Lori A. Shibinette
Commissioner

Melissa A. Hardy
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LONG TERM SUPPORTS AND SERVICES
BUREAU OF DEVELOPMENTAL SERVICES
105 PLEASANT STREET, CONCORD, NH 03301
603-271-5034 1-800-852-3345 Ext. 5034
Fax: 603-271-5166 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

PA PACKET-FUNCTIONAL SCREEN QA CHECKLIST

APPLICANT DEMOGRAPHIC INFORMATION

☐ Applicant Name should be full legal name (no nicknames, etc.)

☐ Check Medicaid number (should be 11 places; AO, OH or BO is old numbering system-okay; **NO** hyphens)

☐ Check the date of birth for accuracy

☐ Enter provider number and name in area agency box

☐ Review address to make sure it is the current address

GUARDIANSHIP

☐ **Guardianship**: If guardian is yes, enter name and address (should be consistent with information on file with DHHS- Bureau of Family Assistance in New Heights). Note- Space is limited to enter two separate guardians with different addresses, agencies can be creative utilizing slashes etc. to get all information into this limited space.

TARGET GROUP

☐ Select correct waiver: DD, ABD or IHS

☐ Disability determination should be **yes (documentation from qualified medical professional supporting this needs to be on file with area agency). * IEP (educational coding) is not diagnosis made by a medical professional.**

RESIDENTIAL SERVICES (MUST SELECT ONE)

☐ He-M 1001: Enhanced Family Care- Cert # needed; Staff Residence Cert #
Licensed Facility – Need License # ***If Cert# has yet to be issued TBD is accepted;**

☐ He-M 525 (residential only or combined res & day) No cert. #;

☐ He-M 521 No cert. #;

☐ Independent Living: Check if CSS ***If CSS is being provided in the family home check N/A as individual does not live independently;** or

☐ Select N/A if not receiving a Residential Service.

DAY/COMMUNITY PARTICIPATION SERVICES (MUST SELECT ONE)

☐ He-M 507- Cert # needed; ***If Cert# has yet to be issued TBD is accepted**

☐ He-M 521 – no cert. #; must have 521 residential services (no He-M 521 day only);

☐ He-M 525 – no cert. #; or

☐ Select N/A if not receiving a Day/CPS Service.

DIAGNOSIS: (RELATES TO ELIGIBILITY FOR DD, IHS OR ABD WAIVER)

☐ **Developmental Disability (DD and IHS Waivers):**

- Intellectual disability (ID) level of Mild, Moderate or Severe must be selected if the individual's diagnosis has a specified level; if the individual has a diagnosis of ID with no specified level or ID, Unspecified then only the ID should be selected. (Borderline ID/Intellectual Functioning or Profound ID should be listed under Other Qualifying Diagnosis section).
- Learning disability (means math, reading, language, processing speed, etc.), the specific type section must be completed (this section cannot be left blank).
- Other qualifying diagnosis: Might be a syndrome i.e. Rett Syndrome or chromosome abnormality. List only qualifying DD conditions in this section.
- Any other condition should be under "Other Medical Conditions" as other medical issues affect level of care.

☐ **Acquired Brain Disorder (ABD Waiver):** Under Infectious brain disease and Other Neurological Disorder if these boxes are checked than the specific type section must be completed (this section cannot be left blank).

☐ **Other Medical Conditions:** This portion of the form has limited space; type in what space allows, an additional page can attached if needed or …

☐ **Mental Illness:** All applicable boxes should be selected. If Other box is selected than the specific diagnosis must be listed (this section cannot be left blank).

☐ **Impairments-** Must check yes or no.

☐ **Specialty Care** – Must check yes or no.

☐ **Therapies** – Must check yes or no (even if not provided under waiver completion of this section is required as it is for level of care).

***Diagnosis in DD section should only be selected for DD and IHS waiver services and Diagnosis in ABD section should only be selected for ABD waiver services. For example, if individual on DD Waiver has Anoxia as a Diagnosis this should be listed under Other Medical Condition(s) not under Acquired Brain Disorder section of form.**

****** **For the following sections: Other Qualifying Condition/Syndrome; Other Neurological Disorders; Underlying Medical condition which effects level of care; and Mental Illness-Other, these sections can no longer indicate "See attached ISA for information". The space in these sections is limited, to ensure all information can be captured a blank text box is at the bottom of page four to list the additional Diagnosis information from these sections. For example, the textbox would include Other Medical Condition(s): Diabetes Type 1, Chronic Kidney Disease, COPD, and Glaucoma.**

ADLS (ACTIVITIES OF DAILY LIVING)

☐ **Page 2- Review Level of Assistance code carefully and match levels with the level of assistance an individual needs to complete the task. Complete all boxes required.**

Make sure to review toileting section, as Incontinence section must also have a box selected.
Make sure to select any adaptive equipment utilized.

IADLS (INSTRUMENTAL ACTIVITIES OF DAILY LIVING)

☐ **Bottom of page 2 and page 3 – Complete all boxes**

Medication Administration and Management Section. Self-Administration should only be selected if the individual has been deemed able to Self-Administer by the Area Agency Nurse.

EMPLOYMENT/VOLUNTEER

☐ Current Employment Status - This section indicates to select one (this will be corrected when the form is redone to Check All That Apply), however the volunteer box should be selected if applicable. For example, if the box is selected for Not Working and the individual volunteers both boxes should be selected.

COMMUNICATION AND COGNITION

☐ **Review and complete all boxes.**

Under Executive Dysfunction please note that this section is Check All That Apply.

SUPERVISION

☐ This section is for level of care purposes. The selection should be consistent with the individual's supervision needs across all settings, regardless of if a service is provided by an agency/vendor in this setting.

BEHAVIOR(S)/MENTAL HEALTH

☐ **Review and complete all boxes.**

Please ensure that under Self-Injurious and Offensive or Violent behavior section the "Indicate behavior(s) exhibited" section is completed. Completion of this section would not be necessary if the selection of "demonstrates no..." boxes are selected.

RISK TO COMMUNITY SAFETY

☐ This section is Check All That Apply, please note if "No known history…" is selected, no other boxes should be selected.

SIGNATURES

☐ If initial request for services or no waiver services provided in the past year a signature from a Dr. or Nurse completing the form is required. Please ensure that the date, print name and phone portion is completed as well.

☐ If a change or renewal request signature of Service Coordinator required, please complete entire section (print name phone and date signed). **For a change (UCR, EMod) the Functional Screen must be updated. Even if there are no changes to previous Functional Screen submitted, it must be reviewed and signed with a current date.**

***The service coordinator name and phone # of person completing the form must be the same person signing the form.**

****Digital signatures (with a Date/Time stamp attestation) are accepted.**