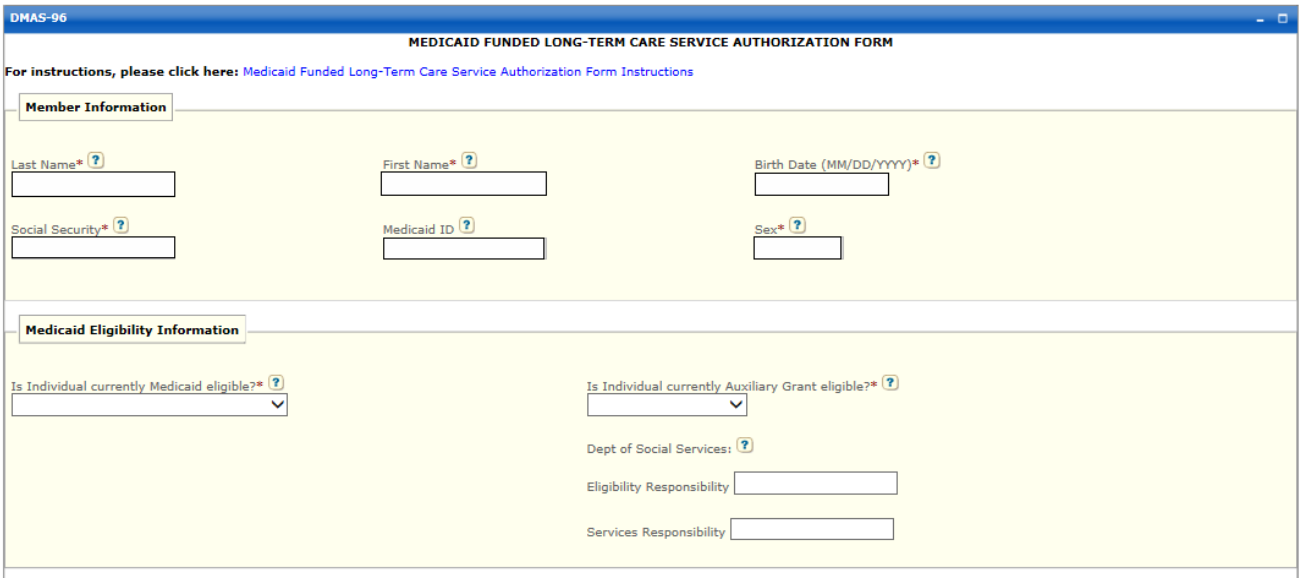
Reset – hitting this button will remove any data entered on the form and set the page back as it appeared upon initial entry. No data entered will be saved.

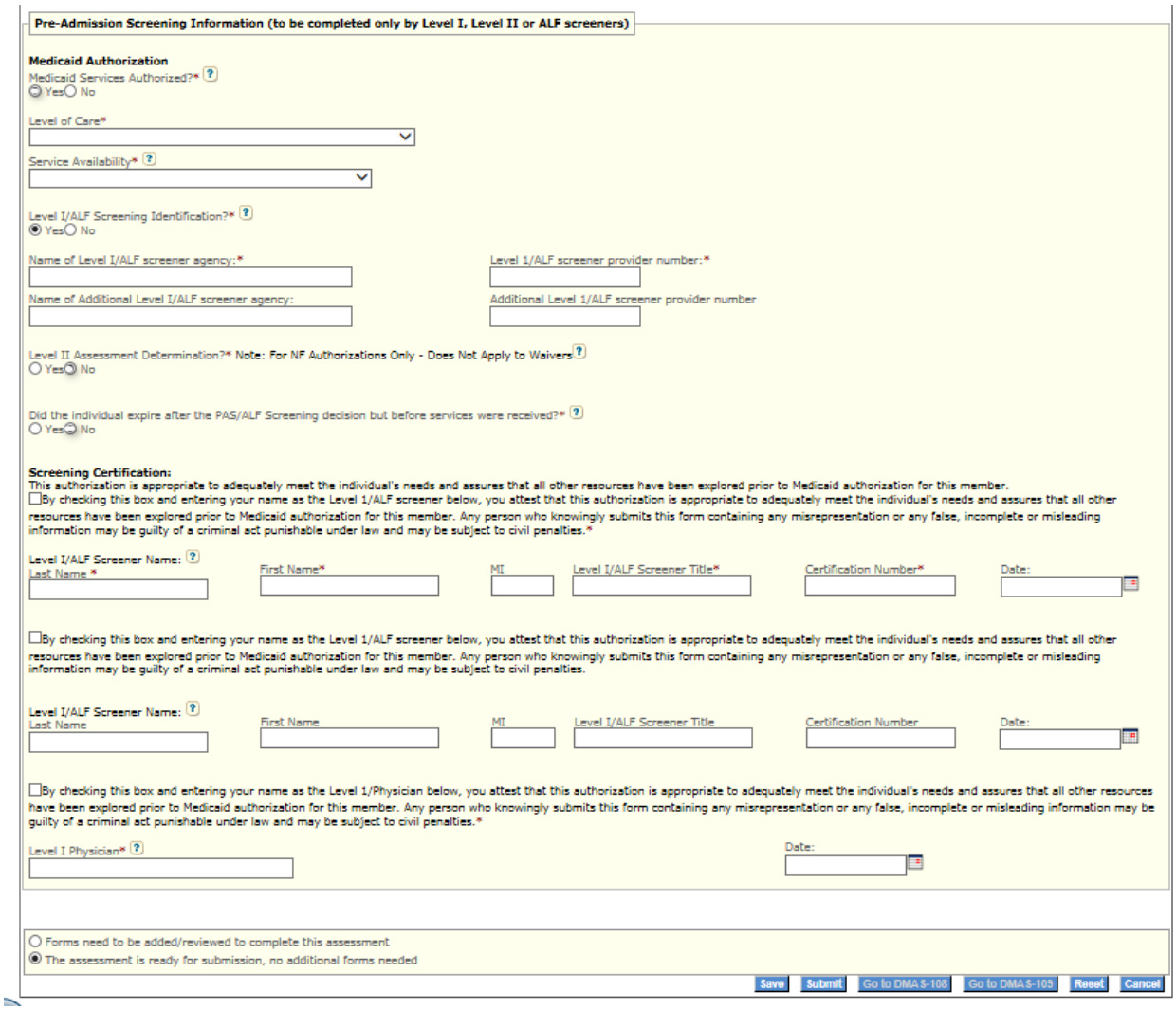
Cancel – hitting this button will disregard any data entered on the form and navigate the user back to the secured portal screen for a different navigation tab selection. No data entered will be saved.

3.5 DMAS96 – Medicaid Funded LTC SA Form

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.

The screen sample below has been broken up in parts display purposes.





The DMAS96 – Medicaid Funded Long Term Care Service Authorization form has both required and optional fields. The required fields are indicated with a red asterisk (*)

The following is a list of fields on the screen and the necessary information for completing the form.

I. Member Information

Last Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

First Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Birth Date* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Social Security* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Medicaid ID – If this field exists on the UAI-A, it will be auto-populated from the information entered on the UAI-A form. This field will be disabled so no entry will be allowed if the Medicaid ID doesn't exist.

Sex* - This field is required and will be auto-populated from the information entered on the UAI-A form.

II. Medicaid Eligibility Information

Is Individual currently Medicaid eligible?* - Please select the appropriate option from the drop down list. This field is required.

> If either "Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission OR within 45 days of application or when personal care begins" OR "Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission" is selected from the drop down the following question will display:
>
> **Has individual formally applied for Medicaid?*** - If member is currently not Medicaid eligible this field will display and is required. Please select the appropriate yes/no response.
>
> *Note:* Formal application for Medicaid is made when the individual or a family member has taken the required financial information to the local Eligibility Department and completed forms needed to apply for the benefits. The authorization for long-term care can be made regardless of whether the individual has been determined Medicaid-eligible, but placement may not be available until the provider is assured of the individual's Medicaid status.

Is Individual currently Auxiliary Grant eligible?* - Please select the appropriate option from the drop down list. This field is required.

Dept of Social Services - The Departments of Social Services with service and eligibility responsibility may not always be the same agency. Please enter, if known, the departments for each in the areas provided.

> **Eligibility Responsibility** – Please enter the name of the agency with eligibility responsibility using up to 25 characters which can include letters, numbers or special characters. This field is situationally required (if applicable).

Service Responsibility – Please enter the name of the agency with service responsibility using up to 25 characters which can include letters, numbers or special characters. This field is situationally required (if applicable).

III. Pre-Admission Screening Information

Note: This section is to be completed only by Level I, Level II or ALF screeners.

Service Authorization

Medicaid Services Authorized?* - Please select the appropriate yes/no response. This field is required

If Medicaid services are authorized this field will display and is required.

Level of Care* - Please select the appropriate option from the drop down list.

Exceptions: Authorizations for NF, PACE, Tech or the EDCD Waivers are interchangeable. Screening updates are not required for individuals to move between the services because the alternate institutional placement is a NF. NF = EDCD, Tech, or PACE. Alzheimer's Assisted Living Waiver's alternate institutional placement is a NF; however, the individual must also have a diagnosis of Alzheimer's OR Alzheimer's Related Dementia and meet the NF criteria. NF = Alzheimer's ALF – the following authorization levels are appropriate for AAL waiver: 01, 11, 12 OR 16 as long as the criteria above are met.

If Medicaid services are **not** authorized this field will display and is required.

Reason No Medicaid Services Authorized*- Please select the appropriate option from the drop down list.

If ALF services authorized are (11 or 12), the following displays and is required.

Targeted Case Management for ALF?* - Please select the appropriate yes/no response.

ALF Reassessment Completed?* - Please select the appropriate yes/no response.

ALF Provider Name* - Please enter the ALF provider's name.

ALF Provider Number* - Please enter the ALF provider's 10 digit NPI.

ALF Admit Date* - Please enter the ALF admission date in the format MM/DD/YYYY or utilize the calendar widget.

If Long Term Care services authorized, the following displays and is required:

Service Availability* - Please select the appropriate option from the drop down list.

If Nursing Home services authorized, the following displays and is required.

Length of Stay* - Please select the appropriate option from the drop down list.

If Technology Assisted Waiver services authorized, the user will see the DMAS-108 (Technology Assisted Waiver – Adult Referral) or DMAS-109 (Technology Assisted Waiver – Pediatric Referral) buttons at the bottom of the screen. Based on the member's age, one or the other will be required as part of the DMAS-96 submission.

Note: If a DMAS-108 or DMAS-109 form is completed as part of the DMAS-96 and the user toggles to another form but later needs to return to the DMAS-108/DMAS-109 form, selection of the DMAS-96 button will take the user back to the combined DMAS-96/DMAS-108 or -109 form for review or update.

Level I/ALF Screening Identification?* - Please select the appropriate yes/no response.

If Level 1/ALF Screening Identification is 'yes', the following displays:

Name of Level I/ALF screener agency* - Please enter the name of the agency represented by the Level I/ALF screener. This is a required field.

Level 1/ALF screener provider number* - Please enter the 10 digit NPI of the Level I/ALF screener's agency. This is a required field.

Name of Additional Level I/ALF screener agency - Please enter the name of the agency represented by the Level I/ALF screener. This field is situationally required (if applicable).

Additional Level 1/ALF screener provider number - Please enter the 10 digit NPI of the Level I/ALF screener's agency. This field is situationally required (if applicable).

Level II Assessment Determination?* - Please select the appropriate yes/no response. This field is required.

Note: For NF Authorizations Only – Does Not Apply to Waivers

If Level II Assessment Determination is 'yes', the following will display and are required.

Complete for the screener who completed the Level II for a diagnosis of MI, MR/ID, or RC:

Name of Level II screener * - Please enter the name of the Level II screener. This is a required field

Level II screener provider number* - Please enter the 10 digit NPI/API of the Level II screener. This is a required field.

Type of Referral* - Please select the appropriate option from the drop down list.

Did the individual expire after the PAS/ALF Screening decision but before services were received?* - Please select the appropriate yes/no response. This field is required.

Screening Certification – This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this member.

Level I/ALF Screener Attestation:* By checking this box and entering your name as the Level I/ALF screener below, you attest that this authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this member. Any person who knowingly submits this form containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. – Please check attestation box if Level I/ALF Screener is entered.

Level I/ALF Screener - **Last Name*** - Please enter the Level I/ALF Screener's last name. This is a required field.

Level I/ALF Screener – **First Name*** - Please enter the Level I/ALF Screener's first name. This is a required field.

Level I/ALF Screener –**Middle Initial** - Please enter the Level I/ALF Screener's middle initial. This is an optional field.

Level I/ALF Screener Title* - Please enter the Level I/ALF Screener's title. This is a required field.

Level I/ALF Screener – **Certification Number*** - Please enter the Level I/ALF Screener's 8 character certification number. This is a required field. This is the certification number from the certificate of completion presented to the screener from VCU after completing the appropriate level of assessment screening training.

This number, along with the name (first, last and middle initial, if entered) will be validated against a database of certificates awarded by VCU. The screener's name and certification number entered must match exactly that entered on their certificate of completion.

The start and expiration date of the certificate will be compared to the attestation date (following). If a match is found and within the correct dates, the assessment can be submitted; if not, the user will receive messages indicating the issue to be resolved.

Date – This field defaults to the current date and displays in the format MM/DD/YYYY.

Level I/ALF Screener Attestation: By checking this box and entering your name as the Level I/ALF screener below, you attest that this authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this member. Any person who knowingly submits this form containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. – Please check attestation box if Level I/ALF Screener (second screener) is entered.

