PREADMISSION EVALUATION (PAE) FOR LONG-TERM CARE

FOR TENNCARE USE ONLY:

APPROVAL DECISION	LEVEL OF CARE	APPROVAL DATE	END DATE	REVIEWER	REVIEW DATE
YES NO	1 2 H P	_____ --	_____	_____	_____
YES NO	1 2 H P	_____ --	_____	_____	_____
YES NO	1 2 H P	_____ --	_____	_____	_____
YES NO	1 2 H P	_____ --	_____	_____	_____

SERVICE REQUESTED:
[ ] Nursing Facility – Level 1 Care [ ] Nursing Facility – Level 2 Care [ ] PACE Program [ ] HCBS E & D Waiver

APPLICANT

Name (Last, First, Middle) _____ Date of Birth_____

Street Address _____

City _____ State _____ Zip _____

SSN _____-_____-_____ **AND** Medicaid Number (if currently eligible) _____

DESIGNEE

Name (Last, First, Middle) _____

Street Address _____

City _____ State _____ Zip _____

Phone Number(s) _____

Applicant MUST identify the person that s/he wants to receive information about this application OR sign below to show that s/he chooses not to have anyone else receive this information:

☐ I certify that I do NOT want a designated correspondent. _____
(Applicant Signature)

LONG TERM CARE PROVIDER (Nursing Facility, PACE or AAAD)

Name _____ Contact Name_____

Street Address _____

City _____ State _____ Zip _____

Provider Number _____ Phone _____ Fax _____

If the SUBMITTING AGENCY is *other than* the Provider listed above, the following must be completed:

SUBMITTING AGENCY

Name _____ Contact Name_____

Street Address _____

City _____ State _____ Zip _____

Provider Number _____ Phone _____ Fax _____

SUBMISSION TYPE

☐ New PAE
☐ Previously submitted PAE (also check one of the following)
☐ Certification Update (update PAE to extend 90 day date)
☐ Response to a denied PAE
☐ Correction of information (SSN, Request Date, etc.)

Return Completed Form to:

Bureau of TennCare, Division of Long Term Care

By FAX: 615-741-9260
By U.S. Mail: P.O. Box 450, Nashville, TN 37202-0450
By Other Delivery: 310 Great Circle Road, Nashville, TN 37243

FUNCTIONAL ASSESSMENT (Complete ALL functional areas; circle ONLY ONE answer for each functional area):
A=Always; U=Usually; UN=Usually Not; N=Never

I. TRANSFER

Can applicant transfer without physical help from others?

- **A**. Applicant is **always able** to self transfer without physical help from others.
- **U.** Applicant **requires cueing, stand-by assistance and/or supervision** to transfer, **OR** requires **contact guard assistance and/or hands-on physical assistance 1-3 days per week**.
- **UN.** Applicant **requires contact guard assistance and/or hands-on physical assistance 4 or more days per week.**
- **N**. Applicant is **never able** to transfer without physical help from others.

II. MOBILITY

Can applicant walk without physical help from others?

- **A**. Applicant is **independent** with walking.
- **U.** Applicant **requires cueing, stand-by assistance and/or supervision** to walk, **OR** requires **physical assistance 1-3 days per week**.
- **UN.** Applicant **requires physical assistance 4 or more days per week** to walk.
- **N.** Applicant is **never able** to walk without physical help from others.

Can applicant self-propel a wheelchair without physical help from others?
NOTE: Response is required IF applicant is usually not (UN) or never (N) able to walk without physical help from others.

- **A**. Applicant is **always able** to self-propel a wheelchair without physical help from others.
- **U.** Applicant **requires physical assistance 1-3 days per week** to propel a wheelchair.
- **UN.** Applicant **requires physical assistance 4 or more days per week** to propel a wheelchair.
- **N.** Applicant is **never able** to self-propel a wheelchair without physical help from others.

III. EATING

Can applicant place food/drink in the mouth without physical help from others?

- **A**. Applicant is **independent** with placing food/drink in the mouth.
- **U.** Applicant **requires physical assistance 1-3 days per week** to place food/drink in the mouth.
- **UN.** Applicant **requires physical assistance 4 or more days per week** to place food/drink in the mouth.
- **N**. Applicant is **never able** to place food/drink in the mouth without physical help from others.

IV. TOILETING

Can applicant use a toilet without physical help from others?

- **A**. Applicant is **independent** in toileting.
- **U.** Applicant **requires physical assistance 1-3 days per week** to toilet.
- **UN.** Applicant **requires physical assistance 4 or more days per week** to toilet.
- **N.** Applicant is **never able** to use a toilet without physical help from others.

