Questionnaire

T1005 Agency-Directed Respite and S5150 Consumer-Directed Respite

Instructions:

Always send this questionnaire with a fully-completed DMAS-98 Community Based Care Request for Services Form.

Answer each question fully and completely. If more space is needed to answer any questions, please use the "Additional Information" space on the DMAS-98 form. Providing all of the requested information necessary to review your request will decrease the chance of it being pended for additional information and expedite the authorization decision.

For EDCD and HIV/AIDS Waivers, screening documentation (as specified in the Provider Manuals) must be submitted when a recipient has never been in the EDCD or HIV/AIDS Waiver, or has not received Waiver or Nursing Facility services within the 6 months prior to the start of care.

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Provider Contact Name:
Provider Contact Number:
Is the recipient currently in the EDCD or HIV/AIDS waiver program? ☐ Yes ☐ No
If no, to previous question, has the recipient been discharged from a Nursing Facility within the past 6 months? ☐ Yes ☐ No
Is this a new enrollee for this agency? ☐ Yes ☐ No
Is this a transfer from another agency? ☐ Yes ☐ No
If Yes to previous question, what is the last date of service from the previous provider?
What is the name of the unpaid primary caregiver requesting Respite?
Is respite the sole waiver service? ☐ Yes ☐ No
If Yes to previous question, what is the date the DMAS-300 was signed by the provider?
For HIV/AIDS Waiver only: Does the primary caregiver live with the recipient? ☐ Yes ☐ No

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Continue here if this a new enrollment for EDCD or AIDS Waiver, or the recipient has not received EDCD or AIDS Waiver services within 6 months of SOC, or has been d/c from NF within 6 months of SOC. The information from the UAI is only needed for new enrollments. UAI must be updated if greater than 6 months old.	
Date the most recent UAI signed and dated.	
If UAI has been updated/revised, date of update.	

ADLs	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40			Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing											
Dressing											
Toileting											
Transferring											
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating/Feeding											

Continence	Needs Help?		Incontinent Less than weekly 1	External Device/ Indwelling/ Ostomy Self care 2	Incontinent Weekly or more 3	External Device Not self care 4	Indwelling Catheter Not self care 5	Ostomy Not self care 6
	No 00	Yes						
Bowel								
Bladder								

Comments:

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

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JOINT MOTION (From page 6 of the UAI)

☐ Normal Limits or instability corrected

☐ Limited Motion

☐ Instability uncorrected or immobile

Recent Weight Gain/ Loss (From page 6 of the UAI)? If weight ratio is an issue, please describe in Additional Comments.

☐ Yes
☐ No

Current Medical Services (From page 7 of the UAI). List up to 4. Include Rehabilitation Therapies and/or Special Medical Procedures.

Medical/Nursing Needs (From page 7 of the UAI). Please State the identified medical/nursing needs.

Short Term Memory Loss

☐ Yes
☐ No

Long Term Memory Loss

☐ Yes
☐ No

Judgment Problems

☐ Yes
☐ No

	Behavior Pattern (From page 8 of the UAI) ☐ Appropriate ☐ Wandering/Passive Less than weekly ☐ Wandering/Passive Weekly or More ☐ Abusive/Aggressive /Disruptive<Weekly ☐ Abusive/Aggressive /Disruptive> Weekly ☐ Comatose	
	Date DMAS 96 signed by M.D.	
	Medicaid Authorization Level of Care from the DMAS 96. Please state the number of the Level of Care Indicated, _____.	
	DMAS 97- Individual meets Nursing Facility Criteria. ☐ Yes ☐ No	
	Date DMAS 97 completed.	
	Please enter Client Case Summary Information (from pg 12 of UAI), if indicated.	