Level I/ALF Screener - **Last Name** - Please enter the Level I/ALF Screener's last name. A second screener is required for all services except ALF. This is a situationally required field (if applicable).

Level I/ALF Screener – **First Name** - Please enter the Level I/ALF Screener's first name. A second screener is required for all services except ALF. This is a situationally required field (if applicable).

Level I/ALF Screener –**Middle Initial** - Please enter the Level I/ALF Screener's middle initial. This is an optional field.

Level I/ALF Screener Title - Please enter the Level I/ALF Screener's title. A second screener is required for all services except ALF. This is a situationally required field (if applicable)

Level I/ALF Screener – **Certification Number** - Please enter the Level I/ALF Screener's 8 character certification number. This is a situationally required field (if applicable). This is the certification number from the certificate of completion presented to the screener from VCU after completing the appropriate level of assessment screening training.

This number, along with the name (first, last and middle initial, if entered) will be validated against a database of certificates awarded by VCU. The screener's name and certification number entered must match exactly that entered on their certificate of completion.

The start and expiration date of the certificate will be compared to the attestation date (following). If a match is found and within the correct dates, the assessment can be submitted; if not, the user will receive messages indicating the issue to be resolved.

Date – This field defaults to the current date and displays in the format MM/DD/YYYY.

Level I Physician Attestation:* By checking this box and entering your name as the Level I/Physician below, you attest that this authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this member. Any person who knowingly submits this form containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. – Please check attestation box if Level I Physician is entered.

Level I Physician - Please enter the Level I Physician's name. This is required for all services except ALF. This is a situationally required field (if applicable)

The assessment is ready for submission, no additional forms needed. – If selected, the 'Submit button will display. When the button is hit, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, all forms entered for this assessment will be submitted. Either this option or the following option is required.

Additional forms are needed to complete this assessment. – If selected a set of buttons will display representing each of the assessment forms for selection. Once a button for another form is clicked, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, you will be routed to the selected form. Either this option or the previous option is required.

Additional Forms Available:
- UAI – Part A
- UAI – Part B
- DMAS-95 MI/MR/RC
- DMAS-95 MI/MR/SUPL
- DMAS-96
- DMAS-97
- DMAS-108 (conditionally)
- DMAS-109 (conditionally)

Navigation Buttons

Save - this will save any data entered. The user will be given the option to save and continue the form entry or save and come back in later and recall the assessment from the Assessment Tracking Summary via the 'Recall' link.

Please note that completing one form and progressing to another does an auto-save to ensure the capture of any data entered.

Submit (if displayed) - will trigger the form edits for the DMAS-96 form and if successful display a submission successful screen or will display error messages that need to be resolved before submission.

Reset – hitting this button will remove any data entered on the form and set the page back as it appeared upon initial entry. No data entered will be saved.

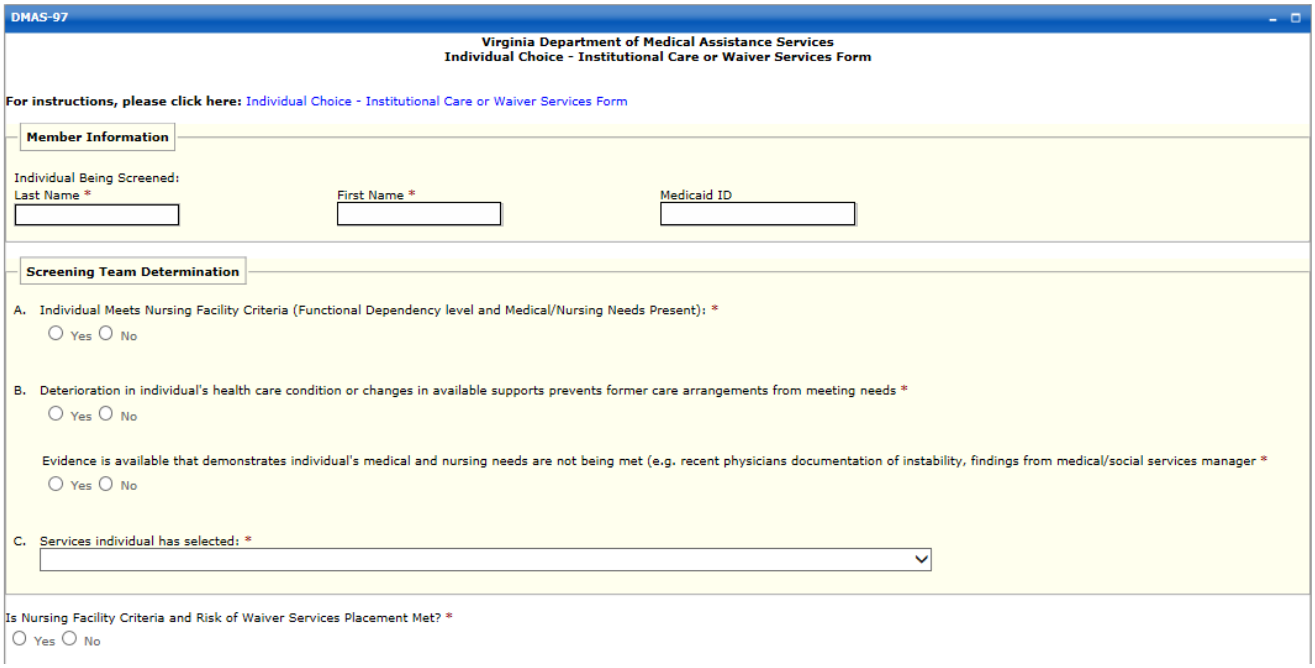
Cancel – hitting this button will disregard any data entered on the form and navigate the user back to the secured portal screen for a different navigation tab selection. No data entered will be saved.

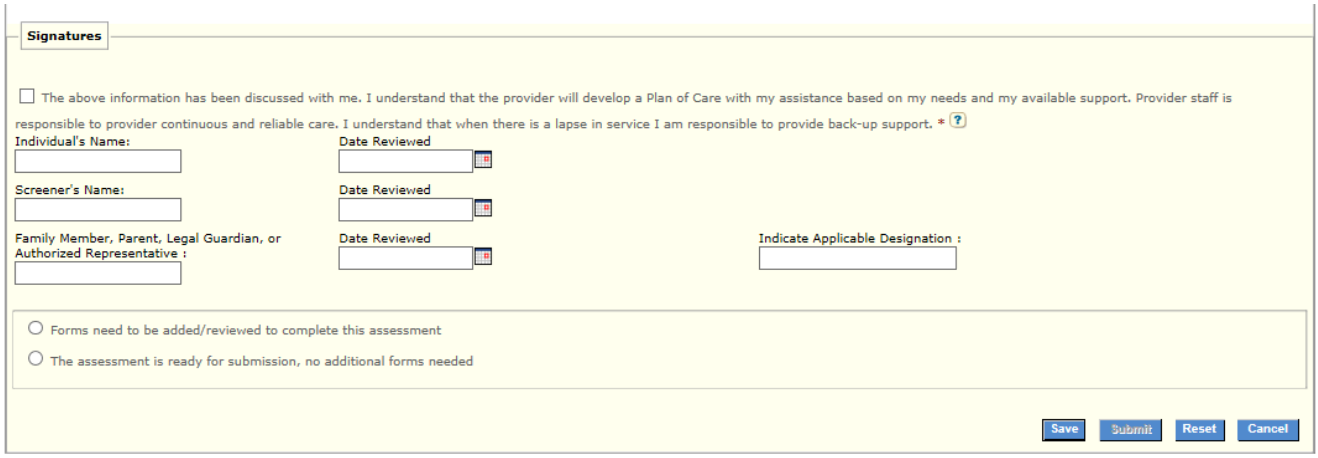
3.6 DMAS97 – Individual Choice – Institutional Care or Waiver Services Form

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.

Note: In addition to the electronic confirmation described above, a paper copy of the DMAS 97 – Individual Choice - Institutional or Waiver Services form with the individual's signature must be retained in the individual's record by the screening entity.

The screen sample below has been broken up in parts display purposes.





The DMAS97 – Individual Choice – Institutional Care or Waiver Services Form has both required and optional fields. The required fields are indicated with a red asterisk (*)

The following is a list of fields on the screen and the necessary information for completing the form.

Complete this form when authorizing nursing facility or home- and community-based care services.

Last Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

First Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Medicaid ID – If this field exists on the UAI-A, it will be auto-populated from the information entered on the UAI-A form. This field will be disabled so no entry will be allowed if the Medicaid ID doesn't exist.

1. Screening Team Determination:

"Individual" refers to the individual being screened and, if applicable, the family member, parent, legal guardian or authorized representative.

A. Individual Meets Nursing Facility Criteria (Functional Dependency level and Medical/Nursing Needs Present)* - Please select appropriate yes/no response. This is a required field.

If the individual meets the nursing facility criteria, the following will display and will be required.

Application for the individual to a nursing facility has been made and accepted.

Facility* - Please enter the name of the facility the member has made application to or been accepted in to using up to 30 characters which can include letters, numbers or special characters. This field is required.

Contact* - Please enter the name of the contact person at the facility the member has made application to or been accepted in to using up to 20 characters which can include letters, numbers or special characters. This field is required.

B. Deterioration in individual's health care condition or changes in available supports prevents former care arrangements from meeting needs.

Describe* - Please describe the deterioration in the member's health or any changes supporting the change using up to 40 characters which can include letters, numbers or special characters. This is a required field.

Evidence is available that demonstrates individual's medical and nursing needs are not being met (e.g. recent physicians documentation of instability, findings from medical/social services manager.

Describe* - Please describe the evidence that demonstrates that the member's needs are not being met using up to 40 characters which can include letters, numbers or special characters. This is a required field.

C. Individual has selected* - Please select the appropriate response. This is a required field. Selection options include:

- Nursing Facility Services
- Elderly or Disabled with Consumer Direction Waiver Services
- Program for the All Inclusive Care of the Elderly (PACE), if in service area
- Alzheimer's Assisted Living Waiver
- Technology-Assisted Waiver (for adults or children)
- Managed Care Organization (MCO) choices , if available in service area
  (For comparison chart, please contact the Enrollment Broker)

Is Nursing Facility Criteria and Risk of Waiver Services Placement Met?* - Please select the appropriate yes/no response. This is a required field.

If nursing facility criteria and risk of waiver services placement have not been met, continue with section IV Signatures.

If nursing facility criteria and risk of waiver services placement have been met, the following sections need to be completed.

II. Choice and Payment Responsibility

Medicaid will pay for someone to come into your home to care for you as long as in-home services will safely meet your needs and is less costly than nursing facility care. The screening team does not authorize the amount of services, or time of the day or days of the week on which services will be provided. You may choose to receive in-home services if there is an available provider in your area and you have additional support from family and/or friends or are able to maintain health, safety and welfare without additional help when in-home services are not being provided.

To stay at home, help in the following areas is needed* - Please check any help the member needs to stay in their home. Please check all that apply. At least one is required.

Needs List:
- Respite
- Housekeeping
- Meal Preparation
- Shopping
- Laundry
- Supervision (Submit DMAS-100)
- Personal Care
- ADLS
- PERS (Submit DMAS-100A)
- Transportation
- Skilled Nursing Needs/Private Duty Nursing

III. Documentation of Individual Choice (The following has been presented and discussed with the individual)* - Please check any documentation of the individual's choice. At least one is required.

Documentation options include:

- The findings and results of the individual's evaluation and needs.

- A choice between Institutional Care (nursing facility) and the appropriate Home- and Community-Care Based Waiver, PACE (if available in service area) or MCO (if available in service area).

- The individual understands when a diagnosis of mental illness, mental retardation/intellectual disabilities or related condition exists a secondary screening is required to determine if additional services are necessary. Services can not start until the completion of the secondary assessment. For NF = Level II Screening

- The individual's right to a fair hearing and the appeal process.

- The individual's right to choice of provider(s).

    - If known, insert provider name here - If the individual's right to choice of provider is checked, this field will display and is situationally required (if applicable). Please enter the provider's name.

- The individual's right of choice of service(s).

- The individual's potential to have a patient pay amount, based on his or her income, regardless of the amount of institutional or community-based care received.

- The individual understands that, by using Consumer-Directed Services, he or she bears the responsibilities associated with employing his or her own personal attendants. Note: DMAS is not the employer for Consumer-Directed Services.

- The individual's (or authorized representative's) consent to exchange information with the Department of Medical Assistance Services (DMAS) by signing and dating this form. This consent will remain in effect until revoked by the individual (or authorized representative) in writing.

At Risk: for waiver service authorizations – individuals must also meet the 'at risk' definition in order to receive services. At risk is defined according to 42 CFR 441.302(1): "….when there is a reasonable indication that a individual might need the services in the near future (that is, a month or less) unless he or she receives home and community based services."

IV. Signatures

The above information has been discussed with me. I understand that the provider will develop a Plan of Care with my assistance based on my needs and my available support. Provider staff is responsible to provider continuous and reliable care. I understand that when there is a lapse in service I am responsible to provide back-up support.* - Please select confirming that the information was discussed with the member. This field is required.

Note: In addition to the electronic confirmation described above, a paper copy of the DMAS 97 – Individual Choice - Institutional or Waiver Services form with the individual's signature must be retained in the individual's record by the screening entity.

Individual's Name* - Please enter the member's name (last, first and middle initial). This is a required field.

Date* - Please enter the date of the discussion in the MM/DD/YYYY format or utilize the calendar widget. This field is required.

Screener's Name* - Please enter the screener's name (last, first and middle initial). This is a required field.

