California Dept. of Health Care Services - Community Based Adult Services (CBAS)
-- CBAS Eligibility Determination Tool (CEDT) --

Part 1

NAME: _____ SEX: ☐ M ☐ F CIN: _____

BIRTHDATE: _____ AGE: _____ PREFERRED LANGUAGE: _____

CAREGIVER: _____ CONTACT #: _____

CBAS REQUESTED BY: _____ DATE: _____

DATE ASSESSED: _____ INTERVIEW (F2F) LOCATION: _____

A. DIAGNOSES / CONDITIONS *(Capture Source for each Diagnosis – e.g., MR,F2F,CG)*

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

B. MEDICATIONS *(Capture Source for each Medication – e.g., MR,F2F,CG) (Capture all Meds including OTC Meds)*

1.	6.	11.	16.
2.	7.	12.	17.
3.	8.	13.	18.
4.	9.	14.	19.
5.	10.	15.	20.

C. ASSISTIVE/SENSORY DEVICES

☐ Dentures _____ ☐ Vision _____ ☐ Hearing _____ ☐ Prosthesis _____

Explain: *(Capture Source of Information – e.g., MR,F2F,CG)*

D. SYSTEMS REVIEW

1. NEUROLOGICAL ☐ Within normal limits

☐ Expressively Aphasic – Unable to express basic needs
☐ Receptively Aphasic – Unable to understand basic communication
☐ Pain: _____
☐ Other: _____
☐ Seizures
☐ Spasticity
☐ Compromised Motor Function

Explain *(Capture Source of Information – e.g., MR,F2F,CG)*

2. RESPIRATORY / CARDIAC ☐ Within normal limits

☐ Oxygen - ☐ Continuous ☐ Intermittent
☐ Tracheostomy
☐ Ventilator ☐ BiPAP ☐ CPAP ☐ Nebulizer
☐ SOB ☐ Edema
☐ Pain: _____

☐ Pacemaker/Defibrillator
☐ BP/Pulse Monitor - ☐ Self ☐ Caregiver
Frequency: _____
☐ Other: _____

Explain: *(Capture Source of Information – e.g., MR,F2F,CG)*

3. GASTROINTESTINAL / GENITOURINARY

☐ Regular Diet ☐ Special Diet: _____
☐ Feeding Tube - ☐ NG Tube ☐ PEG Tube
☐ IV Feedings ☐ Dysphagia
☐ Requires modified food/liquid consistency
☐ Overweight ☐ Underweight
☐ Pain: _____
☐ Other: _____

Bladder ☐ Normal
☐ Bladder incontinence
☐ Indwelling Foley catheter
☐ Suprapubic catheter
Bowel ☐ Normal
☐ Bowel incontinence
☐ Ostomy

Explain: *(Capture Source of Information – e.g., MR,F2F,CG)*

4. ENDOCRINE ☐ Within normal limits

☐ Diabetes Mellitus
☐ Diet Controlled
☐ Oral medication
☐ Insulin Injections
☐ Sliding Scale Coverage

☐ Blood Glucose Monitoring - ☐ Self ☐ Caregiver
Frequency: _____

Explain: *(Capture Source of Information – e.g., MR,F2F,CG)*

5. INTEGUMENTARY ☐ Within normal limits; skin is intact

☐ Previous skin problems
☐ Pain: _____

Explain: *(Capture Source of Information – e.g., MR,F2F,CG)*

Describe current skin lesions, stasis ulcers, wounds, bruising, or other skin integrity issues.

Location:	Description: (include, size, healing status)	Wound Care/Treatment: (include frequency)

6. MUSCULO-SKELETAL ☐ Within normal limits

☐ Ambulatory
☐ Independent ☐ Cane ☐ Walker ☐ Orthotics
☐ Wheelchair ☐ Able to self-propel wheelchair
☐ Scooter
☐ Bed Bound
☐ Transfer Needs

☐ Weakness ☐ Contractures
☐ Limited range of motion ☐ Joint replacement
☐ Paralysis
☐ Hemiplegia ☐ Paraplegia ☐ Quadriplegia
☐ History of falls in last 6 months ☐ Poor Balance
☐ Pain: _____
☐ Other: _____

Explain: *(Capture Source of Information – e.g., MR,F2F,CG)*

7. COGNITIVE & BEHAVIORAL FACTORS ☐ Within normal limits

Dementia Stage: _____
☐ Cognitive Loss ☐ Memory Loss
☐ Confused ☐ Limited Response
☐ Poor Judgment

☐ Isolated ☐ Self-neglect ☐ Wandering
☐ Disruptive ☐ Agitated ☐ Aggressive
☐ Substance Abuse
☐ Other: _____

Explain: *(Capture Source of Information – e.g., MR,F2F,CG)*

E. MEDICATION MANAGEMENT ☐ Independent

☐ Medication management assistance needed - ☐ Human assistance ☐ Device assistance
☐ Hx of Non-Adherence
Reasons for non-adherence: ☐ Forgetfulness, Confusion, Cognitive Deficits ☐ Physical disability
☐ Cost, Health Beliefs, Side Effects ☐ Other Causes
☐ Central lines

Explain: *(Capture Source of Information – e.g., MR,F2F,CG)*

F. ADL/IADLs

Independent: Able to perform for self with or without device.
Supervision: No physical help req'd; needs cueing or to be monitored, even w/ device.
Assistance: Physical help required, even with device.
Dependent: Unable to do for self, even with physical help, cueing or device.

