New Jersey Department of Human Services
Division of Aging Services

INSTRUCTIONS FOR COMPLETING THE LONG TERM CARE RE-EVALUATION (WPA-1) FORM

1. Enter (print) the Name of the participant.

2. Enter (print) the Care Manager's name.

3. Enter the 12-digit Medicaid or JACC Number.

4. Enter the date that the WPA-1 form is being completed.

5. Enter the date the previous assessment/re-evaluation was completed.

6. Check the Program of enrollment.

7. **Functional Status**

   A. Indicate if the participant can recall 3 items from memory after 5 minutes by checking Yes or No.

   B. Indicate if the participant can perform or verbalize all or almost all steps in a multi-task sequence without dues for initiation by checking Yes or No.

   C. Indicate how well the participant makes decisions about organizing the day by checking one of the following:

   - Independent – Decisions consistently reasonable.
   - Modified Independence– Some difficulty in new situations only.
   - Minimally Impaired – In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times.
   - Moderately Impaired – Decisions consistently poor or unsafe, cues/ supervision required at all times.
   - Severely Impaired– Never/rarely makes decisions.

   D. Indicate how well the participant expresses himself or herself and makes self understood by checking one of the following:

   - Understood – Expresses ideas without difficulty.
   - Usually Understood – Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required.
   - Often Understood – Difficulty finding words or finishing thoughts - prompting usually required.
   - Sometimes Understood – Ability limited to making concrete requests.
   - Rarely/Never Understood.

   E. Indicate if the participant receives nourishment via an enteral tube feeding by checking Yes or No.

   F. Indicate the participant's Self-Performance in the following Activities of Daily Living (ADL).

   NOTE: Scoring is to reflect each activity as it has occurred over the past 3 days, except for Bathing which is to reflect its occurrence over the past 7 days.

   <u>ACTIVITIES OF DAILY LIVING</u>

   - Bed Mobility – *How the participant: Moves to and from lying position. Turns side to side. Positions self while in bed.*
   - Eating – *How the participant: Puts food into his/her mouth, drinks liquids, feeds self finger foods. For tube feeding, is person able to administer own tube feeding?*
   - Transfer – *How the participant: Moves to and between surfaces (does NOT include to/from bath or toilet). Moves to and from bed, chair, or wheelchair? Moves to a standing position?*
   - Toilet Use – *How the participant: Uses the toilet or commode, bedpan, urinal. Transfers on/off toilet. Cleans self after toilet use or incontinent episode. Changes incontinence pad, manages ostomy or catheter and adjust clothing.*
   - Locomotion in Home/Building – *If wheelchair bound, is he/she self-sufficient once in chair?*
   - Locomotion Outside Home/Building – *If wheelchair bound, is he/she self-sufficient once in chair?*
   - Upper Body Dressing – *How the participant: Dresses and undresses his/her street clothes, above the waist. Puts on pullover clothes, closes fasteners.*
   - Lower Body Dressing – *How the participant: Dresses and undresses*

his/her street clothes, underwear, from waist down. Applies prostheses and orthotics. How the participant puts on a belt, pants, skirts, shoes and socks.

- Bathing (scoring over the past 7 days) – *How the participant takes a full body bath/shower or sponge bath (excludes washing of back and hair). Describe how the participant washes each part of body (arms, upper and lower legs, chest, abdomen and perineal area).*

EXTENT OF SELF-PERFORMANCE

Assess participant's ADL Self Performance during the LAST 3 DAYS considering all episodes of these activities. Determine the 3 most dependent (highest level) episodes of assistance and then code using the least dependent of these 3 episodes.

**Exception: Bathing is assessed for last 7 days. Bathing is coded for the single most dependent episode over the past 7 days.

"Independent" means no help, setup or oversight.

"Set Up" means article or device provided within reach of the client.

"Supervision" means oversight, encouragement, or cueing.