Date* - Please enter the date of the discussion in the MM/DD/YYYY format or utilize the calendar widget. This field is required.

Family Member, Parent, Legal Guardian, or Authorized Representative* - Please enter the name (last, first and middle initial) of any family member, parent, legal guardian or authorized representative present during the discussion. This is a required field.

Date* - Please enter the date of the discussion in the MM/DD/YYYY format or utilize the calendar widget. This field is required.

Indicate Applicable Designation* - Please enter the member's applicable designation using up to 20 characters which can include letters, numbers or special characters. This is a required field.

The assessment is ready for submission, no additional forms needed. – If selected, the 'Submit button will display. When the button is hit, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, all forms entered for this assessment will be submitted. Either this option or the following option is required.

Additional forms are needed to complete this assessment. – If selected a set of buttons will display representing each of the assessment forms for selection. Once a button for another form is clicked, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, you will be routed to the selected form. Either this option or the previous option is required.

Additional Forms Available:
- UAI – Part A
- UAI – Part B
- DMAS-95 MI/MR/RC
- DMAS-95 MI/MR/SUPL
- DMAS-96

- DMAS-97

Release Form (button) – This button will also display with the additional forms. If this form was accidently selected and is really not needed, clicking this button will remove any data entered, remove the form and return the user to the previous screen.

Navigation Buttons

Save - this will save any data entered. The user will be given the option to save and continue the form entry or save and come back in later and recall the assessment from the Assessment Tracking Summary via the 'Recall' link.

Please note that completing one form and progressing to another does an auto-save to ensure the capture of any data entered.

Submit (if displayed) - will trigger the form edits for the DMAS-97 form and if successful display a submission successful screen or will display error messages that need to be resolved before submission.

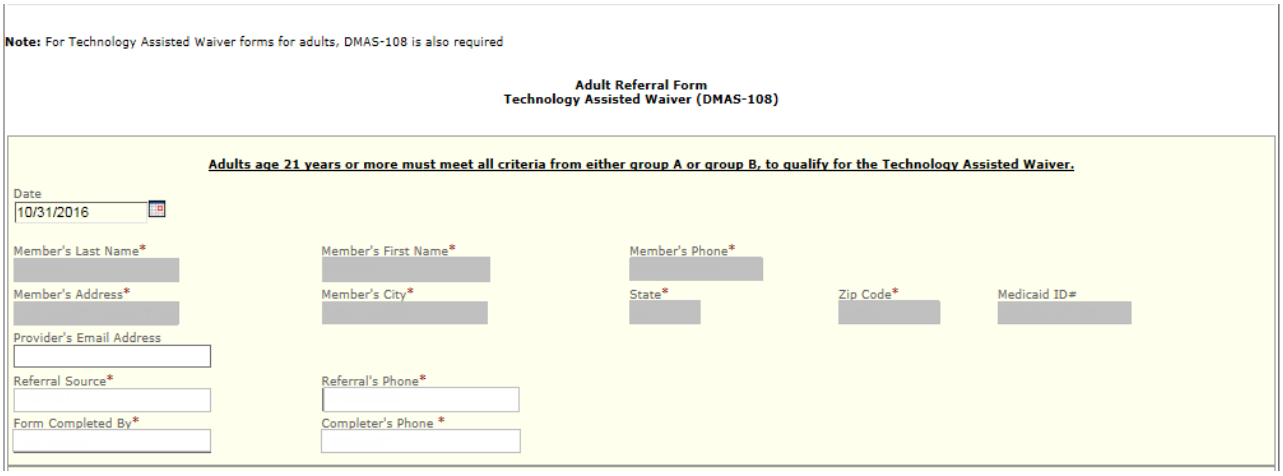
Reset – hitting this button will remove any data entered on the form and set the page back as it appeared upon initial entry. No data entered will be saved.

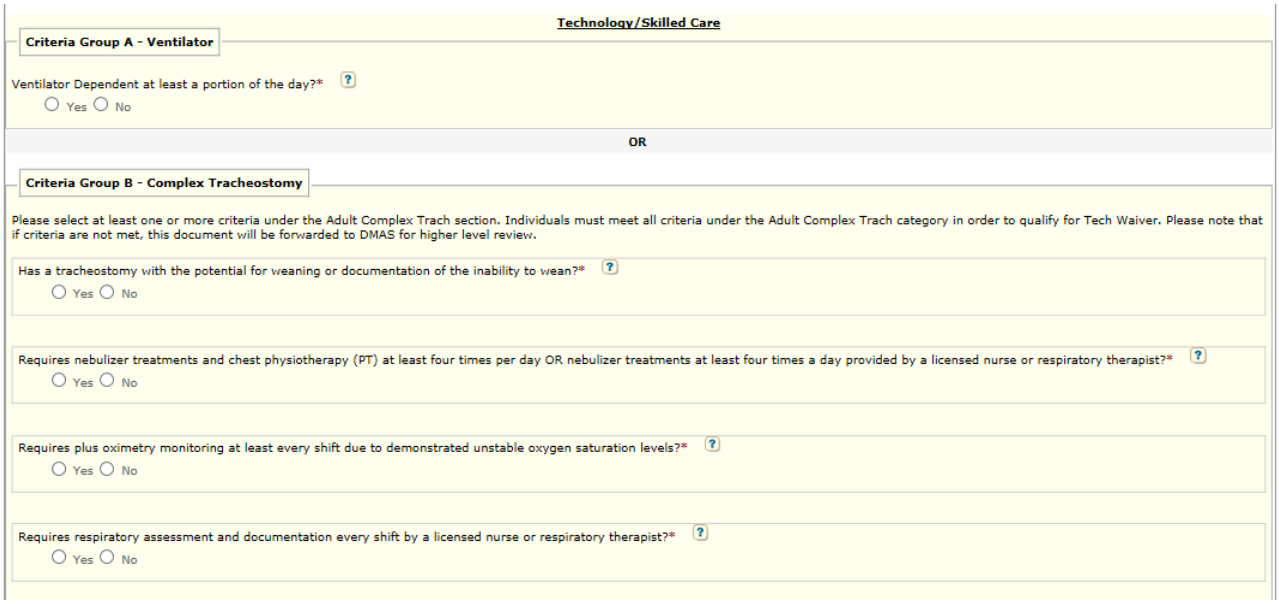
Cancel – hitting this button will disregard any data entered on the form and navigate the user back to the secured portal screen for a different navigation tab selection. No data entered will be saved.

3.7 DMAS108 - Technology Assisted Waiver – Adult Referral

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.

Screen sample below:





The DMAS108 – Technology Assisted Waiver – Adult Referral Form has both required and optional fields. The required fields are indicated with a red asterisk (*)

The following is a list of fields on the screen and the necessary information for completing the form.

Complete this form when authorizing technology assisted waiver – adult referral services.

To qualify for the Technology Assisted Waiver, the member must have a positive answer to Group A or a minimum of one selection in Group B of the form. The form can be submitted with at least one negative response in either Group A or B for record purposes.

Member's Last Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Member's First Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Member's Phone * - This field is required and will be auto-populated from the information entered on the UAI-A form.

Member's Address * - This field is required and will be auto-populated from the information entered on the UAI-A form.

Member's City * - This field is required and will be auto-populated from the information entered on the UAI-A form.

Member's State * - This field is required and will be auto-populated from the information entered on the UAI-A form.

Member's Zip Code * - This field is required and will be auto-populated from the information entered on the UAI-A form

Member's Medicaid ID - If this field exists on the UAI-A, it will be auto-populated from the information entered on the UAI-A form. This field will be disabled so no entry will be allowed if the Medicaid ID doesn't exist.

Provider's Email Address – Please enter the provider's email address with a valid domain. This field is optional.

Referral Source * - Please enter the first and last name of the source referring the member for services. This field is required.

Referral's Phone * - Please enter the referral source's phone number including area code. This field is required.

Form Completed By * - Please enter the first and last name of the person completing the DMAS-108 form. This field is required.

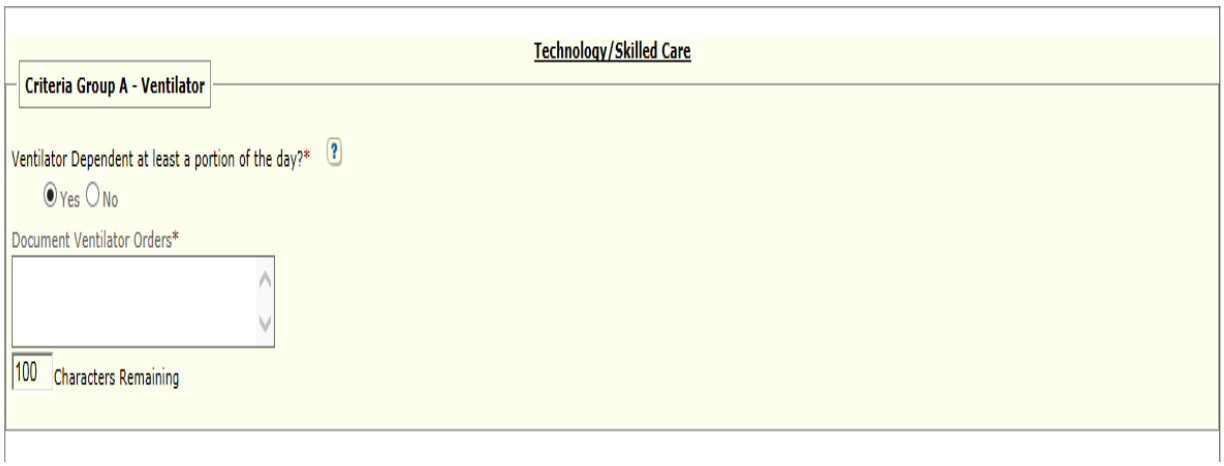
Completer's Phone * - Please enter the phone number (including area code) of the person completing the DMAS-108 form. This field is required

Criteria Group A – Ventilator

To qualify for the Technology Assisted Waiver the member must have a positive answer to Group A or a minimum of one selection in Group B of the form. The form can be submitted with at least one negative response in either Group A or B for record purposes.

Ventilator Dependent at least a portal of the day? * - Please select the appropriate Yes/No radio button. This selection is required.

If 'Yes' is selected, the additional entry will display and Group B selections will no longer display on the screen.



Document Ventilator Orders * - Please enter the ventilator orders associated with the previous question, if the 'yes' radio button is selected. This field is situationally required.

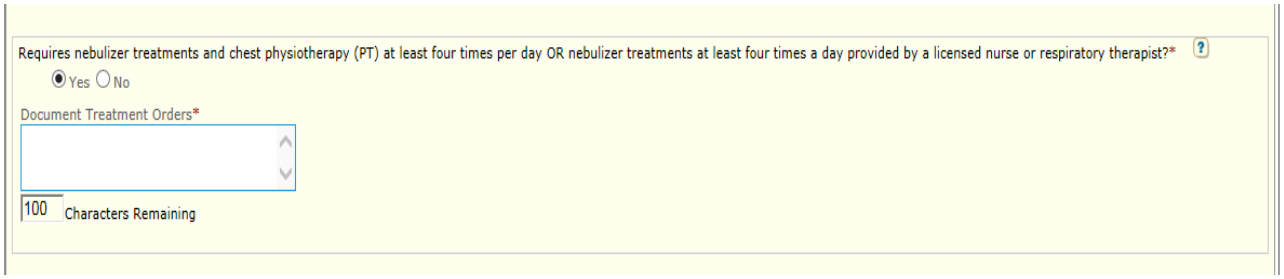
Criteria Group B – Complex Tracheostomy

If Group A selection is not made or is 'no' then at least one or more criteria under the Adult Complex Trach section is required. Individuals must meet all criteria under the Adult Complex Trach category in order to qualify for Tech Waiver.

Has a tracheostomy with the potential for weaning or documentation of the inability to wean?* - Please select the appropriate Yes/No radio button. This selection is required.

Requires nebulizer treatments and chest physiotherapy (PT) at least four times per day OR nebulizer treatments at least four times a day provided by a licensed nurse or respiratory therapist?* - Please select the appropriate Yes/No radio button. This selection is required.

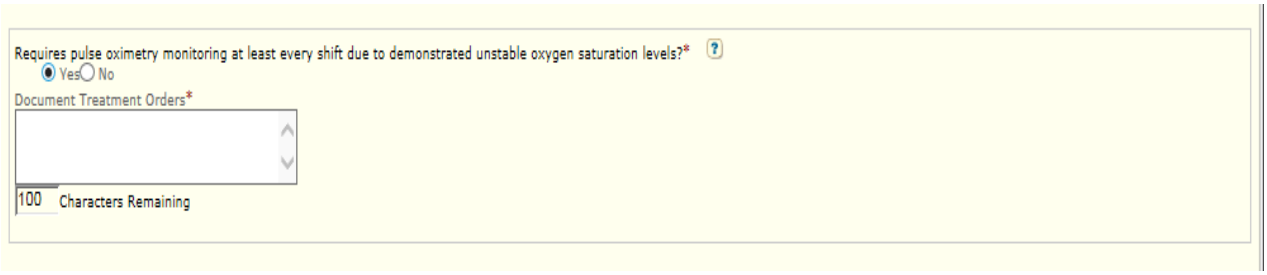
If 'Yes' is selected, the additional entry will display.



Document Treatment Orders * - Please enter the treatment orders associated with the previous question, if the 'yes' radio button is selected. This field is situationally required.

Requires pulse oximetry monitoring at least every shift due to demonstrated unstable oxygen saturation levels?* - Please select the appropriate Yes/No radio button. This selection is required.