ADLs	Independent?	Explain Responses & Identify Source
Ambulation	☐ Y ☐ N	
Bathing	☐ Y ☐ N	
Dressing	☐ Y ☐ N	
Feeding	☐ Y ☐ N	
Toileting	☐ Y ☐ N	
Transferring	☐ Y ☐ N	
IADLs		
Hygiene	☐ Y ☐ N	
Medication Mgmt	☐ Y ☐ N	
Additional IADL Exceptions:		
Transportation	☐ Y ☐ N	
Access Resources	☐ Y ☐ N	
Meal Preparation	☐ Y ☐ N	
Money Mgmt	☐ Y ☐ N	

G. ADDITIONAL SUPPORT INFORMATION

Currently Receiving Other Non-CBAS Services/Waivers

NOTE: check boxes only if known and readily available during F2F and/or review of available and relevant documentation.

☐ IHSS Services Received - Hrs/Month: _____
☐ In-Home Waiver
☐ Assisted Living Waiver
☐ Home/Community Based DD Waiver
☐ MSSP
☐ Other: _____
☐ Nursing Facility/Acute Hospital Waiver
☐ Specialty Mental Health Waiver Services
☐ Hospice Services
☐ Home Health Services
☐ Physical Therapy
☐ Meals on Wheels

Explain: *(Capture Source of Information – e.g., MR,F2F,CG)*

Recent Health Care Encounters

Within last 6 months Unknown? ☐

☐ PCP Visit
☐ Clinic Visit
☐ Specialty Physician Visit
☐ Emergency Room Visit
☐ Inpatient Mental Health
☐ CBAS Center
☐ Hospitalization
☐ Nursing Facility

Explain: *(Capture Source of Information – e.g., MR,F2F,CG)*

H. AE&MN QUALIFICATION CRITERIA

Part 2

Category	Criteria
Basic Qualifications ☐ Y ☐ N Qualifies? (requires Y for all of first five choices **OR** Y for sixth choice)	☐ Y ☐ N The person is 18 years of age or older ☐ Y ☐ N The person has one or more chronic or post-acute medical, cognitive, or mental health conditions List qualifying medical, cognitive, or mental health condition(s) _____ _____ _____ ☐ Y ☐ N A physician, nurse practitioner, or other health care provider has, within his or her scope of practice, requested CBAS services. ☐ Y ☐ N The person requires Ongoing or Intermittent Protective Supervision by a skilled health or mental health professional to improve, stabilize, maintain, OR minimize deterioration of the medical, cognitive, or mental health condition(s) listed above. ☐ Y ☐ N CBAS is required to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services, nursing facility services, or nursing or intermediate care facility services for the developmentally disabled providing continuous nursing care. **OR** ☐ Y ☐ N Participant resides in an ICF/DD-H and that resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur. Explain:
Other Chronic or Post-Acute Conditions ☐ Y ☐ N Qualifies? (requires Y for at least one choice)	The candidate has one or more medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization: ☐ Y ☐ N Needs Monitoring, **OR** Treatment, **OR** Intervention For Condition(s) _____ **OR** ☐ Y ☐ N Candidate resides in an ICF/DD-H Explain:
Living Situation ☐ Y ☐ N Qualifies? (requires Y for at least one of four choices)	The participant's network of non-CBAS center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following: ☐ Y ☐ N Lives alone To provide sufficient and necessary care or supervision: ☐ Y ☐ N Family or Caregivers not available ☐ Y ☐ N Participant resides with one or more individuals, but they are unwilling or unable ☐ Y ☐ N Family or caregivers available, but those individuals require respite in order to continue Explain:

Deterioration Potential

☐ Y ☐ N Qualifies?
(requires Y)

☐ Y ☐ N A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if adult day health care services are not provided.

Explain:

CORE Professional Nursing Services

☐ Y ☐ N Qualifies?
(requires Y for one or more of the five Core Professional Nursing Services listed)

1 - Health Status

To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant participant's condition or conditions require:

☐ Y ☐ N Intermittent Observation, **AND** Assessment, **AND** Monitoring

For Condition(s) _____

Explain:

2 - Medication Regimen

To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant's condition or conditions require:

☐ Y ☐ N Monitoring and assessment of the participant's medication regimen, administration and recording of the participant's prescribed medications, and intervention, as needed, based upon the assessment and the participant's reactions to his or her medications.