"Limited Assistance" means physical help in guided maneuvering of limbs or other non-weight-bearing assistance.

"Extensive Assistance" means weight-bearing assistance. Participant performed part of activity completing greater than 50% of task on own.

"Maximal Assistance" means weight-bearing assistance. Participant involved and completed less than 50% of task on own.

"Total Dependence" means full performance of the activity by another. No involvement by participant.

"Did Not Occur" means the activity was not performed by participant or others.

G. Nursing Facility Level of Care Criteria

1. Does the participant meet the ADL Index criteria of 6 or greater and have any 3 ADLs (limited assist or greater)?

   If checking "Yes" here, then Section 10. A. would also be completed to confirm that the participant remains eligible.

   If checking "No" here, if 3 ADL criteria is not met, conference case with OCCO.

2. Does the participant meet the CPS Score criteria of 3 or greater and have any 3 ADLs (supervision or greater)?

   If checking "Yes" here, then Section 10. A. would also be completed to confirm that the participant remains eligible.

   If checking "No" here, if 3 ADL criteria is not met, conference case with OCCO.

3. Does the participant meet the ADL Assistance criteria by requiring limited assistance or greater in Locomotion, Dressing AND Bathing?

   If checking "Yes" here, then Section 10. A. would also be completed to confirm that the participant remains eligible.

   If Checking "No" here as well as checking "No" in Option 1 and 2, then Section 10. B. would also be completed to state that the participant is thought to be ineligible and the Care Manager would discuss voluntary disenrollment and make a referral to OCCO for a comprehensive assessment to be completed if the participant refuses to withdraw.

NOTE: Participant must meet at least one of the above three (3) criteria to continue to meet clinical eligibility for Nursing Facility Level of Care.

If it appears that three (3) ADL criteria is not met for a participant, yet the participant meets the ADL Index criteria of 6 or greater or meets CPS Score criteria of 3 or greater, it is possible that the ADL criteria may be miscoded. Before finishing the rest of the

form, the Care Manager shall alert his or her Case Management Supervisor that the Care Manager is to conference the case with the Regional Office of Community Choice Options to verify appropriate coding outcomes. Once that discussion between OCCO and the Care Manager has occurred about the participant's care needs, a WPA-1 LTC Re-Evaluation form shall be completed in its entirety illustrating the clinical eligibility of the participant. Depending on the outcome of the conversation between OCCO and the Care Manager, a new WPA-1 form may be necessary. The requirement that all LTC Re-Evaluations occur annually remains even when a conference call with OCCO is necessary.

8. **Social Support Network**
Identify social support concerns in areas such as the following:

- **Involvement of Participant**
Is the participant at Least interacting with others (e.g., likes to spend time with others)? Openly expresses conflict or anger with family/friends?

- **Change in Social Activities**
Does the participant show a decline in his or her involvement with social, religious, occupational or other preferred activities? If there was a decline, is participant distressed by this fact?

- **Isolation**
Indicate length of time participant is alone during the day (morning and afternoon). Does the participant say or indicate he/she feels lonely?

- **Informal Supports**
Identify the primary and secondary caregivers. Identify the help the participant receives from informal supports, such as advice, emotional support, ADL care, IADL care. Indicate the hours provided for ADL and IADL care.

- **Caregiver Status**
Status of current primary caregiving arrangements. Is the caregiver unable to continue in caring activities (e.g., caregiver has decline in health, new job, other responsibilities)? Primary caregiver is not satisfied with support received from family and friends (e.g., other children of participant). Primary caregiver expresses feelings of distress, anger, or depression.

9. **Physical Environment**
The participant's **living arrangement** can be described by the following:

- Does participant live alone or with others (how many others)?
- Did participant recently move in with another person (did other persons move in with participant)?
- Identify if participant lives in house, apartment, Assisted Living Facility, Adult Family Care Home, other.
- Does participant share a bedroom and/or a bathroom?
- Participant or primary caregiver feels that participant would be better off in another living environment.

