

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

NAME: \_\_\_\_\_ SEX:  M  F CIN \_\_\_\_\_

PREFERRED LANGUAGE: \_\_\_\_\_

FACILITY: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

DATE ASSESSED: \_\_\_\_\_ LIVING ARRANGEMENT:  HOME  ICF/  B&C  OTHER \_\_\_\_\_

AUTHORIZED REP/LEGAL REPRESENTATIVE: \_\_\_\_\_ CONTACT #: \_\_\_\_\_

**A.** The below classes are **categorically eligible** for CBAS:  Regional Center consumer  MSSP Waiver (enrollee)  
 Specialty mental health services (eligible or receiving)  Individual eligible for 195 or more hours/month IHSS

**B.** Likely to meet NF-B level of care as determined by DHCS or current IPC indicates a need for assistance or supervision with three (3) of the following ADL/IADLs: bathing, dressing, self feeding, toileting, ambulation, transferring, medication management and hygiene and one nursing intervention provided at ADHC. **Presumptively eligible:**  Yes  No

**C. Unconfirmed classification by ADHC:**  
 Category 1: NF-A or NF-B LOC  
 Category 2: Organic/Acquired or Traumatic Brain Injury AND/OR Chronic Mental Health  
 Category 3: Alzheimer's disease or Other Dementia (Stage 5,6 or 7)  
 Category 4: Mild Cognitive Impairment including Moderate Alzheimer's (Stage 4)  
 NA Category 5: Developmental Disability [currently categorically eligible during ADHC to CBAS transition]

**D. Stage of Alzheimer's disease or dementia:**  
 \_\_\_\_\_  
 Needed only if qualifying as Category 3 or 4

E. DIAGNOSES:	MEDICATIONS: <i>(use back of page or attachments, if needed)</i>	
1.	1.	6.
2.	2.	7.
3.	3.	8.
4.	4.	9.
5.	5.	10.

**F. MEDICATION ADMIN:**(mark all that apply)  Self Administers  Family/Caregiver Administered  CBAS Administers  
 Hx of Non-Compliance  Administers with other assistance: \_\_\_\_\_  
 Unable to self-administer due to:  PHYSICAL disability  MENTAL disability  Forgetful

\*Explain: \_\_\_\_\_

G. ADL/IADLs:	Independent	Supervision	Assistance	Dependent
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>IADLs</b>				
Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Mgmt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Additional IADL Exceptions:</b>				
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access Resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Explain ADL/IADLs:**

**H. ASSISTIVE/SENSORY DEVICES**

Dentures \_\_\_\_\_

Vision \_\_\_\_\_

Hearing \_\_\_\_\_

Other \_\_\_\_\_

\*Explain: \_\_\_\_\_



<p><b>6. MUSCULO-SKELETAL</b></p> <p><input type="checkbox"/> Not applicable, within normal limits</p> <p><input type="checkbox"/> Ambulatory / Independent</p> <p><input type="checkbox"/> Cane    <input type="checkbox"/> Walker</p> <p><input type="checkbox"/> Wheelchair    <input type="checkbox"/> Able to self-propel wheelchair</p> <p><input type="checkbox"/> Wheelchair Bound</p> <p><input type="checkbox"/> Bed Bound</p> <p><input type="checkbox"/> Contractures</p> <p><input type="checkbox"/> Paralysis            <input type="checkbox"/> Paresis</p> <p>    <input type="checkbox"/> Hemiplegia    <input type="checkbox"/> Paraplegia</p> <p>    <input type="checkbox"/> Quadriplegia</p> <p><input type="checkbox"/> Transfer Description _____</p> <p><input type="checkbox"/> Other: _____</p> <p>*Explain: _____</p>	<p><b>7. OVER-ALL SIGNIFICANT FACTORS</b></p> <p><input type="checkbox"/> Frail                            <input type="checkbox"/> Weak</p> <p><input type="checkbox"/> Isolated                      <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Pain Indicators            <input type="checkbox"/> Self-neglect</p> <p><input type="checkbox"/> Poor Judgment            <input type="checkbox"/> Hx of Substance Abuse</p> <p><input type="checkbox"/> Overweight                <input type="checkbox"/> Underweight</p> <p><input type="checkbox"/> Cognitive and Behavioral Factors</p> <p>    <input type="checkbox"/> Cognitive Loss            <input type="checkbox"/> Wandering</p> <p>    <input type="checkbox"/> Memory Loss            <input type="checkbox"/> Aggressive</p> <p>    <input type="checkbox"/> Disruptive                <input type="checkbox"/> Agitated</p> <p>    <input type="checkbox"/> Limited Response        <input type="checkbox"/> Confused</p> <p>*Explain: _____</p>
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**J. Current Care Plan and Circumstance Description**

Current - Services	Describe Intervention and Frequency of Treatment
<b>Professional Nursing Services</b>	
<b>Personal Care / Social Services</b>	
<b>Therapeutic Services</b>	
<b>In-Home Supportive Services</b>	# of hours _____
<b>Description of caregiver situation</b>	
<b>Description of home environment issues</b>	

**COMMENTS / ONSITE REVIEW FINDINGS:**

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## K. REVIEWER DETERMINATION

A copy of the current IPC or other relevant documentation may be attached to validate nursing interventions and/or condition, etc, however, the IPC alone should not be used to determine ineligibility for CBAS.

### The individual meets the following criteria:

- Categorically Eligibility
- Presumptively Eligibility
- Nursing Facility Level A (NF-A) or above
- Organic, Acquired or Traumatic Brain Injury and/or Chronic Mental Illness PLUS demonstrated need for assistance or supervision with at least 2 of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management and hygiene OR 1 ADL/IADL listed above and money management, accessing resources, meal preparation or transportation.
- 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
- Mild Cognitive Impairment including moderate Alzheimer's disease or other dementias characterized by the descriptors of, or comparable to, Stage 4 Alzheimer's disease. Plus demonstrated need for assistance or supervision with at least 2 of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management and hygiene

#### Assessor

The individual meets the criteria for Community Based Adult Services (CBAS)

The individual does not meet the criteria for CBAS.

NE Assessor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### QA Reviewer

QA Reviewer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agree  Disagree

Disagreement Reason: \_\_\_\_\_

#### 2nd Level Reviewer

The individual meets the criteria for Community Based Adult Services (CBAS)

The individual does not meet the criteria for CBAS.

2<sup>nd</sup> Level Reviewer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For an individual that does not meet the criteria for CBAS, the Program Director was notified on:

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Comments: \_\_\_\_\_