IF INCONTINENT: Can applicant perform incontinence care without physical help from others?
Check Type(s): [ ] Bowel [ ] Bladder

- **A**. Applicant is **independent** with incontinence care.
- **U.** Applicant **requires physical assistance 1-3 days per week** with incontinence care.
- **UN.** Applicant **requires physical assistance 4 or more days per week** with incontinence care.
- **N.** Applicant is **totally dependent** on others for incontinence care.

IF INDWELLING CATHETER or OSTOMY is present, can applicant perform self-care without physical help from others?

- **A**. Applicant is **independent** with indwelling catheter or Ostomy care.
- **U.** Applicant **requires physical assistance 1-3 days per week** with indwelling catheter or Ostomy care.
- **UN.** Applicant **requires physical assistance 4 or more days per week** with indwelling catheter or Ostomy care.
- **N.** Applicant is **totally dependent** on others for indwelling catheter or Ostomy care.

V. ORIENTATION

Is applicant oriented to both PERSON (remembers name; recognizes family) AND PLACE (knows where s/he is and able to locate common areas in living environment)?

- **A**. Applicant is **always oriented** to both person and place.
- **U.** Applicant is **usually oriented** to both person and place (becomes disoriented to person and/or place 1-3 days per week).
- **UN.** Applicant is **usually not oriented** to person and/or place (becomes disoriented to person and/or place 4 or more days per week).
- **N.** Applicant is **never oriented** to person and/or place.

FUNCTIONAL ASSESSMENT (Complete ALL functional areas; circle ONLY ONE answer for each functional area):
A=Always; U=Usually; UN=Usually Not; N=Never

VI. COMMUNICATION

EXPRESSIVE: Can applicant express basic wants and needs?

- **A**. Applicant is **always able** to express basic wants and needs using verbal or written language or assistive communication device.
- **U.** Applicant is **usually able** to communicate basic wants/needs using verbal/written language or assistive communication device (requires assistance 1-3 days per week).
- **UN.** Applicant is **usually not able** to communicate basic wants/needs using verbal/written language or assistive communication device (requires assistance 4 or more days per week).
- **N.** Applicant is **never able** to communicate basic wants/needs.

RECEPTIVE: Can applicant understand and follow very simple instructions (e.g., perform basic activities of daily living such as dressing or bathing) without continual staff or caregiver intervention?

- **A**. Applicant is **always able** to understand and follow very simple instructions.
- **U.** Applicant is **usually able** to understand and follow very simple instructions (1-3 days per week).
- **UN.** Applicant is **usually not able** to understand and follow very simple instructions (4 or more days per week).
- **N.** Applicant is **never able** to understand and following very simple instructions.

VII. MEDICATIONS – Includes: PO, IV, IM, Enteral, Rx otics, optics, topicals, inhalers and continuous SQ pain management

Is applicant physically or mentally able to self-administer medications with limited help from others (e.g., reminding, encouraging, reading labels, opening bottles, handing to applicant, monitoring dosage)?

- **A**. Applicant is **always physically and mentally capable** of self administering prescribed medications.
- **U.** Applicant is **usually physically and mentally capable** of self administering prescribed medications with limited assistance (requires assistance with administration of prescribed medications 1-3 days per week).
- **UN.** Applicant is **usually not physically and/or mentally capable** of self administering prescribed medications despite the availability of limited assistance (requires assistance with administration of prescribed medications 4 or more days per week).
- **N.** Applicant is **never able** to self administer prescribed medications, despite the availability of limited assistance.

NOTE: If **'UN'** or **'N'** is marked, please list medications for which assistance is needed, and provide explanation regarding why applicant is unable to self administer with limited help from others _____

_____

_____

INSULIN ADMINISTRATION only: If on a fixed dose of insulin, can individual inject insulin with a pre-filled syringe; or if on sliding scale, can applicant draw up and inject insulin?

- **A**. Applicant is **always able** to inject a fixed dose of insulin with a pre-filled syringe; or, if on a sliding scale, is able to draw up and self inject insulin.
- **U.** Applicant **requires physical assistance 1-3 days per week** to inject a fixed dose of insulin with a pre-filled syringe; OR, if on a sliding scale, requires physical assistance 1-3 days per week to draw up and/or inject insulin.
- **UN.** Applicant **requires physical assistance 4 or more days per week** to inject a fixed dose of insulin with a pre-filled syringe; OR, if on a sliding scale, requires physical assistance 4 or more days per week to draw up and/or inject insulin.
- **N.** Applicant **requires physical assistance** with insulin administration **on a daily basis**.

NOTE: If **'UN'** or **'N'** is marked, please provide explanation regarding why applicant is unable to inject insulin with a pre-filled syringe or draw up and inject sliding scale insulin. _____

_____

VIII. BEHAVIOR

Does applicant require continual staff intervention for a persistent pattern of dementia-related behavioral problems (i.e., aggressive physical behavior, disrobing, or repetitive elopement)?