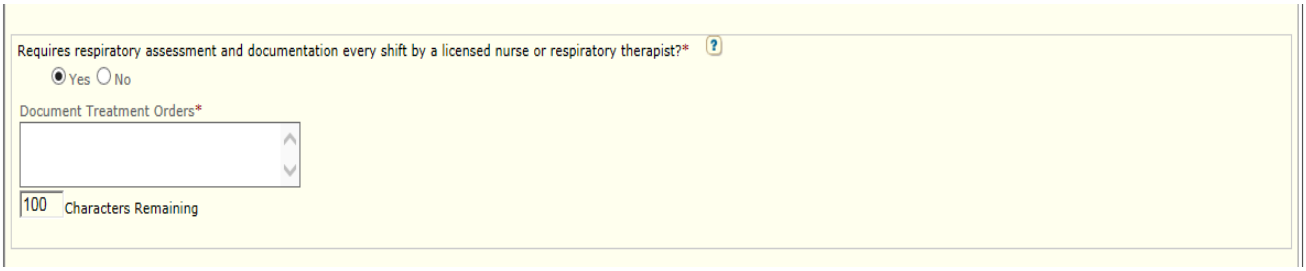
If 'Yes' is selected, the additional entry will display.



Document Treatment Orders * - Please enter the treatment orders associated with the previous question, if the 'yes' radio button is selected. This field is situationally required.

Requires respiratory assessment and documentation every shift by a licensed nurse or respiratory therapist?* - Please select the appropriate Yes/No radio button. This selection is required.

If 'Yes' is selected, the additional entry will display.



Document Treatment Orders * - Please enter the treatment orders associated with the previous question, if the 'yes' radio button is selected. This field is situationally required.

Has a physician's order for oxygen therapy with documented usage?* - Please select the appropriate Yes/No radio button. This selection is required.

If 'Yes' is selected, the additional entry will display.

Document Treatment Orders * - Please enter the treatment orders associated with the previous question, if the 'yes' radio button is selected. This field is situationally required.

Requires tracheostomy care at least daily?* - Please select the appropriate Yes/No radio button. This selection is required.

If 'Yes' is selected, the additional entry will display.

Document Treatment Orders * - Please enter the treatment orders associated with the previous question, if the 'yes' radio button is selected. This field is situationally required.

Has a physician's order for tracheal suctioning as needed?* - Please select the appropriate Yes/No radio button. This selection is required.

Is deemed at risk of requiring subsequent mechanical ventilation?* - Please select the appropriate Yes/No radio button. This selection is required.

The assessment is ready for submission, no additional forms needed. – If selected, the 'Submit button will display. When the button is hit, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, all forms entered for this assessment will be submitted. Either this option or the following option is required.

Additional forms are needed to complete this assessment. – If selected a set of buttons will display representing each of the assessment forms for selection. Once a button for another form is clicked, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, you will be routed to the selected form. Either this option or the previous option is required.

Additional Forms Available:
- UAI – Part A
- UAI – Part B
- DMAS-95 MI/MR/RC
- DMAS-95 MI/MR/SUPL
- DMAS-96
- DMAS-97

Navigation Buttons

Save - this will save any data entered. The user will be given the option to save and continue the form entry or save and come back in later and recall the assessment from the Assessment Tracking Summary via the 'Recall' link.

Please note that completing one form and progressing to another does an auto-save to ensure the capture of any data entered.

Submit (if displayed) - will trigger the form edits for the DMAS-96 form and if successful display a submission successful screen or will display error messages that need to be resolved before submission.

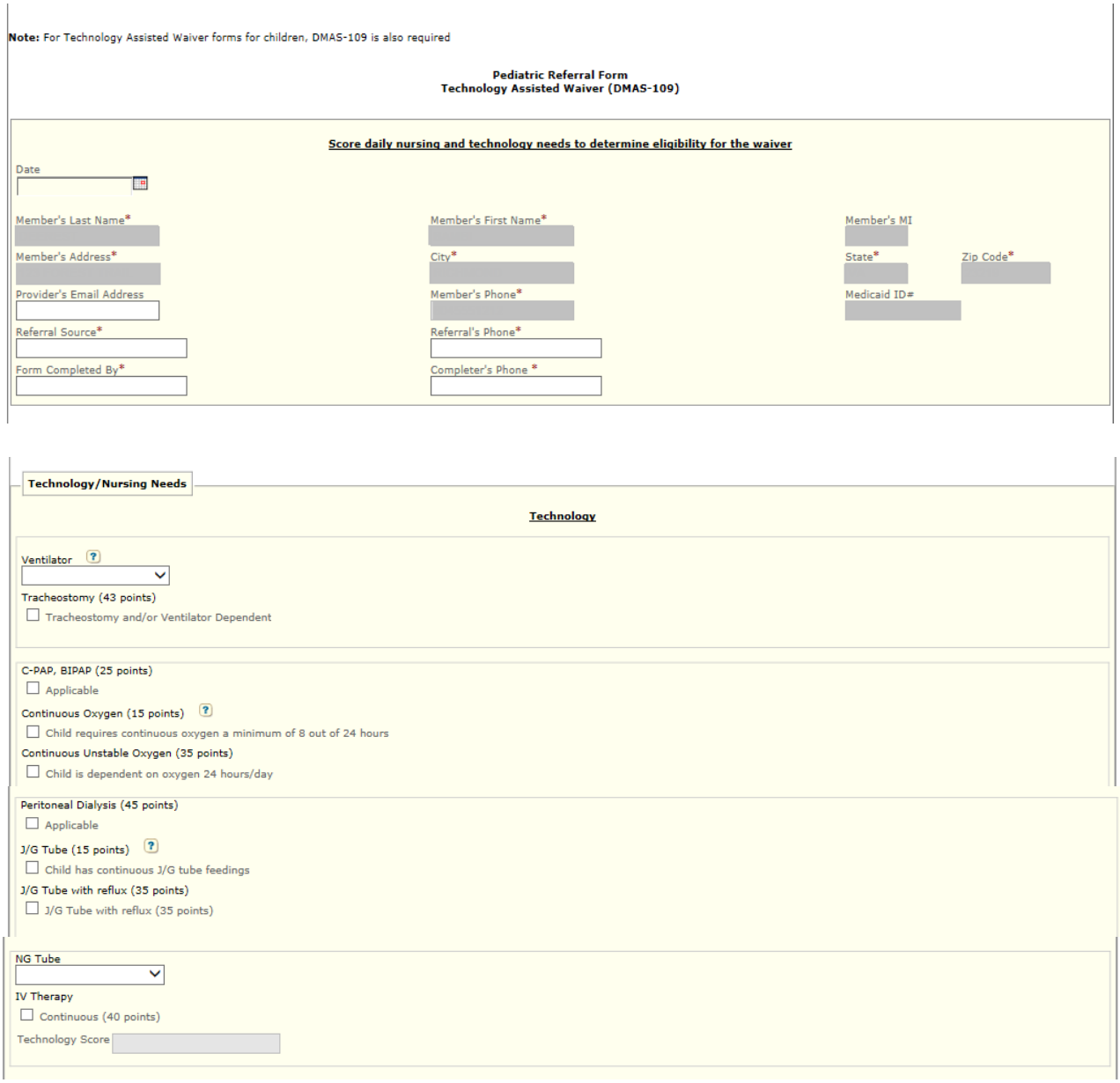
Reset – hitting this button will remove any data entered on the form and set the page back as it appeared upon initial entry. No data entered will be saved.

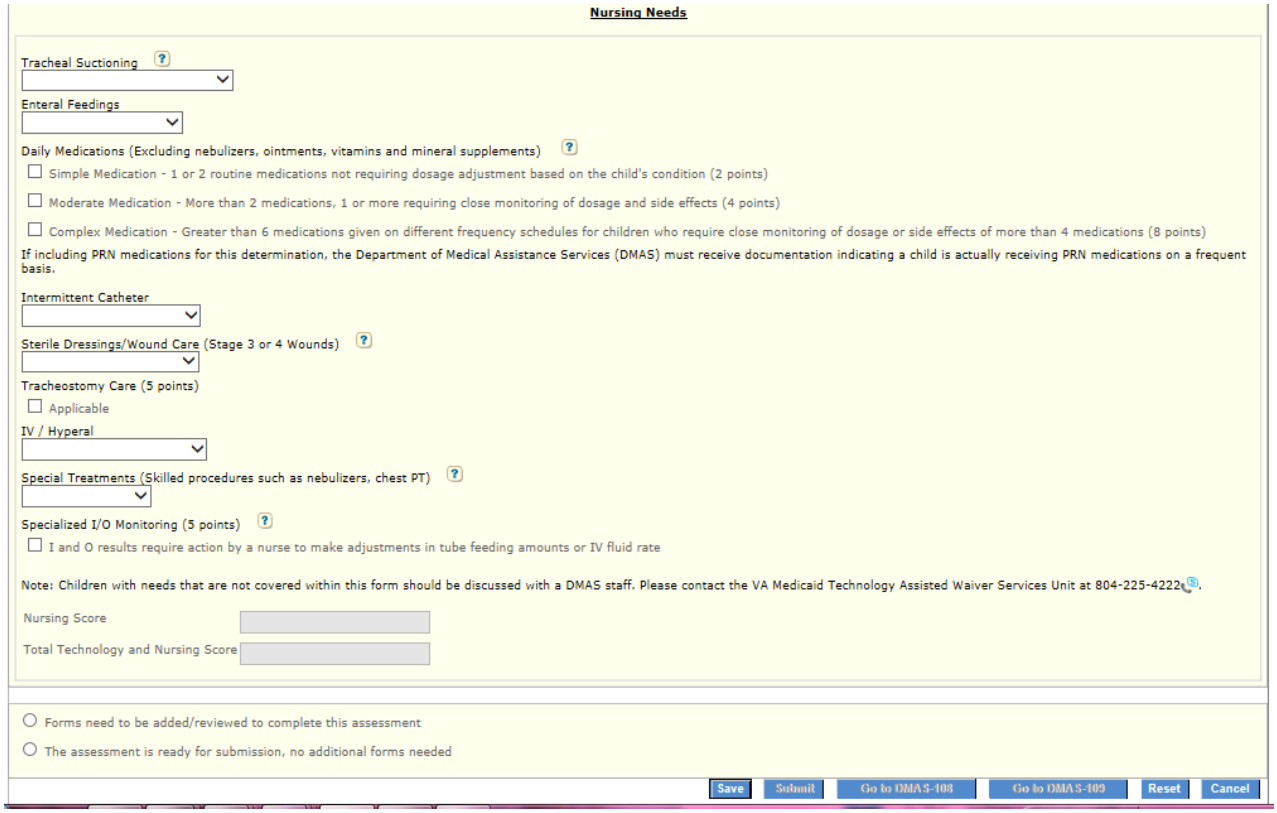
Cancel – hitting this button will disregard any data entered on the form and navigate the user back to the secured portal screen for a different navigation tab selection. No data entered will be saved.

3.8 DMAS109 - Technology Assisted Waiver – Pediatric Referral

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.

Screen sample below:





If the user selects 'Tech Assisted Waiver' on the DMAS-96 Level of Care option and the calculated age is less than 21 years old, then the DMAS-109 form will append to the DMAS-96 form.

The screen captures the various medical needs, and dependency levels.

All children on the technology assisted waiver program receiving, or to receive services, must complete this page.

This form consists of a series of required, situationally required and optional fields.

Member's Last Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Member's First Name* - This field is required and will be auto-populated from the information entered on the UAI-A form.

Member's Phone * - This field is required and will be auto-populated from the information entered on the UAI-A form.

Member's Address * - This field is required and will be auto-populated from the information entered on the UAI-A form.

Member's City * - This field is required and will be auto-populated from the information entered on the UAI-A form.

Member's Medicaid ID - If this field exists on the UAI-A, it will be auto-populated from the information entered on the UAI-A form. This field will be disabled so no entry will be allowed if the Medicaid ID doesn't exist.

Provider's Email Address – Please enter the provider's email address with a valid domain. This field is optional.
Member's State * - This field is required and will be auto-populated from the information entered on the UAI-A form.

Member's Zip Code * - This field is required and will be auto-populated from the information entered on the UAI-A form

Referral Source * - Please enter the first and last name of the source referring the member for services. This field is required.

Referral's Phone * - Please enter the referral source's phone number including area code. This field is required.

Form Completed By * - Please enter the first and last name of the person completing the DMAS-108 form. This field is required.

Completer's Phone * - Please enter the phone number (including area code) of the person completing the DMAS-108 form. This field is required

Technology

Ventilator – If applicable, please select the appropriate option from the drop down.

Tracheostomy (43 points)
Tracheostomy and/or Ventilator Dependent – If applicable, please click the checkbox.

Note: If an option was selected on the previous Ventilator question, this field will be auto-checked.

C-PAP, BIPAP (25 points)
Applicable – If applicable, please click the checkbox.

Continuous Oxygen (15 points)
Child requires continuous oxygen a minimum of 8 out of 24 hours – If applicable, please click the checkbox.

Continuous Unstable Oxygen (35 points)
Child is dependent on oxygen 24 hours/day – If applicable, please click the checkbox.

Note: If 'Continuous Oxygen' is checked, this option is disabled.

