Long Term Care Professional Medical Information Page (PMIP)

Dear Medical Provider:

The following participant had a functional assessment to determine eligibility for long term services and supports. The State of Colorado requires that a licensed medical professional complete this form to ensure the accuracy of the medical information obtained during the assessment. Section 2 **must** be completed by a primary care professional (MD, DO, APN, PA).

Participant Last Name:_____ First Name:_____ Middle Initial:____
Street address:_____
City:_____ Zip:_____ Telephone:_____
State:_____ Date of Birth:_____
Gender: ❍ Male ❍Female ❍ Transgender ❍Nonbinary/gender-nonconforming

Section 1- Assessed Needs and Information

Please review and note any inaccuracies in the following information that was obtained during the functional assessment.

I. Diagnoses

1. Diagnoses reported during the assessment:

For Physician- ICD.10 Code (If not present, enter "no diagnosis")	*Diagnosis*	*Affects Functioning*	*Receiving Treatment*	*Requires follow-up/ referral*

2. Additional diagnoses that affect the participant's functioning that were not reported:

For Physician- ICD.10 Code	Diagnosis

3. *Participant has been diagnosed with a life limiting illness.*
   ❍ No ❍ Yes
4. Additional updates to diagnoses:

II. Medications

1. *Medications reported during assessment ❍ None Identified*

Name	***Dose***

2. *Over the counter medications, vitamins, or supplements reported during assessment*
   ❍ None Identified
3. Are there any medications, vitamins or supplements not listed that the participant should be taking? ❍ No ❍ Yes, identify:
4. Are there any medications, vitamins, or supplements listed that the participant should **not** be taking? ❍ No ❍ Yes, identify:
5. Corrections, additions, or other feedback:

III. Health Status

1. *Known allergies or adverse drug reactions:_____*
2. *Current height:_____ft. _____in.*
3. *Current weight:_____lbs.*
4. *In last year:*
   - *☐ Received physical examination*
   - *☐ Seen by primary care provider*
   - *☐ Gone to hospital emergency room*
   - *☐ Stayed overnight or longer in a hospital*
     - *☐ Hospital admission was planned*
   - *☐ Spent time in a nursing facility*
   - *☐ Had two or more falls or any fall with injury*
     Type of injury:_____
   - *☐ Fear of falling keeps participant from doing things*

5. ☐ *Received crisis or urgent behavioral or mental health support in last 90 days*
6. Corrections, additions, or other feedback:

Section 2- Ability for Participant to Direct Services

Colorado offers participant-directed services that allow participants to select and manage their own staff.

1. Participant is interested in enrolling in Participant-Directed Services.
   ❍ No ❍ Yes
2. Participant is in stable health.
   ❍ No ❍ Yes
3. Participant has sound judgement and is able to direct and manage his/her care.
   ❍ No ❍ Yes
4. Participant requires in-home monitoring for health conditions.
   ❍ No ❍ Yes, recommendations for monitoring:

Notes and other feedback with regards to participant-directed services:

IV. Additional Health and Functioning Information- Not mandatory to review for completion of the form

1. Health Information Documented During Assessment:
   a. *Participant is at risk of developing pressure ulcers:*
   b. *Participant has wounds or skin conditions, if yes, identify type:*
   c. *Treatments and monitoring:*
   d. *Therapies:*
   e. Corrections, additions, or other feedback:
2. Memory and Cognition Information Documented During Assessment:
   a. *Impairment with: 1) Memory; 2) Attention; 3) Problem Solving; 4) Planning; 5) Judgment*
   b. Corrections, additions, or other feedback:
3. Sensory and Communication Information Documented During Assessment:
   a. *Hearing, vision, and communication devices and aides*
   b. *Assistive devices meet participant's hearing, vision, and/or communication needs*
   c. *Hearing, vision, and/or communication worse in the last 3 months*
   d. *Functional communication impairments, diagnoses, or issues*
   e. *Participant demonstrates the following sensory integration symptoms*
   f. *Devices or interventions to modulate sensory input*
   g. *Need for referral for sensory processing disorder*
   h. Corrections, additions, or other feedback:
4. Functioning Information Document During Assessment:
   a. *Equipment used to complete ADLs and IADLs*
   b. *Ability to select an outfit that is appropriate and safe for the weather*
   c. *Bowel program is currently being used*
   d. Corrections, additions, or other feedback:

Medical provider name:_____ Address:_____
City:_____ State:_____ Zip:_____
Name of person completing the PMIP:_____
Title of person completing the PMIP:_____ Date Completed:_____
Signature of Licensed Medical Professional verifying this information:_____

