PCI Screen 2.0

I. Participant, Representative, & Decision Support Information

I.A. Participant Information

1. Participant's name

_____

2. Participant's Medicaid number

_____

3. Participant's date of birth

_____/_____/_____

4. Participant's age

5. Participant's primary phone number

_____

6. Participant's secondary phone number

_____

7. Participant's email address

_____

8. Gender

- ☐ Male
- ☐ Female

9. Current health care coverage

- ☐ Medicaid
- ☐ Medicare
- ☐ Self or family pays for full cost
- ☐ Medicare with Medicaid co-payment
- ☐ VA
- ☐ Private insurance
- ☐ IHS
- ☐ Other
- ☐ None

10. Participant household size

11. Participant's approximate total monthly income

$

12. Participant's approximate total assets

$

13. Participant is likely eligible for Medicaid based on income and assets

- ☐ No
- ☐ Yes

14. Participant is likely eligible for Long Term Care (LTC) Medicaid based on income and assets

- ☐ No
- ☐ Yes

15. Is the participant homeless?

- ☐ No
- ☐ Yes

16. Home address

_____

17. City

_____

18. State

_____

19. Zip code

_____

20. Is participant's current residence a facility or assisted living home?

- ☐ No
- ☐ Yes

21. Name of facility

_____

22. Mailing address (if different than home address)

_____

23. City

_____

24. State

_____

25. Zip code

_____

26. Select the client's current living arrangement.

- [ ] Alone
- [ ] With spouse/partner only
- [ ] With spouse/partner and other(s)
- [ ] With child (not spouse/partner)
- [ ] With parent(s) or guardian(s)
- [ ] With sibling(s)
- [ ] With other relative(s)
- [ ] With nonrelative(s)

27. Are there any safety concerns about the current living arrangement?

- [ ] No
- [ ] Yes

27a. Describe the safety concerns

28. Marital status

- [ ] Never Married
- [ ] Married
- [ ] Partner / Significant Other
- [ ] Widowed
- [ ] Separated
- [ ] Divorced

29. Participant is an Alaska resident

- [ ] No
- [ ] Yes

30. Ethnicity - Hispanic or Latino

- [ ] No
- [ ] Yes

31. Race

- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White/Caucasian
- [ ] Other

31a. If participant is AK Native or American Indian: Name of primary care provider:

31b. If the participant is AK Native or American Indian: Name of Tribal Health Organization (THO):

32. Participant's primary language

- [ ] English
- [ ] French
- [ ] American Sign Language
- [ ] Hmong
- [ ] Korean
- [ ] Russian
- [ ] Spanish
- [ ] Tagalog
- [ ] Yupik
- [ ] Other

32a. If other was selected, identify language

33. Does the participant need an interpreter?

- [ ] No
- [ ] Yes

34. Is participant a Trust Beneficiary?

- [ ] No
- [ ] Yes

35. Identify Trust Beneficiary type

- [ ] Alzheimer's Disease & Related Dementias (ADRD)
- [ ] Mental illness
- [ ] Developmental disability
- [ ] Chronic alcoholism and other substance abuse disorders
- [ ] Traumatic Brain Injury (TBI)

36. Participant is a US Veteran

- [ ] No
- [ ] Yes

37. Participant is interested in learning more about Veteran funded services

- ☐ No, not interested
- ☐ No, already enrolled
- ☐ Yes

I.B. Representative & Decision Support Information

38. Participant has a guardian or other legally authorized representative

- ☐ No
- ☐ Yes

39. Name of Authorized Representative

_____

40. Primary phone number

_____

41. Secondary phone number

_____

42. Email address

_____

_____

_____

_____

43. Mailing address

_____

44. City

_____

45. State

_____

46. Zip code

_____

47. Representative type

- ☐ Parent
- ☐ Power of Attorney
- ☐ Guardian
- ☐ Delegated Parental Authority
- ☐ Representative Payee
- ☐ Conservator
- ☐ Unknown
- ☐ Other

48. Caller informed that representative needs to provide documentation as part of the application

- ☐ No
- ☐ Yes

49. Participant has a decision support who is assisting with completing the PCI

- ☐ No
- ☐ Yes, decision support is not a legally authorized representative (e.g. guardian)
- ☐ Yes, decision support is a legally authorized representative (e.g. guardian)

50. Would the participant like assistance in making decisions about their health and safety during the Assessment and Support Planning process?

- ☐ No
- ☐ Yes

50a. Describe the assistance requested

_____

_____

_____

_____

51. Decision support name

_____

52. Relationship to participant

- ☐ Spouse
- ☐ Parent/Non-guardian
- ☐ Partner/Significant Other
- ☐ Friend
- ☐ Neighbor
- ☐ Independent Advocate
- ☐ Other relative
- ☐ Other informal helper
- ☐ Service/provider agency

II. CCMC Status (Use with Participants <22 years old)

II.A. CCMC Status

1. Is the participant 21 years of age or younger?

- ☐ No
- ☐ Yes

2. Physician or other medical provider has suggested applying for CCMC and/or the participant may have complex medical needs

- ☐ No
- ☐ Yes

2a. Information about item person volunteered

3. Does the participant have a severe and chronic physical condition that would result in long-term care in a facility for more than 30 days per year?