If checked, the following options will display:

Check all conditions that apply (minimum 2 required to qualify as continuous unstable)

- **Diuretics** - if applicable, please click the checkbox
- **Albuterol treatments at least 24 hours/day around the clock** - if applicable, please click the checkbox
- **Weight is below 15th percentile for age and gain does not follow normal curve for height** - if applicable, please click the checkbox
- **Greater than three (3) hospitalizations in the last six (6) months for respiratory problems** - if applicable, please click the checkbox
- **Daily oxygen desaturation below physician ordered parameters requiring nursing intervention** - if applicable, please click the checkbox
- **Physician ordered fluid intake restrictions** - if applicable, please click the checkbox

Peritoneal Dialysis (45 points)
Applicable - if applicable, please click the checkbox

J/G Tube (15 points)
Child has continuous J/G tube feedings - if applicable, please click the checkbox

J/G Tube with reflux (35 points) – If applicable, please click the checkbox.

Note: If 'Child has continuous J/G tube feedings' is checked, this option is disabled.

Check any that apply (minimum 1 required to qualify as with reflux)

- **Swallow study within the last six (6) month that demonstrated reflux** – If applicable, please click the checkbox.
- **Aspiration pneumonia within the last twelve (12) months** – If applicable, please click the checkbox.
- **Need for suctioning due to reflux on a daily basis (not oral secretions)** – If applicable, please click the checkbox.

NG Tube – If applicable, please select the appropriate option from the drop down.

IV Therapy
Continuous (40 points) – If applicable, please click the checkbox.

Technology Score – This field is display only. It's a calculation based on the entries made on the form in the Technology section.

Nursing Needs

Tracheal Suctioning – If applicable, please select the appropriate option from the drop down.

Enteral Feedings – If applicable, please select the appropriate option from the drop down.

Daily Medications (Excluding nebulizers, ointments, vitamins and mineral supplements)

- **Simple Medication - 1 or 2 routine medications not requiring dosage adjustment based on the child's condition (2 points)** – If applicable, please click the checkbox. (Note: If the other medication options are checked, they will be unchecked if this option is selected.
- **Moderate Medication - More than 2 medications, 1 or more requiring close monitoring of dosage and side effects (4 points)** – If applicable, please click the checkbox. (Note: If the other medication options are checked, they will be unchecked if this option is selected.
- **Complex Medication - Greater than 6 medications given on different frequency schedules for children who require close monitoring of dosage or side effects of more than 4 medications (8 points) -** If applicable, please click the checkbox. (Note: If the other medication options are checked, they will be unchecked if this option is selected.

Intermittent Catheter – If applicable, please select the appropriate option from the drop down.

Sterile Dressings/Wound Care (Stage 3 or 4 Wounds) – If applicable, please select the appropriate option from the drop down.

Tracheostomy Care (5 points)
Applicable - If applicable, please click the checkbox.

IV/Hyperal – If applicable, please select the appropriate option from the drop down.

Special Treatments (Skilled procedures such as nebulizers, chest PT) – If applicable, please select the appropriate option from the drop down.

Specialized I/O Monitoring (5 points)

I and O results require action by a nurse to make adjustments in tube feeding amounts or IV fluid rate - If applicable, please click the checkbox.

Nursing Score – This field is display only. It's a calculation based on the entries made on the form in the Nursing section.

Total Technology and Nursing Score – This field is display only. It's a calculation based on the calculated totals of the Technology and Nursing sections.

The assessment is ready for submission, no additional forms needed. – If selected, the 'Submit button will display. When the button is hit, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, all forms entered for this assessment will be submitted. Either this option or the following option is required.

Additional forms are needed to complete this assessment. – If selected a set of buttons will display representing each of the assessment forms for selection. Once a button for another form is clicked, the current form will be edited and error messages displayed (if appropriate). Once the errors have been cleared, you will be routed to the selected form. Either this option or the previous option is required.

Additional Forms Available:
- UAI – Part A
- UAI – Part B
- DMAS-95 MI/MR/RC
- DMAS-95 MI/MR/SUPL
- DMAS-96
- DMAS-97

Navigation Buttons

Save - this will save any data entered. The user will be given the option to save and continue the form entry or save and come back in later and recall the assessment from the Assessment Tracking Summary via the 'Recall' link.

Please note that completing one form and progressing to another does an auto-save to ensure the capture of any data entered.

Submit (if displayed) - will trigger the form edits for the DMAS-96 form and if successful display a submission successful screen or will display error messages that need to be resolved before submission.

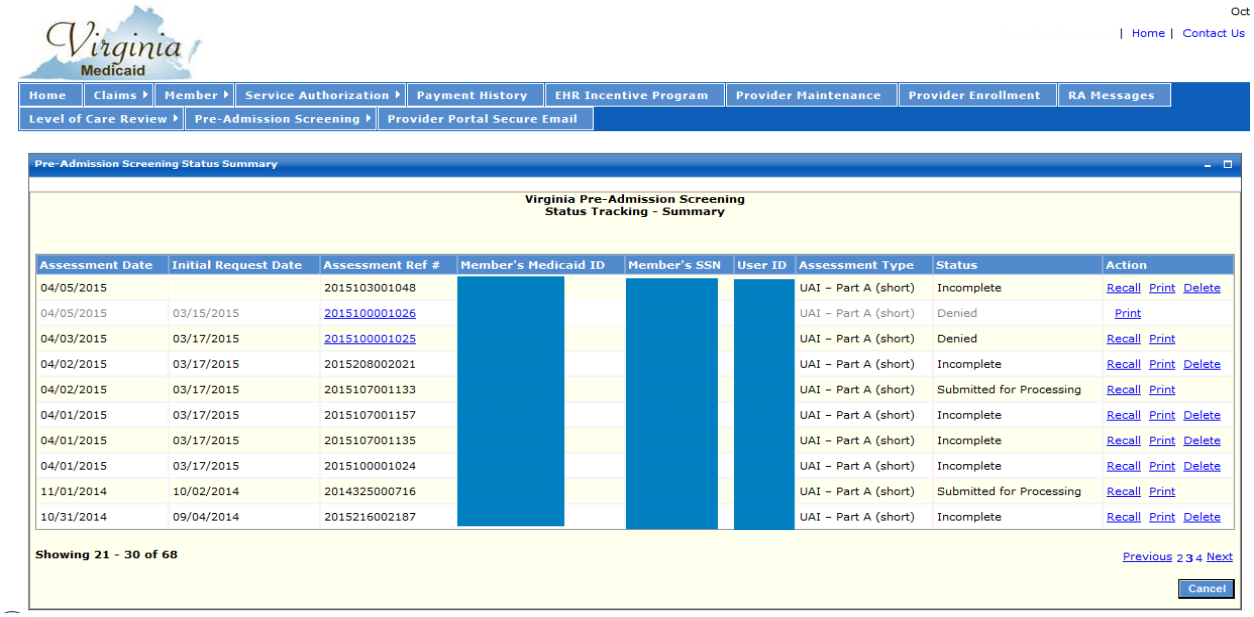
Reset – hitting this button will remove any data entered on the form and set the page back as it appeared upon initial entry. No data entered will be saved.

Cancel – hitting this button will disregard any data entered on the form and navigate the user back to the secured portal screen for a different navigation tab selection. No data entered will be saved.

3.9 Pre-Admission Screening (ePAS) Tracking Summary

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.

Screen sample below:



The Pre-Admission Screening (ePAS) Tracking - Summary is a display screen reflecting all screenings submitted by the authorized user.

From this screen the authorized user can retrieve detail on individual assessments.

The default display/sort order for this screen is the by SSN/assessment date. All columns, with the exception of the Action column, include ascending/descending sort toggles. The user can change the sort order (of all records not just those on the display page) by leveraging this sort toggles.

The following is a list of fields on the screen and their functionality.

Status Tracking - Summary

Assessment Date – This field contains the date the member's assessment was conducted.

Initial Request Date – This field contains the date the member's assessment was initially requested.

Assessment Reference # - This field is the unique number associated with the member's assessment. For any assessment, other than those with the status of 'Submitted for Processing' or 'Incomplete' this field will act as a hyperlink. Clicking on this hyperlink will transfer the user to the detail screen containing the status and/or error messages associated with this assessment.

This is a 13-digit unique reference number assigned to the assessment at the time of entry. The number will be the Julian date of the date submitted, followed by a three digit number to ensure the reference number is unique.

Member's Medicaid ID – This is the member's 12-digit Medicaid ID and will be displayed, if entered, as part of the assessment.

Member's SSN – This is the member's 9-digit social security number and will be displayed if entered as part of the assessment.

User ID – This is the User ID of the person who signed in to the secured portal and submitted the pre-admission screening assessment. The summary and detail associated with assessments can only be viewed by the person who entered them online.

Assessment Type – This field indicates whether the assessment was short form (UAI-A) or long form (UAI-B).

Status – This is the current status of the assessment.

Valid statuses are:
- Incomplete (Saved)
- Submitted for Processing (Submitted)
- Successfully Processed (Approved)
- Denied (Denied)
- Void (Voided)

Action – Links that allow the user to conduct specific functions

Valid Actions are:
- Recall – Gives the user the capability of recalling the assessment in order to update it (if the status is 'Incomplete' or 'Submitted for Processing') or to review or leverage as a template (if the status is 'Successfully Processed' or 'Denied') Note: Once a Denied assessment is recalled it will be greyed out and the 'Recall' link will no longer appear.
- Delete – Lets the user delete assessments that have not been processed

- Print – Lets the user open a pdf version of the data entered on the assessment. This copy will open in a new window for saving to a local drive and/or printing.
  Note: When this link is clicked the user will receive a request pop up screen to print specific forms or all forms. All PDF forms will include the current status of the assessment in the upper right hand corner.

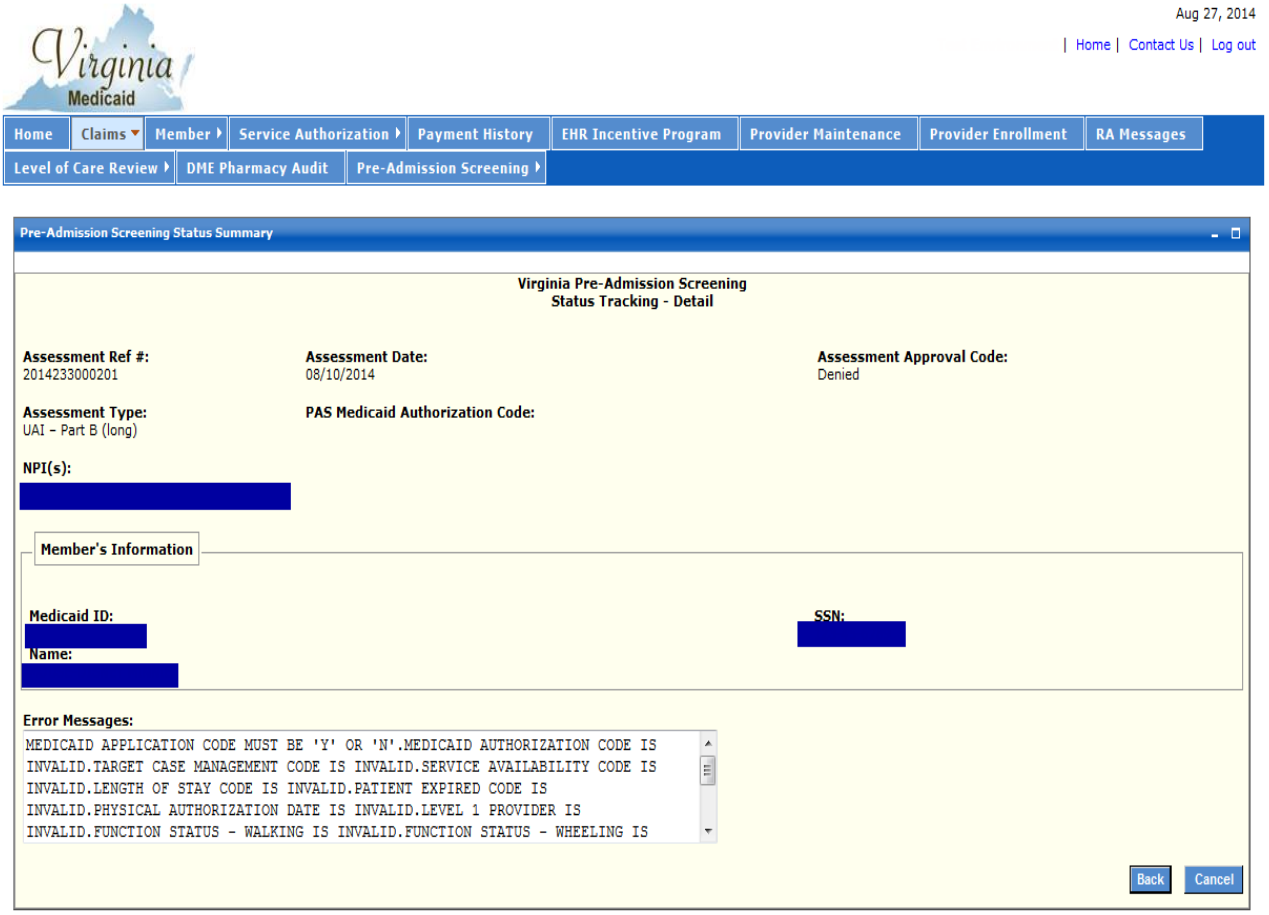
Page Display – Displays the current number of assessments within the total number (i.e. 10 of 40)

Page Navigation – Users can navigate between the pages using the page navigation

3.10 Pre-Admission Screening (ePAS) Tracking Detail

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.

Screen sample below:



The Pre-Admission Screening (ePAS) Tracking - Detail is a display screen reflecting all detail associated with the selected screening from the Pre-Admission Screening (ePAS) Tracking - Summary.

From this screen the user can review the status of the assessment and any error messages that might be associated.