Explain:

3 - Oral or Written Communication

To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant's condition or conditions require:

☐ Y ☐ N Professional nursing services to communicate accurate information regarding changes in the participant's condition, signs, or symptoms to health care providers, social service provider, participant’s family, or caregiver.

Explain:

4 - Personal Care Service Supervision

To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant's condition or conditions require:

☐ Y ☐ N Supervision of the provision of personal care services, and assistance, as needed

Explain:

5 - Skilled Nursing Care and Intervention

To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant's condition or conditions require:

☐ Y ☐ N Skilled Nursing Care and Intervention to provide self-care while at a CBAS Center.

Explain:

CORE Personal Care / Social Services ☐ Y ☐ N Qualifies? (requires Y for one or more of the five services listed)	**Personal Care & Social Services** To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant participant's condition or conditions require: ☐ Y ☐ N Supervision/assistance with ADL's/IADL's ☐ Y ☐ N Protective group supervision and interventions to assure participant safety and to minimize the risk of injury, accident, inappropriate behavior, or wandering ☐ Y ☐ N Individual observation, assessment and monitoring of psychosocial issues on an intermittent basis ☐ Y ☐ N Group work to address psychosocial issues. ☐ Y ☐ N Care Coordination (e.g., medical appointments, transportation) Explain:
CORE Therapeutic Activities ☐ Y ☐ N Qualifies? (requires Y for one or more of the two services listed)	To maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization the participant participant's condition or conditions require: ☐ Y ☐ N Group or individual activities to enhance the social, physical or cognitive functioning of the candidate ☐ Y ☐ N Facilitated participation in group or individual activities because of frailty/cognitive functioning level that precludes them from active participation in scheduled activities Explain:

I. CBAS ELIGIBILITY DETERMINATION – Eligibility Categories

Part 3

The individual meets the following CBAS eligibility categories: (Check all that apply)

☐ Category 1

☐ **Nursing Facility Level A (NF-A) or above**
☐ **AND** Meets ADHC eligibility and medical necessity (AE&MN) criteria (Qualifies for all Categories in Part 2).

Explain:

☐ Category 2

☐ **Organic, Acquired or Traumatic Brain Injury and/or Chronic Mental Illness**
☐ **AND** Meets ADHC eligibility and medical necessity (AE&MN) criteria (Qualifies for all Categories in Part 2).
☐ **AND** Demonstrated need for assistance or supervision with at least 2 of the following ADLs/IADLs:

Bathing, dressing, self-feeding, toileting, ambulation, med. management, transferring, hygiene

OR 1 ADL/IADL listed above and 1 IADL from below:

Money management, accessing resources, meal preparation, transportation

Explain:

☐ Category 3

☐ **Alzheimer's disease or other dementia:** moderate to severe Alzheimer's disease or other dementia characterized by the descriptors of, or comparable to, Stages 5, 6 or 7 Alzheimer's disease
☐ **AND** Meets ADHC eligibility and medical necessity (AE&MN) criteria (Qualifies for all Categories in Part 2).

Explain:

☐ Category 4

☐ **Mild Cognitive Impairment including moderate Alzheimer's disease or other dementias** characterized by the descriptors of, or comparable to, Stage 4 Alzheimer's disease
☐ **AND** Meets ADHC eligibility and medical necessity (AE&MN) criteria (Qualifies for all Categories in Part 2).
☐ **AND** Demonstrated need for assistance or supervision with at least 2 of the following ADLs/IADLs:

Bathing, dressing, self-feeding, toileting, ambulation, med. management, transferring, hygiene

Explain:

☐ Category 5

☐ **Individuals who have Developmental Disabilities** meeting the definitions and requirements set forth in title 17, section 54001(a) of the California Code of Regulations, as determined by a Regional Center under contract with the Department of Developmental Services.
☐ **AND** Meets ADHC eligibility and medical necessity (AE&MN) criteria (Qualifies for all Categories in Part 2).

Explain:

☐ DOES NOT MEET eligibility criteria for CBAS – does not meet any of the eligibility Categories listed above.

Explain:

J. SIGNATURES

Face-to-Face Assessor Recommendation

☐ **The individual <u>appears to meet</u> the criteria for Community Based Adult Services (CBAS)**

☐ **The individual <u>does not appear to meet</u> the eligibility criteria for CBAS.**

Assessor Signature/Credential:_____ Date: _____

Health Plan / Field Office Review Section

Optional Quality Review ☐ **Not Applicable**

☐ Agree with Assessor ☐ Disagree with Assessor

Quality Reviewer Signature/Credential: _____ Date: _____

Comments:

2nd Level Review ☐ **Not Applicable**

☐ **The individual <u>meets</u> the criteria for Community Based Adult Services (CBAS)**

☐ **The individual <u>does not meet</u> the criteria for CBAS.**

2nd Level Reviewer Signature/Credential: _____ Date: _____

For existing CBAS participants that <u>do not meet</u> the criteria for CBAS, CBAS Center Program Director was notified on:

Date:_____ Time:_____

Comments:

Comment Page