- [ ] No
- [ ] Yes

3a. Information about item person volunteered

4. Participant has a severe and chronic physical condition which results in a prolonged dependency on medical care OR prolonged dependency on technology (de vice or instrument to replace or support a normal bodily function) to maintain health and welfare?

- [ ] No
- [ ] Yes

4a. Information about item person volunteered

5. Does the participant experience acute exacerbations or life-threatening conditions?

- [ ] No
- [ ] Yes

5a. Information about item person volunteered

6. Does the participant need extraordinary supervision and observation beyond what is considered appropriate for age and/or stage of development?

- [ ] No
- [ ] Yes

6a. Information about item person volunteered

7. Does the participant need frequent or life-saving administration of specialized treatments, or dependency on mechanical support devices?

- [ ] No
- [ ] Yes

7a. Information about item person volunteered

III. DD Status

III.A. DD Status

1. Participant potentially experiences DD

- [ ] No
- [ ] Yes

2. Participant has established DD eligibility

- [ ] No, participant has not applied or has applied but not received a response
- [ ] No, participant has previously been denied but would like to reapply
- [ ] No, has previously been denied and should be referred for non-DD services
- [ ] Yes, has established DD eligibility

3. Harmony case number

4. Eligibility approval date

_____/_____/_____

5. Eligibility expiration date

_____/_____/_____

6. Participant has a current DDRR

- [ ] No
- [ ] Yes

7. Is the participant receiving or has the participant received special education to address learning needs through an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) prior to the age of 22 ?

- [ ] No
- [ ] Yes

8. Has the participant received therapy or special instruction to help with speech/language skills or to help them communicate with others?

- [ ] No
- [ ] Yes

9. Has the participant received therapy or special instruction to help them move better?

- [ ] No
- [ ] Yes

10. Has the participant received therapy or special instruction to help them learn to do things like dress or feed themselves, or complete personal hygiene?

- [ ] No
- [ ] Yes

11. Is the participant currently enrolled in an education program?

- [ ] No
- [ ] Yes

12. Has the participant ever received help from a job coach or received services to help find or keep a job?

- [ ] No
- [ ] Yes

13. Is the participant age 15 or younger?

- [ ] No
- [ ] Yes

14. Does the participant have someone who helps them make decisions about their money or where they want to live like a guardian or conservator?

- [ ] No
- [ ] Yes

IV. Exploring Options & Level of Care (LOC) Screen

IV.A. Options & LOC Screen

1. Participant is interested in Medicaid funded HCBS and /or PCS

- [ ] No
- [ ] Yes, already enrolled in Medicaid
- [ ] Yes, need to enroll in Medicaid

2. Participant receives nursing services (e.g., wound care, tube feeding, uncontrolled diabetes) at least one time per week

- [ ] No
- [ ] Yes

3. Participant receives skilled therapies, including physical, occupational, speech, or respiratory, a total of three or more times per week

- [ ] No
- [ ] Yes

4. Challenges with participant's thinking

- [ ] None
- [ ] Orientation - Difficulty knowing time, where he/she is, and why he/she is there
- [ ] Short Term - Problems remembering new information
- [ ] Confusion - Often confused
- [ ] Conversation - Difficulty conversing with others
- [ ] Making needs known - Difficulty making personal needs known

5. Support needs with Activities of Daily Living (ADLs)

5a. Bed mobility- Moving around bed, adjusting position

- [ ] Independent
- [ ] Minimum or Stand-by Assist
- [ ] Hands-on or Total Assist

5b. Transferring- Moving between diffferent surfaces, bed, chair, etc.

- [ ] Independent
- [ ] Minimum or Stand-by Assist
- [ ] Hands-on or Total Assist

5c. Locomotion- Moving around residence

- [ ] Independent
- [ ] Minimum or Stand-by Assist
- [ ] Hands-on or Total Assist

5d. Eating/Drinking

- [ ] Independent
- [ ] Minimum or Stand-by Assist
- [ ] Hands-on or Total Assist

5e. Toileting- Using, transferring, changing

- [ ] Independent
- [ ] Minimum or Stand-by Assist
- [ ] Hands-on or Total Assist

5f. Personal Hygiene- Personal hygiene care

- [ ] Independent
- [ ] Minimum or Stand-by Assist
- [ ] Hands-on or Total Assist

5g. Bathing

- [ ] Independent
- [ ] Minimum or Stand-by Assist
- [ ] Hands-on or Total Assist

5h. Dressing- Getting dressed/undressed

- [ ] Independent
- [ ] Minimum or Stand-by Assist
- [ ] Hands-on or Total Assist