The following is a list of fields on the screen and their functionality.

Status Tracking - Detail

Assessment Reference # - This is a 13-digit unique reference number assigned to the assessment at the time of entry. The number will be the Julian date of the date submitted, followed by a three digit number to ensure the reference number is unique.

Assessment Date – This field contains the date the member's assessment was conducted.

Status – This is the current status of the assessment.

Valid statuses are:

- Successfully Processed (Approved)
- Denied (Denied)
- Void (Voided)

Assessment Type – This field indicates whether the assessment was short form (UAI-A) or long form (UAI-B).

PAS Medicaid Authorization Code
00 – None
01 – Nursing Facility
02 – PACE/LTCPHP
04 – EDCD
08 – Other Service Recommended
09 – Active Treatment for MI/MR Condition
11 – Adult Care Residential Living
12 – Adult Care Regular Assisted Living
15 – Technology Assisted Waiver
16 – Alzheimer's Waiver

NPI(s) – This is the 10-digit number associated with the provider. Up to three different NPIs can be displayed based on what was entered on the assessments.

Member's Medicaid ID – This is the member's 12-digit Medicaid ID, if it was submitted as part of the assessment.

Member's SSN – This is the member's 9-digit social security number.

Last Name – This field will display the member's last name – up to 19 characters.

First Name – This field will display the member's first name – up to 12 characters.

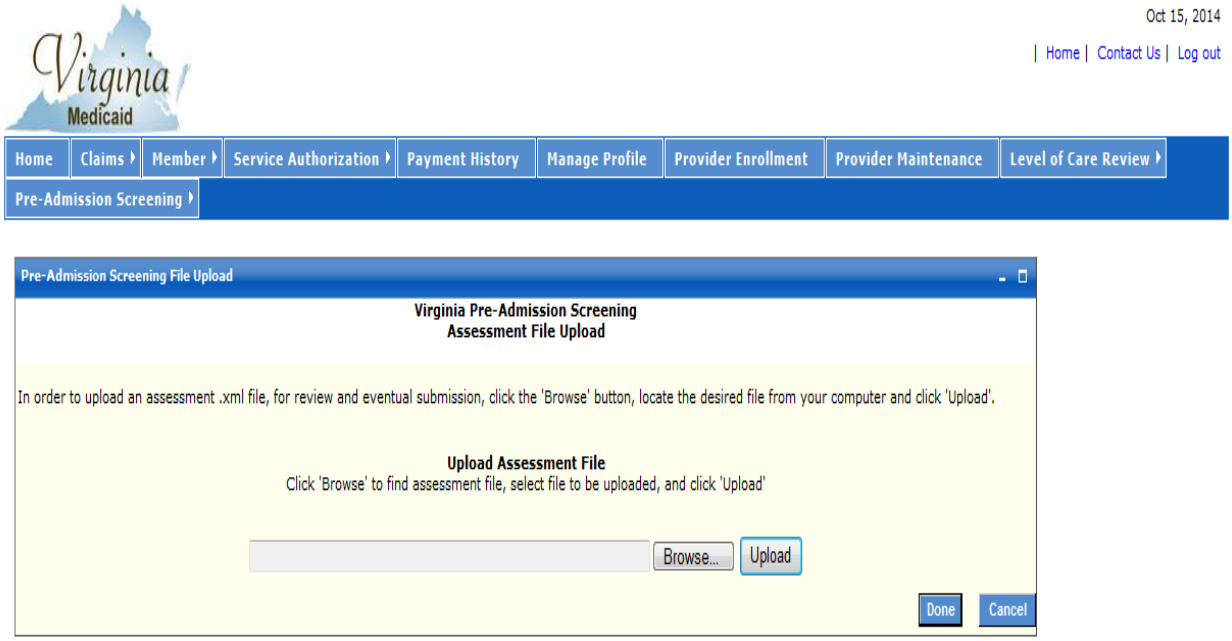
Error Messages – This section will contain any error messages associated with the submitted assessment. The authorized user will have review the message, recall the denied assessment to create a copy, make the correction online and save the correction for resubmission.

Message scrolling – Authorized users should check to ensure that all error messages are viewed by use of the scrolling functionality that will display any additional error messages that may not appear on the screen.

3.11 Assessment File Upload

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.

Screen sample below:



Providers are able to upload a single assessment file in xml format to be loaded into the assessment screens. From there they can be reviewed, modified and ultimately submitted.

Users can also upload offline forms (See 3.14 Offline Forms) to the assessment screens from this same screen. From there they can be reviewed, modified and ultimately submitted.

Important: When completing any of the DMAS forms offline, once the data is uploaded to ePAS, the remainder of the form MUST be completed online to avoid duplicate data entry. To the extent feasible, the best practice for working offline is to complete as much of the DMAS form(s) as possible prior to uploading the data to ePAS. The remainder of the data may be entered online by the appropriate LDSS or LHD staff to complete the PAS process.

To upload the file the user will click the 'Browser' button and locate the desired file on their personal hard drive. Once located, click the 'Upload' button to upload the file to the portal's databases. By uploading the file to

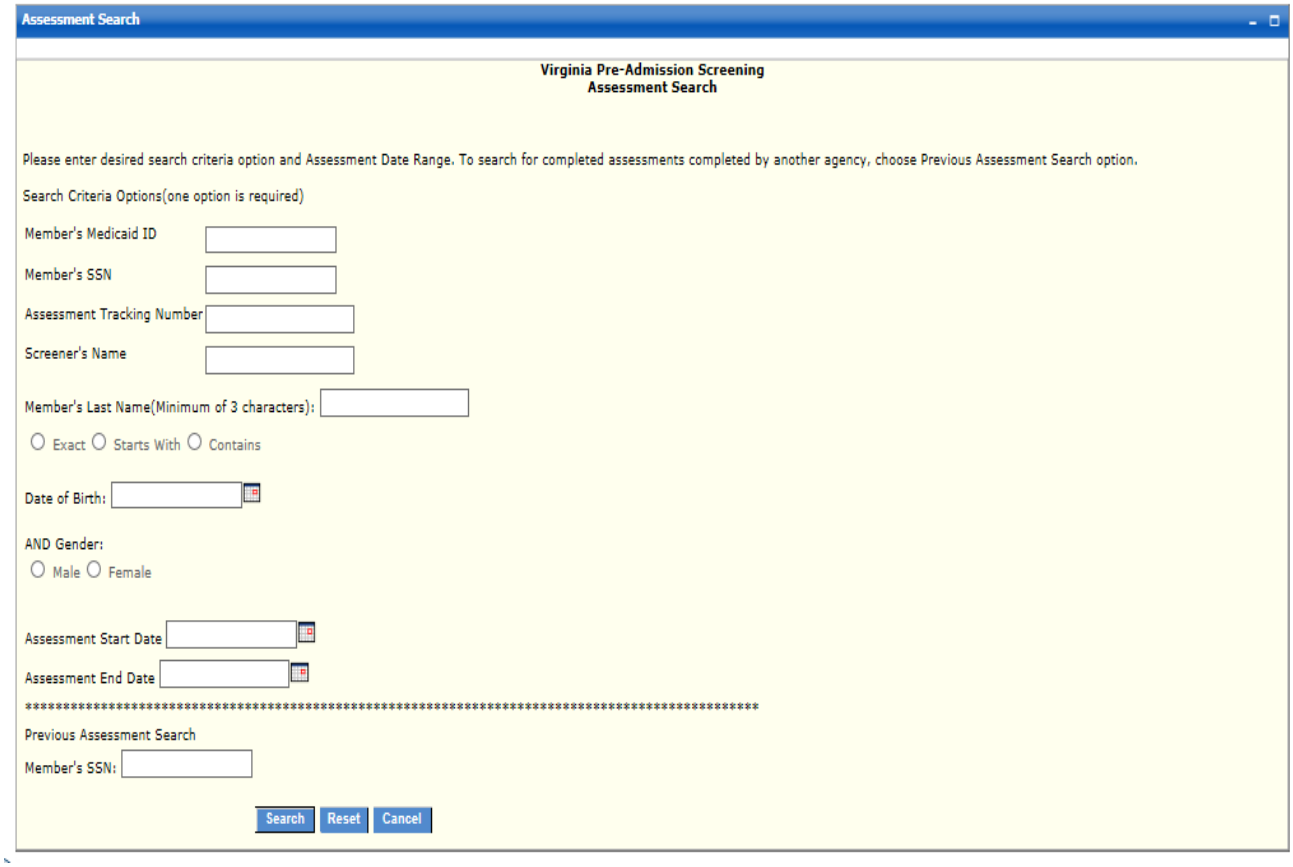
the portal's databases, the authorized user should make future additions or change on-line directly into ePAS by recalling the assessment. Do not attempt to upload new information from an offline form into the uploaded assessment as the data will be uploaded in its entirety as a new assessment.

Once the upload is complete, the user will be able to **recall** the assessment from the Assessment Tracking Screen, where it will be in an 'Incomplete' status.

Recalling the assessment will let the user review and modify the assessment, save and or submit the assessment.

3.12 Assessment Search

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.



The Pre-Admission Screening Assessment Search screen contains two separate functional areas. The top section will be used to enter the assessment search criteria and corresponding assessment dates.

The Assessment Search enables the user to enter search criteria in order to retrieve assessments that are in process or were previously submitted (including both approved and denied assessments).

The following is a list of fields on the screen and their functionality.

Assessment Search - Criteria

Member's Medicaid ID - This is the member's 12-digit ID number. One of the search criteria (Medicaid ID, SSN, Assessment Tracking Number, Screener's Name, Member's Last Name or Member's DOB/Gender) OR an entry in the Previous Search Assessment section is required.

Member's SSN – This is the member's 9-digit social security number. One of the search criteria (Medicaid ID, SSN, Assessment Tracking Number, Screener's Name, Member's Last Name or Member's DOB/Gender) OR an entry in the Previous Search Assessment section is required.

Assessment Tracking Number – This is the 13-digit unique reference number associated with the assessment. One of the search criteria (Medicaid ID, SSN, Assessment Tracking Number, Screener's Name, Member's Last Name or Member's DOB/Gender) OR an entry in the Previous Search Assessment section is required.

Screener's Name – This field will be used to find an exact match between the entered name and one of the following screener's names:

- DMAS96 – Level 1 Screener 1
- DMAS96 – Level 1 Screener 2 (if applicable)
- DMAS96 – Level II Screener 1 (if applicable)

One of the search criteria (Medicaid ID, SSN, Assessment Tracking Number, Screener's Name, Member's Last Name or Member's DOB/Gender) OR an entry in the Previous Search Assessment section is required.

Member's Last Name Search – This is a search field that will be used to search against the last name of a member. The user has the option for an exact match (default), starts with or contains search. A minimum of 3 characters is required but the more data supplied the more timely the search and more finite the search results. One of the search criteria (Medicaid ID, SSN, Assessment Tracking Number, Screener's Name, Member's Last Name or Member's DOB/Gender) OR an entry in the Previous Search Assessment section is required.

Member's Date of Birth and Gender – This is a combination search leveraging the member's date of birth (in the format MM/DD/YYYY or via the calendar widget) **and** member's gender (via the male or female radio buttons). One of the search criteria (Medicaid ID, SSN, Assessment Tracking Number, Screener's Name, Member's Last Name or Member's DOB/Gender) OR an entry in the Previous Search Assessment section is required.

Assessment Start Date – This is the beginning date of the range of pre-admission screening assessment(s) the user is looking to retrieve. The date must be in the format MM/DD/YYYY. This field is required and is used to limit the search results.

Assessment End Date – This is the end date of the range of pre-admission screening assessment(s) submitted in the format MM/DD/YYYY. This field is required. This field can be the same as the Assessment Start Date if only one assessment date is needed. The difference between the Assessment Start and End Dates cannot be more than 31 days.

Enter the required fields for the desired assessment(s). Once entered, click 'Search' to obtain results.

Results will display in the existing Assessment Search Results screen.

Previous Assessment Search

The bottom section will be used to enter a member's SSN for searching assessments from within the Medicaid Management Information System (MMIS). This section will search all approved/denied assessments in the MMIS regardless of the user's associated NPI.

One of the search criteria (Medicaid ID, SSN, Assessment Tracking Number, Screener's Name, Member's Last Name or Member's DOB/Gender) OR an entry in the Previous Search Assessment section is required.

For searching for a previous assessment the following is required:

Member's SSN – This is the member's 9-digit social security number.

