norcal Care Coordinator Agency

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ALWP CLIENT PRE-SCREEN FORM

Name of Medi-Cal Beneficiary: _____ Date: _____

Name of Conservator/HCPOA : _____ Tel: _____

Email: _____ Fax: _____

If the Beneficiary does not have capacity to make healthcare decisions, the legal Conservator or HCPOA must submit proof of documentation prior to consideration for enrollment into the ALWP

Beneficiary's Current Residence/Name of Facility: _____

Address: _____

◯ Assisted Living Facility ◯ Assisted Living (**ALW Facility)** ◯ Home ◯ Skilled Nursing Facility ◯ Hospital

Name of ALW Assisted Living Facility that you are interested in: _____

Medi-Cal Number: _____

Date of Birth: _____ Age: _____ Gender: ◯ Male ◯ Female

Must be Medi-Cal Eligible with No Share of Cost or Spend Down Amount

COGNITIVE ISSUES, DIABETES AND OTHER INJECTIONS

Cognitive Issues: ☐ Confused ☐ Dementia ☐ Alzheimer's Disease ☐ Wanders/Exits

Diabetes: ☐ Finger sticks ☐ Insulin ☐ Needs assistance ☐ Other Injections _____

Healthcare Power of Attorney (HCPOA) is required for anyone with dementia or other cognitive diagnosis

Behavioral Issues (History of violence, etc.) ◯ Yes ◯ No

Mental Health diagnosis/history ◯ Yes ◯ No ☐ Bipolar Disorder ☐ Schizophrenia ☐ Manic Depression

Comments:

PRE-SCREEN ASSESSMENT
Please complete all questions to the best of your ability

Scoring: **0 = Independent** **1 = Supervision:** Reminding and/or set-up of supplies **2 = Limited:** Client able to do most tasks, hands-on assist <3x/week **3 = Extensive:** Most, but not all, tasks done by others >3x/week **4 = Total Dependence:** All aspects of activities of daily living, requires hands-on assistance

	0	1	2	3	4
BED MOBILITY - *(how client moves and positions self).*	◯	◯	◯	◯	◯
TRANSFER - (*how client moves between bed, wheelchair, toilet, etc.*)	◯	◯	◯	◯	◯
LOCOMOTION IN RESIDENCE - (*how client moves around residence, walker, cane, W/C*)	◯	◯	◯	◯	◯
DRESSING - *(how client puts on, fastens, and takes off clothing).*	◯	◯	◯	◯	◯
EATING - (*how client eats and drinks).*	◯	◯	◯	◯	◯
TOILET USE/INCONTINENT- (*transfers on/off toilet or commode).*	◯	◯	◯	◯	◯
PERSONAL HYGIENE - (*washing up, brushing teeth, combing hair, shaving).*	◯	◯	◯	◯	◯
BATHING - *(how client takes bath/shower).*	◯	◯	◯	◯	◯

Does the client have IHSS services?	◯ Yes	◯ No
Does the client have any open sores/wounds?	◯ Yes	◯ No

MEDICATIONS

◯ Five or less prescription medications ◯ Six or more prescription medications

Is the client physically capable of taking medications without assistance (opening bottles, etc.)	◯ Yes	◯ No
Does the client know what the medications are for?	◯ Yes	◯ No
Does the client know how to take the medications? (by mouth or topically).	◯ Yes	◯ No
Does the client know how often to take the medications?	◯ Yes	◯ No
Is the client capable of communicating if the medication has unintended side effects?	◯ Yes	◯ No
Does the client require supplemental oxygen?	◯ Yes	◯ No

List of Primary Diagnoses: Attach a Physician's Report (LIC 602) if available

List of prescription medications: