Department for Aging and Disability Services

KDADS CARE Resident Review required documentation checklist,

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CONFIDENTIAL

A RESIDENT REVIEW is required when an individual, in a Nursing Facility (NF) or Nursing Facility for Mental Health (NFMH), with a PASRR determination letter that authorized a temporary PASRR stay for Level II and the persons stay requires an extended length of time to the facility. Or if the person has had a recent Change in Condition that now meets criteria for a level II PASRR

Client Name_____

Facility Name and Address_____

_____

Name/Title/Phone/Email of contact person from your facility_____

_____

Name/Address/Phone of Client Guardian/DPOA (if applicable) _____

_____

Check List (at the time of submission to KDADS all items below must be provided, if all items are not provided at submission this will cause delays in processing)

_____ KDADS Current Release of Information (ROI) dated/signed

_____ Current Guardianship, DPOA legal documents

_____ Current History & Physical (H & P) (within last 2 years)

_____ Current Medication Administration Record (MAR)

_____ Current Care Plan

_____ Facility Progress Notes in the last 90 days

_____ Discharge summary from any State Hospital, Psych Unit or BHU since the original Level II screen or last resident review.

If applicable:

_____ MDS* (admission MDS and the MDS current that shows there has been a change of condition)

*For a Resident Review Change in Condition: This is a person that has come to your facility on a level I that did not trigger for a level II, but now meets the criteria. Which are 2 inpatient psych hospitalizations, or 2 partial psych hospitalizations, or 1 inpatient and 1 partial psych hospitalizations, or supportive services (CMHC, VA) or Interventions (APS, LEO, Housing Authority) include all the above in the check list and the MDS below.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I,_____, Social Security Number ---------- DOB___/___/___
Name of client **[optional]**

hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that signing this form is voluntary.

Providing the information: P**erson(s)/Organization(s)** (check all that applies)

_____ Community mental health center(s): *Numbers* _____
_____ Community developmental disability organization(s): *Numbers*_____
_____ Adult Protective Services: Names _____
_____ Hospitals/nursing facility/LEO: Names_____
_____

Other(s): name/address/phone_____

Receiving the information:

Person(s)/Organization(s) (check all that applies)

____ Area Agency on Aging:
name _____
____ Kansas Department for Aging and Disability Services

____ Acentra Health

Other(s):
name/address/phone_____

Description of Information to be Used or Disclosed (place a check mark or an "x" next to the item(s) to be used or disclosed):
___ *Recent History and Physical within the last 2 years;* ___ *Medical records for inpatient psych hospitalizations within the last 2 years;* ___ *List of dates showing increase services to a CMHC, VA, etc. for more than 30 days in the last 2 years;* ___ *LEO/APS/Housing Interventions/ reports last 2 years;* ___ *IQ test or documentation including score;* ___ *Partial Hospitalizations or day services to CMHC, VA or the like in the last 2 years*

The purpose of the Use or Disclosure: *Completion of a PASRR Evaluation and for continuum of care.*

The Individual or the Individual's Representative must read or have the following read to them and initial by each item below:

_____ *(Initials)* I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that the refusal to sign this authorization may mean that the use and/or disclosure described in this form will not be allowed.

_____ *(Initials)* I understand this Release is valid for one year from today's date.

_____ *(Initials)* I understand that I may revoke this Release at any time by notifying the **providing organization** in writing. It will not have an effect on actions that were taken prior to the revocation.

_____ *(Initials)* I understand that once the uses and disclosures have been made pursuant to this authorization, the information released may be subject to re-disclosure by any recipient and will no longer be protected by federal privacy laws.

_____ *(Initials)* This will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I certify that I agree to the uses and disclosures listed above and that I have received a copy of this Authorization. (Form must be completed before signing).

_____ _____
Signature Date

_____ _____ _____
Signature of Personal Representative (if applicable) Date Description of Authority

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

	CDDO		CMHC
1	Achievement Services for Northeast Kansas	**1**	Bert Nash Community Mental Health Center Inc.
2	Arrowhead West, Inc	**2**	Central Kansas Mental Health Center
3	Big Lakes Developmental Center, Inc	**3**	Comcare of Sedgwick County
4	Brown County Developmental Services, Inc.	**4**	Community Mental Health Center of Crawford County
5	Butler County CDDO	**5**	Compass Behavioral Health
6	CDDO of Southeast Kansas	**6**	Crosswinds
7	Cottonwood, Inc.	**7**	Elizabeth Layton Center, Inc.
8	Cowley County Community Dev. Disability Org	**8**	Family Services & Guidance Center
9	Developmental Services of Northwest Kansas, Inc.	**9**	Four County Mental Health Center
10	Disability Planning Organization of Kansas	**10**	High Plains Mental Health Center
11	East Central Kansas AAA-CDDO	**11**	Horizons Mental Health Center
12	Futures Unlimited, Inc	**12**	Iroquois Center for Human Development, Inc
13	Harvey - Marion County CDDO	**13**	Johnson County Mental Health Center
14	Hetlinger Developmental Services, Inc	**14**	Kanza Mental Health & Guidance
15	Johnson County Developmental Supports	**15**	Labette Center for Mental Health Services
16	McPherson County CDDO	**16**	Pawnee Mental Health Services
17	Nemaha County Training Center	**17**	Prairie View, Inc
18	New Beginnings Enterprises, Inc.	**18**	South Central Mental Health Counseling Center, Inc
19	Reno County CDDO	**19**	Southeast Kansas Mental Health Center
20	Riverside Resources, INC	**20**	Southwest Guidance Center
21	Sedgwick Co. Developmental Disability Org.	**21**	Spring River Mental Health & Wellness
22	Shawnee County CDDO	**22**	Sumner County Mental Health Center
23	Southwest Developmental Services Inc.	**23**	The Center for Counseling and Consultation
24	Tri-Ko, Inc.	**24**	The Guidance Center, Inc
25	Tri-Valley Developmental Services, Inc	**25**	Valeo Behavioral Healthcare
26	Twin Valley Developmental Services Inc.	**26**	Wyandot Center for Community Behavioral Health Inc.
27	Wyandotte County CDDO		

