



KDADS CARE Special Admission Fax Memo

Fax: 785-291-3427 or E-mail to KDADS.CARE@Ks.gov

CONFIDENTIAL

Client Name _____

Admission Date to Nursing Facility _____ # of pages _____

Nursing Facility Staff/Title _____

Nursing Facility Name _____

Nursing Facility Address _____

Phone/e-mail _____

Please attach the PASRR (Sections A&B of the level 1 CARE assessment)

TRANSFER FROM OTHER LONG TERM CARE/SKILLED NURSING FACILITY

- 1. Name of the facility the person is leaving _____
- 2. Date of the discharge from the facility _____
- 3. Date of the CARE Level I on file _____
Attach the CARE Certificate

A. IDENTIFICATION

1. Social Security # (Optional)
_____ - _____ - _____

2. Customer Last Name

First Name _____ MI _____

3. Customer Address
Street _____
City _____ County _____
State _____ Zip _____
Phone _____

4. Date Of Birth ____/____/____

5. Gender Male Female

6. Date of Assessment ____/____/____

7. Assessor's Name

8. Assessment Location

9. Primary Language
 Arabic Chinese English
 French German Hindi
 Pilipino Spanish Tagalog
 Urdu Vietnamese
 Sign Language Other _____

10. Ethnic Background
 Hispanic or Latino
 Non Hispanic or Latino

11. Race
 American Indian or Alaskan Native
 Asian
 Black or African American
 Native Hawaiian, or Other Pacific Islander
 White
 Other _____

12. Contact Person Information
Name _____
Street _____
City _____
State _____ Zip _____
Phone _____

Guardian Yes No

B. PASRR

1. Is the customer considering placement in a nursing facility? Yes No

2. Has the customer been diagnosed as having a serious mental disorder?
 Yes No

3. What psychiatric treatment has the customer received in the past 2 years (check all that apply)?
 2 Partial hospitalizations
 2 Inpatient hospitalizations
 1 Inpatient & 1 Partial hospitalization
 Supportive Services
 Intervention
 None

For those individuals who have a mental diagnosis and treatment history please record that information _____

4. Level Of Impairment?
 Interpersonal Functioning
 Concentration/ persistence/ and pace
 Adaptation to change
 None

5. Has the customer been diagnosed with one of the following conditions prior to age 18 for Mental Retardation / Developmental Disability, or age 22 for related condition, and the condition is likely to continue indefinitely?
 Developmental Disability (IQ _____)
 Related Condition
 None

For those individuals who have a development disability or related condition please record that information: _____

6. Referred for a Level II assessment?
 Yes No

C. SUPPORTS

1. Live alone Yes No

2. Informal Supports available
 Yes Inadequate No

3. Formal Supports available
 Yes Inadequate No

D. COGNITION

1. Comatose, persistent vegetative state Yes No

2. Memory, recall
____ Orientation
____ 3-Word Recall
____ Spelling
____ Clock Draw

E. COMMUNICATION

1. Expresses information content, however able
 Understandable
 Usually understandable
 Sometimes understandable
 Rarely or never understandable

2. Ability to understand others, verbal information, however able
 Understands
 Usually understands
 Sometimes understands
 Rarely or never understands

F. RECENT PROBLEMS / RISKS

____ Falls (6 mo) ____ Falls (1 mo)

Injured head during fall(s)
 Neglect/ Abuse/ Exploitation
 Wandering
 Socially inappropriate/ disruptive behavior
 Decision Making
 Unwilling/Unable to comply with recommended treatment
 Over the last few weeks / months - experienced anxiety / depression.
 Over the last few weeks/ months - experienced feeling worthless
 None

G. CUSTOMER CHOICE FOR LTC

Home without services
 Home with services
 ALF/ Residential/ Boarding Care
 Nursing Facility (name below):

Anticipated less than 90 days
Street _____
City _____ Zip _____
Phone _____