Identify **environmental problems** in areas such as the following:

- Hazardous or uninhabitable
- Lighting in evening (including inadequate or no lighting in living room, bedroom, kitchen, bathroom, halls).
- Floor and carpeting (e.g., holes in floor, electric wires where participant walks, scatter rugs).
- Bathroom and toilet room (e.g., non-operating toilet, leaking pipes, no rails/grab bars though needed, slippery bathtub, outside toilet).
- Kitchen (e.g., dangerous stove, inoperative refrigerator, infestation by rodents or bugs.
- Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in home with asthmatic).
- Personal safety (e.g., fear of violence, safety issue going to mailbox/visiting neighbors, heavy traffic area).
- Access to home (e.g., difficulty entering/leaving home).
- Access to rooms in house (e.g., unable to climb stairs).
- Is household without cooking facilities/ refrigerator on premises, microwave on premises, telephone accessible and usable, tub/shower/hot water accessible, working smoke detectors, washer/dryer accessible?
- Does home require modifications to remove barriers or home repairs?

Instructions for Completing the Long Term Care Re-Evaluation (WPA-1) Form (Continued)

10. **Verification of Nursing Facility Level of Care**
After completing the assessment, the Care Manager will indicate whether or not the participant meets the Nursing Facility Level of Care by checking one of the two boxes:

A. Care Manager will check the "A" box if participant **continues to meet** clinical eligibility criteria for Nursing Facility Level of Care, sign his/her name, and enter the date of determination. The Care Manager's Supervisor or Care Coordinator will sign the form to indicate he/she reviewed the assessment. (If the Care Manager Supervisor or Care Coordinator is completing the Re-Evaluation form, a qualified staff person may sign the form as reviewer.)

- An individual must be assessed as in need of NF LOC in order to be clinically eligible for continued enrollment in the Global Options for Long-Term Care Medicaid Waivers and the JACC Program.

B. If the Care Manager determines that the participant **no longer meets** the clinical eligibility criteria for Nursing Facility Level of Care, the Care Manager indicates this by checking the "B" box, signing his/her name, and entering the date the determination was made.

- The Care Manager will discuss the re-evaluation with his or her Supervisor. If the Supervisor and Care Manager are in agreement, the Supervisor will sign the determination in the "Reviewed by" line of this section of the form.
- The Care Manager will discuss voluntary program withdrawal with the participant, explaining the reasons for the determination. This discussion should also include other service options that the participant may have once disenrolled from the Waiver. The Care Manager will indicate this by checking the applicable box. When a participant voluntarily disenrolls, a Participant Withdrawal form (CP-18) is to be completed.
- If the participant disagrees with the determination and chooses not to voluntarily withdraw from the program, the Long Term Care Re-evaluation (WPA-1) form should be sent to the Regional Office of Community Choice Options (OCCO) to request a Pre-Admission Screen (PAS) assessment for the participant.

<u>Office of Community Choice Options Responsibilities</u>
The OCCO determination is final. A copy of the assessment as completed by the OCCO Community Choice Counselor is to be given to the Care Management Agency in response to the referral. The Care Manager shall update the WPA-1 form by entering the end result of the OCCO assessment and the date that the determination was made in the OCCO Referral/Outcome Section.

- If OCCO staff finds that the participant continues to meet the NF Level of Care, Waiver enrollment continues. A copy of the assessment completed by OCCO must be secured by the Care Manager for inclusion in the participant's records and for comprehensive care planning purposes.
- If OCCO staff agrees that the participant no longer meets NF Level of Care, the Community Choice Counselor completes the Denial Letter (LTC-14), which advises the individual of his or her ineligibility and the right to appeal the determination. The Denial Letter is either left with the participant or sent to him or her, with a copy to the Care Management site. If the individual appeals, Waiver enrollment and services continue, if the participant indicates such on the LTC-14, until the Fair Hearing is held and a determination is finalized.