Instructions to Complete the KDADS Authorization for Release of Protected Health Information (ARPHI) Form for the CARE Program

Name/SSN/DOB Fields

Name of Client	Please complete this field using the client's full legal name.
Social Security Number	If a copy of the Social Security Number is available, please enter the number as it appears on the card. If the number cannot be verified, leave field blank. This field is optional.
DOB:	Enter the client's full date of birth (MM/DD/YYYY)

"Providing the Information" Box

This box will include the organizations, doctors, and/or family members KDADS will need to contact to obtain the paperwork required to initiate a CARE Level II assessment, Resident Review, or Change of Condition.

Community Mental Health Center (CMHC): Locate the correct CMHC from those listed on Page 2 of the ARPHI form and write the number(s) associated with the CMHC(s) client has been visiting for increased supportive service for 30 consecutive days above and beyond routine visits. If the CMHC is not listed or not a Kansas CMHC, please list the name of the CMHC in the "Other" section in this box.

Community Developmental Disability Organization (CDDO): Locate the correct CDDO from those listed on Page 2 of the ARPHI form and write the number associated with the CDDO(s) the client has been visiting for services and/or the CDDO from which the IQ score can be obtained. If the CDDO is not listed or not a Kansas CDDO, please list the name of the CDDO in the "Other" section in this box.

Adult Protective Services (APS): If client currently has an open case or has had a case filed with APS in the last two (2) years due to a mental health concern, please list the name(s) and location(s) of the APS office(s) where the report(s) were filed. Please use the lines under the "Other" section if more room is needed.

Hospital/Nursing Facility/LEO: If client was admitted for an inpatient psychiatric stay at a facility within the last two (2) years, provide the full name and location of the hospital and/or facility. Do not use abbreviations. Use the lines under the "Other" sections if more room is needed.

When the client has records at a nursing facility or a nursing facility is submitting a Resident Review or Change in Condition, provide the full name of the facility. Use the lines under the "Other" section if more room is needed.

When client has had interactions with law enforcement, please list the agency and location of the interaction. (i.e., Shawnee County Sheriff's Office, Topeka Police Department, etc.)

Others: Please list the following entities under this section, when applicable:

- Law enforcement agency
- Housing authority
- Family member(s)
- Physician(s)
- Organization(s)
- Out-of-state facility
- Any other persons or entities able to provide additional information, such as, IQ, H&P, police record, medication list, psychiatric evaluation(s), inpatient hospital admissions, eviction notices, and/or other important documents required for the CARE Level II referral.

"Receiving the Information" Box

This box will include the organizations and persons receiving information (i.e., CARE Level II Determination Letter).

Area Agency on Aging (AAA): Choose this option if CARE Level I assessment was completed by a AAA assessor.

Kansas Department for Aging and Disability Services: Check this option since CARE Level I information will be received on behalf of KDADS, including any additional information that will need to be obtained to complete the CARE Level II assessment process.

Acentra Health: Check this option if the CARE Level I assessment indicates a need for completion of a CARE Level II assessment.

Others: Provide the name, address, and phone number of any person or entity receiving information from the CARE Level II assessment and/or who will need to receive a copy of the Determination Letter.

- Facility
- Hospital
- Organization
- DPOA/Guardian
- Family member
- Case worker

NOTE: Failure to provide the above information will delay the CARE Level II process and/or prevent a timely Determination Letter from the KDADS CARE program. The assessor is responsible to ensure all information needed is complete on this form.

Description of Information to be Used or Disclosed: Place an "X" next to the items needed by KDADS to complete the CARE Level II process.

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The Individual or Individual's Legal Representative must read or have the following section read to him or her in its entirety and then initial as explained below:

- Please have client initial next to each item to indicate client giving permission for each item.
- If the client has a Guardian, then **only the guardian** may initial each item.
- If the client has a DPOA (or spouse) and client is unable to sign on his or her own, the DPOA (or spouse) may initial each item.

Signature and Date Lines:

- If the client <u>does not</u> have a guardian, the client may sign and date the ARPHI on his or her own, validating it for up to one (1) year.

Signature of Personal Representative Line (when applicable):

- **ONLY** the guardian may sign this line and complete the date line.
- **DPOA** may sign if the client is unable to sign on his or her own.
- **Legal Spouse** may sign if the client is unable to sign on his or her own.

Description of Authority Line:

- If Guardian or DPOA signs this document, a copy of the legal documentation must be furnished to verify authenticity.