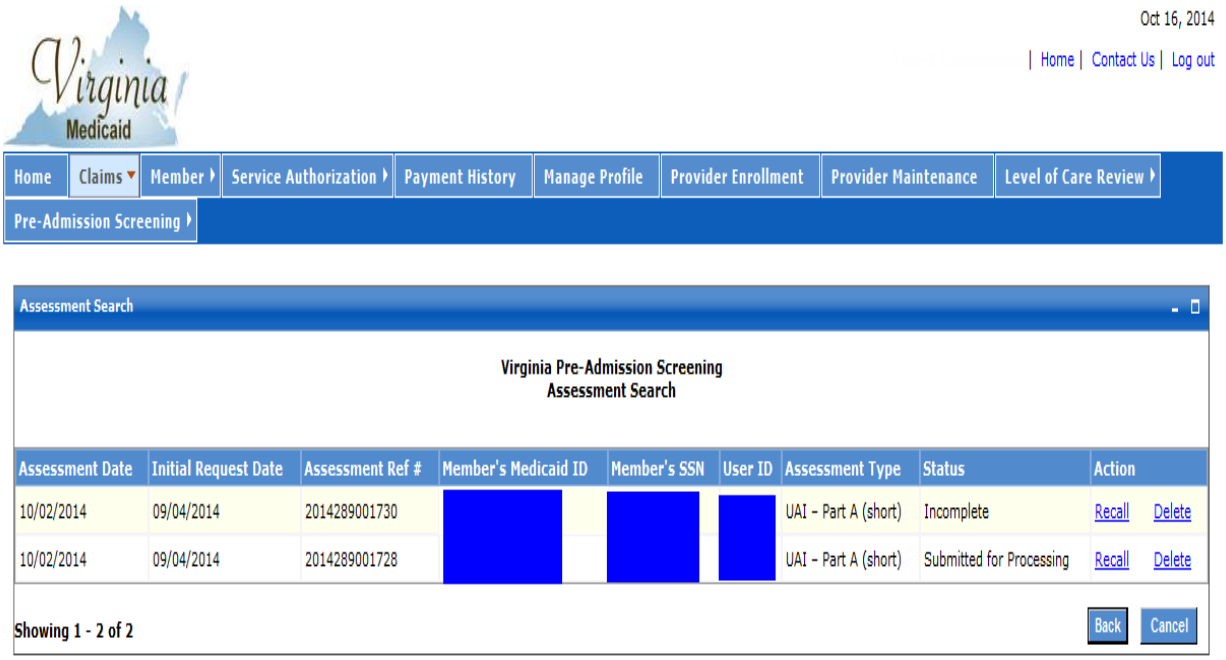
The search results will display an approved assessment or if no approved assessment was found, will display the most current assessment found.

Results will display in the new Previous Assessment Search Results screen.

3.13 Assessment Search Results

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.

Screen sample below:



The Pre-Admission Screening (ePAS) Assessment Search - Results is a display screen reflecting all screenings submitted by the user that meet the previously entered search criteria.

The following is a list of fields on the screen and their functionality.

Assessment Search - Results

Assessment Date – This field contains the date the member's assessment was conducted.

Initial Request Date – This field contains the date the member's assessment was initially requested.

Assessment Reference # - This is a 13-digit unique reference number assigned to the assessment at the time of entry. The number will be the Julian date of the date submitted, followed by two zeros and a three digit number to ensure the reference number is unique.

Member's Medicaid ID – This is the member's 12-digit Medicaid ID and will be displayed, if entered, as part of the assessment.

Member's SSN – This is the member's 9-digit social security number and will be displayed if entered as part of the assessment.

User ID – This is the User ID of the person who signed in to the secured portal and submitted the pre-admission screening assessment. The summary and detail associated with assessments can only be viewed by the person who entered them online.

Assessment Type – This field indicates whether the assessment was short form (UAI-A) or long form (UAI-B).

Status – This is the current status of the assessment.

Valid statuses are:
- Incomplete (Saved)
- Submitted for Processing (Submitted)
- Successfully Processed (Approved)
- Denied (Denied)
- Void (Voided)

Action – Links that allow the user to conduct specific functions

Valid Actions are:
- Recall – Gives the user the capability of recalling the assessment in order to update it (if the status is 'Incomplete' or 'Submitted for Processing') or to review or leverage as a template (if the status is 'Successfully Processed' or 'Denied')
- Delete – Lets the user delete assessments that have not been processed
- Print – Lets the user open a pdf version of the data entered on the assessment. This copy will open in a new window for saving to a local drive and/or printing. Note: Print capability is available only on assessments that have been submitted. Incomplete assessments will not reflect the 'Print' link.

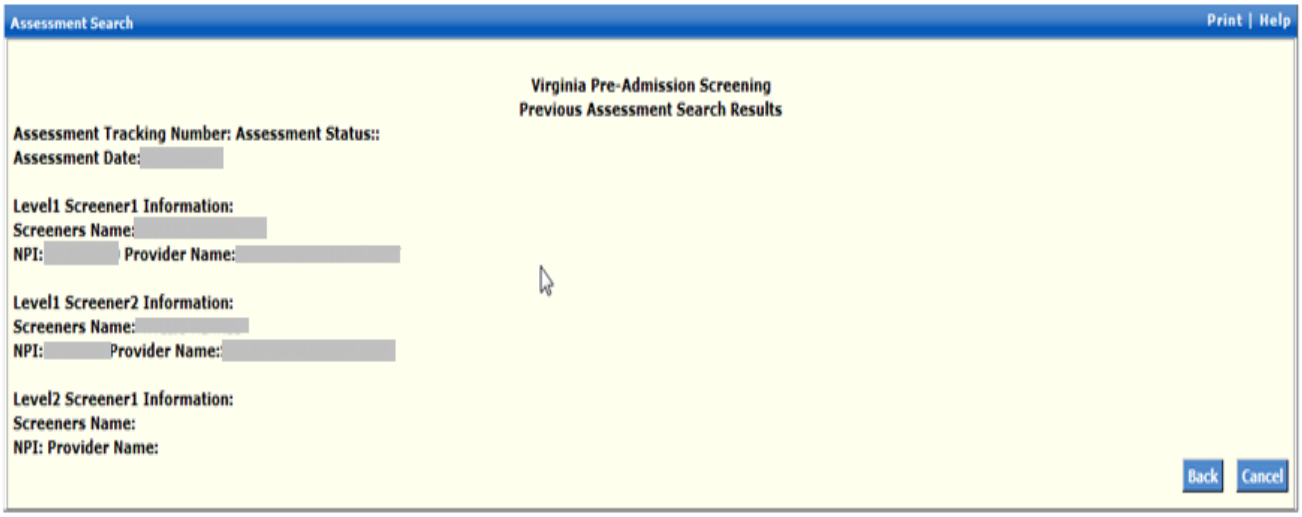
Page Display – Displays the current number of assessments within the total number (i.e. 10 of 40)

Page Navigation – Users can navigate between the pages using the page navigation

3.14 Previous Assessment Search Results

Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.

Screen sample below:



On the Assessment Search screen, if the user enters information in the bottom section for Previous Assessment Search and clicks 'Submit' the screen edits will apply.

The previous assessment search is not limited to just the user's organization. The SSN search will look for any assessments, in date order, current to oldest. If an assessment is found, the following information will display:

Assessment Tracking Number: The unique reference number assigned to the assessment. Note: Because the source of the assessment could be other than ePAS this number may not be in the ePAS format but can still be used for reference purposes if needed.

Status: The status associated with the assessment information being displayed. If an approved assessment is found, it will be displayed even if there is a more current denied or incomplete status. If no approved assessment is found then the most current assessment found will be displayed.

The following is a list of valid possible status indications:

- Successfully Processed/Approved

- Denied
- Void
- Submitted
- Incomplete

If no assessment was found, then a message will display indicating such.

Assessment Date: The date of the assessment in the format MM/DD/YYYY.

Level 1 Screener 1

- **Screener's Name** – The first and last name of the level 1 screener 1 on the DMAS96

- **NPI** – The 10 digit NPI associated with the level 1 screener 1 on the DMAS96

- **Provider's Name** – The name assigned to the NPI entered. Note: this is not entered on the DMAS96, it is informational only based on the NPI.

Level 1 Screener 2 (if applicable to the assessment)

- **Screener's Name** – The first and last name of the level 1 screener 2 on the DMAS96

- **NPI** – The 10 digit NPI associated with the level 1 screener 2 on the DMAS96

- **Provider's Name** – The name assigned to the NPI entered. Note: this is not entered on the DMAS96, it is informational only based on the NPI.

Level 2 Screener 1 (if applicable to the assessment)

- **Screener's Name** – The first and last name of the level 2 screener 1 on the DMAS96

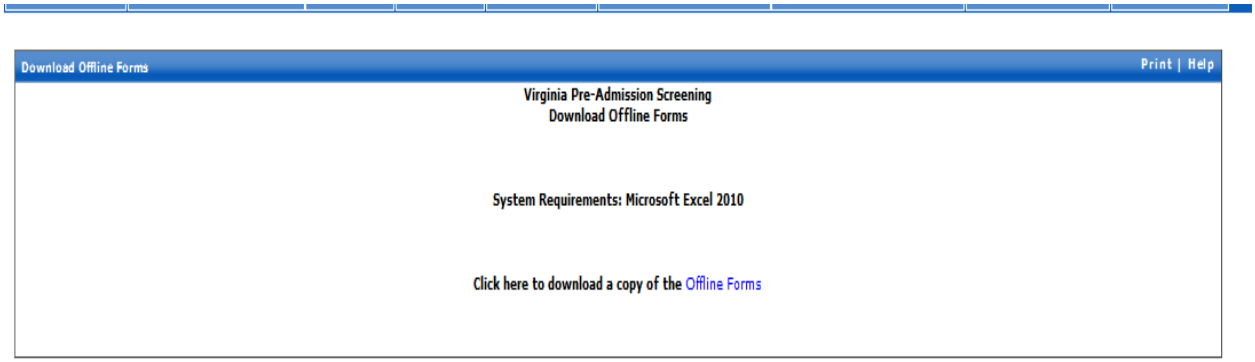
- **NPI** – The 10 digit NPI associated with the level 2 screener 1 on the DMAS96

- **Provider's Name** – The name assigned to the NPI entered. Note: this is not entered on the DMAS96, it is informational only based on the NPI.

3.15 Download Offline Forms

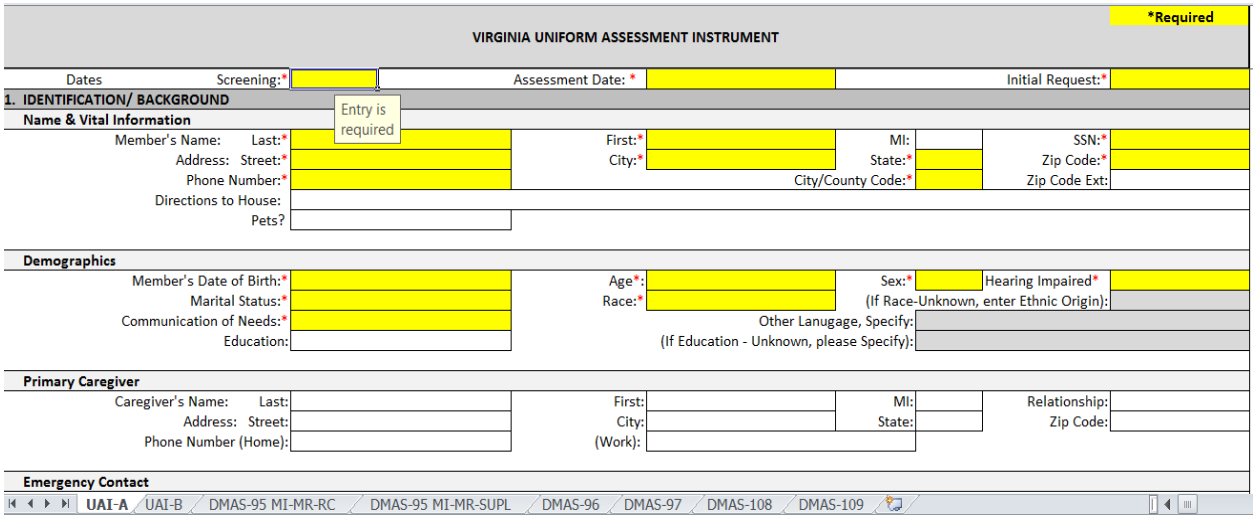
Please Note: If the system is inactive for 30 minutes, the user will be logged off and all data will be lost and require re-entry. Please ensure that you save data before periods of inactivity.

Screen sample below:



Clicking on the 'Offline Forms' link will open the UAI Offline Forms in a new window for saving and using as template.

Sample below (Required cells are highlighted in yellow)



The user can complete as many forms as needed to complete the assessment and save each form for later upload via the Assessment File Upload screen. (See section 3.11 Assessment File Upload). However, once a PAS form is uploaded, additional information and changes should be made online directly into ePAS to ensure completeness of data.

Appendix A – Glossary of Terms

Term	Definition
ADL	Activities of Daily Living
API	Atypical Provider Identifier – assigned by the Commonwealth of Virginia for providers that are not eligible for an NPI (i.e. transportation providers)
Assessment	The combination of all completed forms required by the PAS Provider Manual for a member's pre-admission screening
Assessment Reference #	The 13 digit unique reference number assigned to the assessment at the time of entry. The number will be the Julian date of the date submitted, followed a three digit number to ensure the reference number is unique.
Authorized User	The staff that is responsible for performing provider support functions
CBC	Community-Based Care
CSB	Community Services Board
DMAS	Department of Medical Assistance Services
DBHDS	Department of Behavioral Health and Developmental Services
DOB	Date of Birth
EDCD	Elderly or Disabled with Consumer Direction
ePAS	Electronic Pre-admission Screening Process
IADLs	Instrumental Activities of Daily Living scale
ID	Intellectual Disability
ID#	Identification Number
LDSS	Local Department of Social Services
LHD	Local Health District
MH/MRA	Mental Health/Mental Retardation Assessor
MI/MR/RC	Mental Illness/Mental Retardation/Related Condition
MI/MR/SUPL	Mental Illness/Mental Retardation/Supplemental
MM/DD/CCYY MM/DD/YYYY	MM = Month (i.e. 01 – 12) DD = Day (i.e. 01 – 31) CCYY or YYYY = Year including century (i.e. 2013)
Navigational Tabs	Tabs on a portal page that will take the user to other sections in the portal or bring up documents.
NF	Nursing Facility
NPI	National Provider Identifier
Organization	The person/people who can also establish the

Administrator (OrgAdmin)	Authorized User role and can reset the passwords, activate and deactivate users and lock and unlock user IDs for Authorized Users.
OT	Occupational Therapy
PACE	Program of All-Inclusive Care for the Elderly
PAS	Pre-Admission Screening
PERS	Personal Emergency Response System
Portlets	Sections or 'boxes' that comprise a web portal page
Primary Account Holder	The person who will perform the initial web registration and will establish the security needed to allow the access to secured provider functionality
PT	Physical Therapy Physiotherapy (chest)
QMHP	Qualified Mental Health Professional
ROM	Range of Motion
SSN	Social Security Number
UAI	Uniform Assessment Instrument
User	Any person that will access the Web Portal and leverage the functionality within it

Appendix B – Pre-Admission Screening (ePAS) FAQ

Pre-Admission Screening (PAS)
Virginia Medicaid Web Portal
Frequently Asked Questions
Revised 11/20/2015

General Questions

How do I access the new Virginia Medicaid Web Portal?