Facility/Case Management Agency:_____ Phone Number:_____
Administrator/Case Manager name:_____ Administrator/Case Manager Signature:_____

Appendix 1: Supplemental Assessment Information for the Medical Professional

The comprehensive functional assessment process evaluates a variety of areas beyond functioning and cognition. Information below is pulled from the assessment and may be useful to the medical professional in assisting the participant with referrals, diagnoses, next steps, and other issues. **Note that this information does not require an attestation, it is only for the reference of the medical professional.**

1. Health Information Documented During Assessment:
    a. *Called 911:*
    b. *Called Colorado Crisis Line:*
    c. *Has issues with getting medication filled or refilled regularly:*
    d. *Medication Management:*
        i. *Oral medication*
        ii. *Inhalant/mist medication*
        iii. *Injectable medications*
    e. *Pain:*
        i. *Presence*
        ii. *Frequency*
        iii. *Intensity*
        iv. *Effect on sleep*
        v. *Effect on activities*
        vi. *Intermittent/triggered pain*
        vii. *Concern that pain is affecting behaviors*
    f. *Sleep:*
        i. *Concerns about sleeping*
        ii. *Sleep issues*
        iii. *Had a sleep study*
2. Sensory and Communication Information Documented During Assessment:
    a. *Ability to see in adequate light*
    b. *Issues related to vision*
    c. *Uses assistive device for vision as prescribed/recommended*
    d. *Ability to hear*
    e. *Uses assistive device for hearing as prescribed/recommended*
    f. *Understanding verbal content*
    g. *Ability to express ideas or wants with individuals participant is familiar and unfamiliar with*
3. Functioning Information Documented During Assessment:
    a. *Mobility/transfer:*
        i. *Support needed for wheeling*
        ii. *Support needed for walking*
        iii. *Chair/bed to chair transfer*
    b. *Shower/bathe self*
    c. *Upper and lower body dressing*
    d. *Toilet hygiene, transfer, and menses care*
    e. *Frequency of bladder and bowel incontinence*
    f. *Eating and tube feeding support*

Appendix 2: IHSS Definitions and Examples

- **Ability to Direct One's Care** means the client has the ability to clearly explain to an Attendant how to provide a skilled or unskilled procedure or service.
- **Authorized Representative (AR)** means an individual designated by the client, or by the parent or guardian of the client receiving services, if appropriate, who has the judgment and ability to direct CDASS or IHSS on a client's behalf and meets the qualifications as defined at 10 CCR 2505-10, § 8.510.6 and § 8.510.7 or C.R.S. Section 25.5-6-1202.
- **Consumer Directed Attendant Support Services (CDASS)** means the service delivery option for services that assist an individual in accomplishing activities of daily living through health maintenance, personal care, and homemaker activities. CDASS participants have budget and employer authority and are required to be in stable health. CDASS participants are not eligible for Long-Term Home Health or agency-based home care services.
- **Health Maintenance Activities** means those routine and repetitive skilled health related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if they were physically able, or that would be carried out by family members or friends if they were available. These Activities include any excluded personal care tasks as defined in 10 C.C.R 2505-10 § 8.489, as well as skilled tasks typically performed by a Certified Nursing Assistant (CNA) or licensed nurse that do not require the clinical assessment and judgement of a licensed nurse.
- **In-Home Support Services (IHSS)** means services that are provided in the home and in the community by an Attendant under the direction of the client or client's Authorized Representative, including Health Maintenance Activities and support for activities of daily living or instrumental activities of daily living, Personal Care services and Homemaker services. IHSS Participants direct and manage their care with the support of a licensed Home Care Agency, and are not required to be in stable health. IHSS participants may have utilize other skilled and unskilled services.
- **In-Home Support Services Agencies** provide intake and orientation services, assistance with selecting attendants, verification of attendant skills and competency, attendant training and oversight, supervision by a licensed health professional, and 24-hour back-up staffing. Additionally, IHSS agencies are required to offer additional assistance to all IHSS clients. Examples of the additional supports that may be provided by IHSS agencies include support with selecting and dismissing Attendants, information and referral services, systems advocacy, independent living skills training, and cross disability peer counseling.
- **Licensed Medical Professional** means the primary care provider of the client who possesses one of the following medical licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN) as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.
- **Participant-Directed Programs** are home and community-based services (HCBS) that help people maintain their independence and determine what mix of services and supports works best for them. Participant direction empowers each client to exercise choice and control over decisions made about their long-term services and supports in a highly personalized manner. Options in Colorado are Consumer Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS).
- **Sound Judgment** means an understanding of one's condition and the knowledge to make good decisions regarding one's care.
- **Stable Health** means a medically predictable progression or variation of disability or illness.