SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMPLEX CARE PROGRAM SUPPEMENTAL ASSESSMENT FORM

Applicant_______________________________Medicaid # ______________________

Name & Title of Staff Completing Form____________________Fax/Email ______________________

2nd Staff Contact Name & Title________________________Fax/Email______________________

Facility Completing Form_______________________Date Completed:______________________

Initial Referral ☐ | Recertification ☐ Requested Recertification dates: To______________From ______________

Applicant currently a hospital/acute care inpatient for 10 consecutive days? ☐Yes ☐ No Inpatient Admission Date:_______

(If acute inpatient less than 10 consecutive days please submit referral when applicant is inpatient 10 consecutive days)

Check Applicants Insurance: Medicaid ☐ Medicare A ☐ Medicare # ______________________

☐ **Complete items below that apply to the applicant. Submit the admit note/H&P, insurance carrier(s) and supportive documents. Email documents to Complexcare@scdhhs.gov**

Category/Treatment	Additional Information	Documents to send with referral
Stage 4 Decubitus/pressure ulcer only	(Attach staging note of stage 4 pressure wound only)	
Tracheostomy	Tube/cannula Tracheal cleaning/aspirations Suction Frequency	(Attach tracheostomy care/suction orders)
Oral Suctioning By respiratory care unit or nursing facility staff	Tracheal aspiration Purpose: Suction Frequency———	(Attach care/suction note if applicable)
Total Parenteral Nutrition **Partial Parenteral Nutrition** Given by IV- Intravenous access only, No Antibiotics	2 weeks or more Expected Duration:_ ———_—— Name of TPN/PPN nutrition therapy & IV Site:	(Attach Medication list/orders for TPN/PPN therapy)
Disruptive Behaviors 60% of the time requiring 1:1 assistance or restraints	List conditions /Behaviors:	(Attach additional information) ☐ PASRR Level II-completed ☐ Psychiatry Evaluation recommendation
Diagnosis of Morbid Obesity (BMI 40 or higher and at least 100 pounds over ideal weight must include other d/x and need assistance with 1 ADL)	Bed Lift Type Wheelchair	(Attach charted measurements) Height__________ft. ________in Weight__________lb [or] kg Comorbidity:
Goal directed therapies Received therapist totaling 5 days per week for 2 of 3 disciplines.	PT OT ST	(Attach PT/OT/ST treatment plan/ goals/progress notes)
Ventilator Dependent (life sustaining for 6 or more hours a day)	Name & List settings	(Attach ventilator orders/settings)
Dialysis	Frequency	(Attach Dialysis schedule/ treatment orders)
HIV (CD4 level equal to or less than 500)	Taking 2 or more medications for treatment	(Attach medication list for HIV treatment)
Totally dependent in all activities of daily living (Complete/See definitions on pg. 2)	Describe care needs	

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Applicant Name ____

ADL SELF-PERFORMANCE-- (Code for client's PERFORMANCE during last 7 days--Not including setup)

1. **INDEPENDENT** - No help or oversight - OR - Help/oversight provided only 1 or 2 times during last 7 days
2. **SUPERVISION** - Oversight encouragement or cuing provided 3+ times during last 7 days - OR - Supervision plus physical assistance provided only 1 or 2 times during last 7 days.

LIMITED ASSISTANCE - Client highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 50% or more of the time -OR- More assistance < 50% of the time during last 7 days

3. **EXTENSIVE ASSISTANCE** - While client performed part of activity, over last 7 day period, help of following type(s) provided 50% or more of the time:
   --Weight-bearing support
   --Full caregiver performance during part (but not all) of last 7 days
4. **TOTAL DEPENDENCE** - Full caregiver performance of activity during entire 7 days

DEFINITIONS

A. **TRANSFER** - How the client moves between surfaces - to/from: bed, chair, wheelchair, standing position (EXCLUDE to/ from bath/toilet)
B. **LOCOMOTION** - How the client moves between locations in his/her room and living area. If in a wheelchair, self-sufficiency once in chair.
C. **DRESSING** - How the client puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis.
D. **EATING** - How the client eats and drinks (regardless of skill).
E. **TOILET USE** - How the client uses the toilet (or commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

	Code Here
TRANSFER/ LOCOMOTION	
EATING	

BATHING--How client takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair. Code for most dependent in self-performance and support. Bathing Self-Performance codes appear below.)

1. Independent--No help provided
2. Supervision--Oversight help only
3. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence

	Code Here
BATHING	

CONTINENCE SELF-CONTROL CATEGORIES (Code for client performance over 14 days)

1. CONTINENT - Complete control
2. USUALLY CONTINENT - BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
3. OCCASIONALLY INCONTINENT - BLADDER, 2+ times a week but not daily; BOWEL, once a week
4. FREQUENTLY INCONTINENT - BLADDER, tends to be incontinent daily, but some control present; BOWEL, 2-3 times a week
5. INCONTINENT - Has inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time; or an indwelling catheter/ostomy that controls bladder/bowel

		Code Here
BOWEL CONTINENCE	*Control of bowel movement, with appliance or bowel continence programs, if employed.*	
BLADDER CONTINENCE	*Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants)* With appliances (e.g., Foley) or continence programs, if employed.	

TO BE COMPLETED BY SCDHHS REPRESENTATIVE

☐ Approved Effective Date From________________ To________________________

☐ Denied Reason(s) ____

SCDHHS Representative________________________________ Date:________________________

☐ **Once request is approved/denied, SCDHHS will forward a completed copy of this form to the facility within five (5) business days.** **Please email all documents to Complexcare@scdhhs.gov**

SCDHHS Form 185S
May 2017