- **A**. Applicant **persistently requires staff/caregiver intervention on a daily basis** due to an established and persistent pattern of dementia related behavioral problems.
- **U.** Applicant **persistently requires staff/caregiver intervention 4 or more days per week** due to an established and persistent pattern of dementia related behavioral problems.
- **UN.** Applicant **persistently requires staff/caregiver intervention 1-3 days per week** due to an established and persistent pattern of dementia related behavioral problems.
- **N.** Applicant **does not have** a persistent pattern of dementia related behavior problems requiring staff/caregiver intervention.

NOTE: If **'A'** or **'U'** is marked, please specify the behavioral problems requiring continual staff or caregiver intervention.

_____

_____

NOTE: This page is for LEVEL 2 Nursing Facility Services ONLY:

SKILLED NURSING & REHABILITATIVE SERVICES (Check all that apply and indicate frequency needed):

Reimbursement for Level 2 Nursing Facility Services requires specific supporting documentation for approval. The required supporting documentation is specified below *in italics* for *each* skilled or rehabilitative service. The specified documentation must be included with the PAE, whether submitted by fax, mail or in person. *TennCare does not provide reimbursement for rehabilitative services (see below) for chronic conditions, exacerbations of chronic conditions, or weakness after hospitalization. Rehabilitative services for maintenance of functional status (e.g., routine range of motion exercises, stand-by assistance during ambulation, or applications of splints/braces) are not considered skilled level services.

NEED	SERVICE	FREQUENCY	
		# of times Daily	# of times Weekly
☐	Wound Care for Stage 3 or 4 decubitus *Physician's order and Wound Assessment (describing characteristics and measurements)*		
☐	Other Wound Care (i.e., infected or dehisced wounds) *Physician's order and Wound Assessment (describing characteristics and measurements)*		
☐	Injections, sliding scale insulin *Physician's order for Sliding Scale protocol and Blood Glucose Monitoring Log*		
☐	Injections, other: IV, IM *Physician's Orders – Specify Frequency and Duration*		
☐	Intravenous fluid administration *Physician's Orders – Specify Frequency and Duration*		
☐	Isolation precautions *Lab report with organism and diagnosis to support isolation*		
☐	*Occupational Therapy by OT or OT assistant *Physician's Orders and OT Evaluation – Specify Frequency, Duration, and Diagnosis*		
☐	*Physical Therapy by PT or PT assistant *Physician's Orders and PT Evaluation – Specify Frequency, Duration, and Diagnosis*		
☐	Teaching Catheter/Ostomy care *Skilling for new catheter/Ostomy only – Specify teaching plan*		
☐	Teaching self-injection *Skilling for new diabetics only – Specify teaching plan*		
☐	Total Parenteral nutrition *Physician's Orders*		
☐	Tube feeding, enteral *Physician's Orders*		
☐	Ventilator services *Physician's Orders*		
☐	Peritoneal Dialysis *Physician's Orders*		
☐	PCA Pump *Physician's Orders*		
☐	New tracheostomy or old tracheostomy requiring frequent documented suctioning, multiple times per shift - *Physician's Orders, including date of tracheostomy and documentation of frequency of suctioning required, if applicable*		
☐	Other *If other requests, submit supporting documentation with control number included.*		

CERTIFICATION OF ASSESSMENT

May be completed by a Physician, Nurse Practitioner, Physician Assistant, Registered or Licensed Nurse or Licensed Social Worker.

I certify that the level of care information provided in this PAE is accurate. I understand that this information will be used to determine the applicant's eligibility for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties.

Signature: _____ Credentials: _____ Date: _____

DIAGNOSES relevant to applicant's functional and/or skilled nursing needs: _____

_____

_____

REQUIRED ATTACHMENTS (In addition to the PAE, the following attachments **must** be submitted):

√ A recent History and Physical (completed within 365 days of the PAE Request Date or date of Physician Certification below, whichever is earlier) OR other recent medical records supporting the applicant's functional and/or skilled nursing or rehabilitative needs signed by the physician, nurse practitioner or physician's assistant;

√ Current Physician's Orders for the applicable Service Requested; and

√ Supporting documentation for skilled nursing and/or rehabilitative services (if applicable) as specified on page 4.

PAE REQUEST DATE for Medicaid-reimbursed long-term care services: _____

CERTIFICATION of LEVEL OF CARE

I certify that the applicant requires the level of care provided in a nursing facility and that the requested long-term care services are medically necessary for this applicant. I understand that this information will be used to determine the applicant's eligibility for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties.

Signature of Physician: _____ Date: _____

COMPLETE THE SECTION BELOW *ONLY IF* THE PAE REQUEST DATE MUST BE REVISED

CERTIFICATION UPDATE

I certify that the applicant's medical condition on the revised PAE Request Date is consistent with that described in the initial certification and that Nursing Facility care is medically necessary for the applicant.

Revised PAE Request Date	Signature of Physician	Date of Signature