The new Virginia Medicaid Web Portal can be accessed through the following link:
www.virginiamedicaid.dmas.virginia.gov

All Pre-Admission Screening Forms

The only Pre-Admission Screening form selection I see is UAI Part A. How do I get to the other forms?

All the pre-admission screening reports are available upon completion of the UAI Part A. Since this is necessary for all pre-admission screenings, it's the initial entry. After completing Part A, you'll have the option to submit, if UAI Part A is all that's needed, continue with the long form (UAI Part B), or choose from any for the following supplemental forms:

- DMAS95 – MI/MR/RC Form
- DMAS95 – MI/MR/SUPL Form
- DMAS96 – Medicaid Funded Long Term Care Service Authorization Form
- DMAS97 – Individual Choice – Institutional Care or Waiver Services Form
- Public Pay Short Form
- Reassessment Form

All forms must be completed in their entirely in order to submit a completed pre-admission screening assessment. The required forms vary based upon the service that is being authorized.

How do I know what fields I'm required to enter?

All required fields have a red asterisk (*) immediately following the field label. If there is no asterisk the field is optional or situationally required. An entry should be made if an optional/situationally required field is applicable to the individual the assessment is being completed for.

I entered information in an optional field and another field opened up with required information indicated. Why do I need to complete this information when the original entry was optional?

In some instances, if optional information is entered, it triggers the need for additional information to detail and/or clarify the entry. If the secondary set of information is required, it will also contain the red asterisk indication.

I'm not sure what exactly is being asked for in an entry. Are there any instructions available to assist with this?

All forms have a link at the top that will open a full set instructions for that form in a new window.

In addition, immediately following the field label you may see an information icon that looks like this -  . By clicking on this icon, a new window will open displaying the instructions associated with this form beginning with the field in question.

I've entered information in a field and submitted (or requested another form). There are now red messages on the top of the page and under some of the fields. What do these indicate?

Based on the information required and entered, error messages may be displayed. An error message will appear both at the top of the page as well as under the field in error.

You will need to make the appropriate adjustment/entry and resubmit (or request the additional form needed) in order to continue processing the form. The error messages are intended to serve as a "safeguard" to prevent submission of data and rejection of the data entry at a later point in time.

I have a specific question regarding an individual I'm assessing and it's not answered in the instructions or the User Guide, is there someone I can contact for additional information?

Yes. If you weren't able to find the answer to your question, please refer to the DMAS Preadmission Screening Provider Manual, also on the DMAS Provider Portal in the Provider Resource Section or UAI training on the DMAS website Learning Network.

I've completed the UAI – Part A form but the 'Submit' button is disabled. How do I submit this form?

If the 'Submit' button is disabled, it's an indication that you've either not selected an option of whether to submit or continue to another form, or you've selected an option to go to a subsequent form. If you've chosen an option to complete another form you will be taken to that form for entry. Once completed, you'll be asked the question again if you're ready to submit or need another form. When you're ready to submit, the 'Submit' button will be enabled.

I'm not sure I'll be able to complete this entire form at this time. Can I partially enter the form now and complete the rest later?

Yes, on the bottom of each form there is a 'Save' button. Clicking this will save any data entered. You will be given the option to save and continue the form entry or save and come back in later and recall the assessment from the Assessment Tracking Summary via the 'Recall' link.

Please note that completing one form and progressing to another does an auto-save to ensure the capture of any data entered prior to moving to the next form. The auto-save function is only valid when the user moves from form to form within the pre-admission screening.

As stated previously, please note that if the system is inactive for 30 minutes, you will be logged off and all data entered will be lost and require re-entry. Please ensure that you save data before periods of inactivity. This is different from the auto-save between completed forms.

If I need to reference this form when discussing a completed form, is there a way to distinguish this particular submission?

Yes, on the submission successful page there is a 'Form ID' number. This number is unique within the system and is used to identify each assessment initiated for pre-admission screening using ePAS. The "Form ID" can be used for research/reference purposes. If not previously submitted, the assessment can be updated and submitted using the ePAS generated Form ID Number. If previously submitted, the assessment can be saved as a new assessment, updated and submitted, generating a new Form ID Number.

I have a member that requires an assessment that does not have a social security number. This is a required field, what should I enter?

If the member does not have a social security number, the system will accept a pseudo SSN of 000MMDDYY where MMDDYY is the member's date of birth.

I've successfully completed my online assessment. Do I still need to mail or fax in a copy of the form with my signature?

No, by completing the attestation /signature section of Pre-Admission Screening forms, it's considered your official signature attesting that all the information entered is accurate and correct.

DMAS95 – MI/MR/RC

How do I determine whether the member meets the nursing facility criteria?

The nursing facility criteria determination is described in the Virginia Medicaid Pre-Admission Screening Provider Manual, Appendix B.

This form only applies to nursing facility admissions.

If the member meets the determination criteria and plans are to admit the member to a nursing facility, this form (DMAS95/MI/MR/SA – Level I) needs to be completed as part of the screening process.

If the member does NOT meet nursing facility criteria, do not complete Level 1 screening (DMAS95 MI/MR/SA) and do not refer for a secondary assessment. If the criteria are not met, the individual cannot be admitted to Long-Term Care Services.

How do I determine the diagnosis of serious mental illness?

If the answers to questions 2a, b and c are all 'yes' then indicate that the member has a MI diagnosis. Otherwise the member cannot be referred for Level II for MI.

How do I determine the diagnosis of intellectual disability?

If the member has a level of retardation or disability (mild, moderate, severe, or profound) as described in the American Association on Mental Retardation's Manual on Classification In Mental Retardation (1983) that was manifested before age 18, then indicate a diagnosis of ID.

How do I make the determination of related conditions?

If answers to questions 4 a –d are all 'yes' then the member has a determination of related conditions. Otherwise the member cannot be referred for Level II PAS for related conditions

DMAS95 – MI/MR/SUPL

Do I need to complete this form for a member I'm referring for Level I services?

Based upon the outcome of the Level I screening for MI/ID/RC, the completion of the DMAS-95 MI/MR Supplement will be determined. If the member is identified has having a mental illness, intellectual disability, or related condition during the Level I screening process, a referral for the completion of the Level II screening must be made.

I'm a member of the Community Services Board, which section should I complete?

Section B is to be completed by the Department of Behavioral Health and Developmental Services (DBHDS) contractor or other entity under contract for Level II evaluation process. Community Services Boards (CSB) are only permitted to complete assisted living assessments and annual reassessments. This process has not changed with the implementation of the ePAS system.

I work for the Department of Mental Health, Mental Retardation and Substance Abuse Services, which section should I complete?

Section C is to be completed only by the Department of Behavioral Health and Developmental Services.

DMAS96 – Medicaid Funded LTC SA Form

The member is currently not Medicaid eligible but can authorization for long term care still be made?

If a member has applied for Medicaid they might be eligible for services if formal application for Medicaid is made when the member or a family member has taken the required financial information to the local Eligibility Department and completed forms needed to apply for the benefits. The authorization for long-term care can be made regardless of whether the individual has been determined Medicaid-eligible, but placement may not be available until the provider is assured of the member's Medicaid status.

Are there exceptions for authorized services?

Yes, the following exceptions are applicable to this form:

- Authorizations for NF, PACE, Tech or the EDCD Waivers are interchangeable.
- Screening updates are not required for individuals to move between the services because the alternate institutional placement is a NF. NF = EDCD, Tech, or PACE.
- Alzheimer's Assisted Living Waiver's alternate institutional placement is a NF; however, the individual must also have a diagnosis of Alzheimer's OR Alzheimer's Related Dementia and meet the nursing facility criteria to qualify. NF = Alzheimer's ALF

As a screener or physician, why do I need to complete the attestation along with my name?

Completion of the attestation check box and entry of your name serves as an electronic signature in completing the assessment.

DMAS97 – Individual Choice – Institutional Care or Waiver Services Form

Do I need to complete this form?

This form needs to be completed when authorizing nursing facility or home- and community-based care services, including the Program All-Inclusive Care for the Elderly (PACE).

Item A OR at least one of the conditions in Item B must be completed if authorizing home- and community-based care services.

Item C must be completed to document the individual's choice of institutional services versus waiver services.

In addition to the electronic completion and submission of the DMAS 97, a paper copy of the DMAS 97 – Individual Choice - Institutional or Waiver Services form with the individual's signature must be retained in the individual's record by the screening entity

The member meets the community-based care criteria and has chosen home care services. What section do I need to complete to indicate this?

Section II must be completed in its entirety if community-based care criteria are met, and the individual chooses home- and community-based care services.

I completed Section II do I need to also complete Section III?

Section III must be completed in its entirety regardless of whether institutional care or home- and community-based care is chosen by the individual. Please be sure that each item is discussed with the individual

What is the 'At Risk' definition?

For waiver services authorization – individuals must also meet the 'at risk' definition in order to receive services. At risk is defined according to 42 CFR 441.302 (I): "….when there is a reasonable indication that a individual might need the services in the near future (that is, a month or less) unless he or she receives home and community based services."

Pre-Admission Screening (ePAS) Tracking - Summary

How do I see the status of my assessments?

Once an assessment is submitted, it can be monitored from the Pre-Admission Screening (ePAS) Tracking – Summary screen.

This screen will display all the assessments entered online by the user. When first submitted the assessment can be viewed on this screen with a status of 'Submitted for Processing'.

After the assessment has been processed, the updated status can also be viewed for both approved, denied and voided assessments.

From this screen, the user can link to the Pre-Admission Screening (ePAS) Tracking – Detail screen to view the detail for a specific assessment.

How do I see the detail associated with one of my assessments?

From the summary screen you can link to the Pre-Admission Screening (ePAS) Tracking – Detail. For all processed status (all statuses except 'Submitted for Processing') the Assessment Reference # will be a hyperlink. Clicking on the hyperlink will navigate you to the detail.

Pre-Admission Screening Tracking - Detail

My assessment was processed and denied. How can I tell why?

Once an assessment is submitted, it can be monitored from the Pre-Admission Screening Tracking – Summary screen. If the status of the assessment is 'Denied', you can click on the Assessment Reference # hyperlink to navigate to the detail for this assessment.

Any error messages associated with the assessment can be viewed within the Error Messages scroll box.

Pre-Admission Screening (ePAS) File Upload

I have an assessment in the xml format. Can I submit it or do I need to enter all the data in the individual screens?

If the user has assessments established in the xml format, it can be uploaded to the portal. Once uploaded, the user can recall the assessment and review via the appropriate screens. Once the review is complete, updates made, etc., then the assessment can be submitted for processing.

Note: Assessment means the combination of all completed forms required by the PAS Provider Manual. (See Glossary in Appendix A.)

I have an assessment created in the offline forms. How do upload these now that I'm online.

If the user has assessments established in the offline format, it can be uploaded to the portal via the File Upload Screen. Once uploaded, the user can recall the assessment and review via the appropriate screens. Once the review is complete, updates made **online**, etc., then the assessment can be submitted for processing.

Note: Assessment means the combination of all completed forms required by the PAS Provider Manual. (See Glossary in Appendix A.)

I have an assessment created in the offline forms and uploaded it to the portal. Can I upload additional offline information?

Once an assessment is uploaded, any additional information needed has to be added via the online portal screens. Additional uploads of offline forms will not add to a previous uploaded form though can be uploaded as a new assessment and the previous one (assuming still in an incomplete status) can be deleted.

Pre-Admission Screening (e-PAS) Assessment Search

I have a lot of assessments on my Assessment Tracking Summary screen. Is there an easier way to find an assessment?

By using the Assessment Search option, the user can enter criteria to search for a specific member's assessment. Either the member's Medicaid ID or SSN is required in addition to the assessment date. Results can be further limited by the assessment type.

After submission all assessments that meet the user's criteria are displayed.

I have an assessment that I submitted previously for a member. Is there a way I can use it as a template to create an updated version?

By using the Assessment Search option, the user can find an existing assessment. Leveraging the 'Recall' link on the assessment result line, the assessment can be opened, modified and saved or submitted. The assessment will be assigned a new assessment reference number.

Download Offline Forms

I need to conduct screenings and won't have access to the internet. Is there a way I can complete assessments offline?

By using the Download Offline Forms screen, you can download a complete set of assessments in Excel format. An assessment can be completed for each member being screened. Once the user is online, the completed forms can be uploaded via the File Upload Screen, reviewed within the assessment portal screens and submitted for processing.

Note: Once an assessment is uploaded, any additional information needed has to be added via the online portal screens. Additional uploads of offline forms will not add to a previous uploaded form though can be uploaded as a new assessment and the previous one (assuming still in an incomplete status) can be deleted.