6. Support needs with Instrumental Activities of Daily Living (IADLs)

6a. Light meal preparation

- ☐ Independent
- ☐ Minimum or Stand-by Assist
- ☐ Hands-on or Total Assist

6b. Main meal preparation

- ☐ Independent
- ☐ Minimum or Stand-by Assist
- ☐ Hands-on or Total Assist

6c. Light housework

- ☐ Independent
- ☐ Minimum or Stand-by Assist
- ☐ Hands-on or Total Assist

6d. Routine housework

- ☐ Independent
- ☐ Minimum or Stand-by Assist
- ☐ Hands-on or Total Assist

6e. Laundry

- ☐ Independent
- ☐ Minimum or Standy-by Assist
- ☐ Hands-on or Total Assist

6f. Shopping

- ☐ Independent
- ☐ Minimum or Stand-by Assist
- ☐ Hands-on or Total Assist

V. PCI Indicators

V.A. PCI Indicators

1. Participant may potentially meet NF Level of Care (NF-LOC)

2. Participant may be eligible for DD services - staff should work with the individual to complete DD application and/or connect the individual to the STAR for assistance

V.B. Program Indicators

The participant indicates for the following waivers/next steps if he/she meets the following criteria:

CCMC

CFC

PCS

ALI

APDD - DD Determination necessary to potentially access the Waiver

DD Determination to potentially access ISW/DD Waiver

Veterans Services

VI. PCI Outcomes and Referrals

VI.A. Outcomes and Referrals

1. Recommended services

- ☐ Personal Care Services (PCS)
- ☐ Community First Choice (CFC)
- ☐ Alaskans Living Independently (ALI) Waiver
- ☐ Adults with Physical and Developmental Disability (APDD) Waiver
- ☐ DD Determination to potentially access ISW/DD Waiver
- ☐ Children with Complex Medical Conditions (CCMC)

2. Participant's Medicaid status

- ☐ Enrolled
- ☐ Has submitted an application
- ☐ Will apply
- ☐ Chose not to apply

3. Programs participant would like to pursue

- ☐ Personal Care Services (PCS)
- ☐ Community First Choice (CFC)
- ☐ Alaskans Living Independently (ALI) Waiver
- ☐ Adults with Physical and Developmental Disability (APDD) Waiver
- ☐ Individualized Supports Waiver (ISW)
- ☐ DD Waiver
- ☐ Children with Complex Medical Conditions (CCMC)
- ☐ Non-Medicaid Services

4. Rationale for participant's decision

_____

_____

_____

_____

5. Action steps for pursuing programs

- ☐ Select Care Coordinator
- ☐ Select PCS Agency
- ☐ Refer to STAR for DD eligibility
- ☐ Apply for Medicaid

6. Outcome(s) of contact

- ☐ I&R only
- ☐ Referred to Medicaid program
- ☐ Received Options Counseling
- ☐ Other

7. Benefit options provided

- ☐ Food Stamps
- ☐ Heating Assistance
- ☐ Local Government
- ☐ Medicaid
- ☐ Medicare
- ☐ Mini Grants
- ☐ Nursing Home Transition
- ☐ Public Assistance
- ☐ Senior Benefits
- ☐ Social Security
- ☐ Veterans Services
- ☐ Weatherization
- ☐ Other

8. Resource referrals provided

- ☐ Community Organizations
- ☐ DME
- ☐ Employment
- ☐ Food Program
- ☐ Guardianship
- ☐ Home Modifications
- ☐ Hospice
- ☐ Housing
- ☐ Legal
- ☐ Lifeline
- ☐ Medical Provider
- ☐ Other
- ☐ Private Pay
- ☐ Substance Abuse
- ☐ TABI-ABIN
- ☐ Transportation
- ☐ Tribal

9. Service options provided

- ☐ Adult Day
- ☐ Assisted Living
- ☐ Care Coordination
- ☐ Crisis Services
- ☐ Home Delivered Meals
- ☐ Home Health
- ☐ Independent Living
- ☐ Infant Learning
- ☐ Behavioral Health
- ☐ STAR
- ☐ Other

10. Caller/Participant wants staff to follow up about outcomes and referrals from the PCI

- ☐ No
- ☐ Yes, follow up with caller (if not participant)
- ☐ Yes, follow up with participant

11. Staff should follow up on

_____/_____/_____

12. Summary of contact

_____

_____

_____

_____

13. By responding Yes, participant/caller acknowledges that all of the information provided to staff during the PCI is true and accurate to the best of his/her knowledge

- ☐ No
- ☐ Yes

14. Participant signature

_____

15. Participant received a copy of the PCI/PCI Outcomes and Referrals

- ☐ No, did not request
- ☐ Yes, faxed
- ☐ Yes, mailed
- ☐ Yes, in-person

16. Name of staff conducting the PCI

_____

17. Name of staff agency

_____

18. Staff telephone number

_____

19. Staff email address

_____

20. Status of PCI

- ☐ Complete
- ☐ Incomplete (Document actions to complete in notes)

Title :

Date

Title :

Date