

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES  
COMMUNITY BASED ADULT SERVICES (CBAS)

**Eligibility Screening Tool**

Center Name: \_\_\_\_\_ NPI #: \_\_\_\_\_

Participant Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medi-Cal Number: \_\_\_\_\_

**A. Demonstration of Categorical Eligibility Review**

Checked box indicates eligibility for CBAS. DHCS will verify.

- |                                                                                               |                                                    |                                                                              |                                                                                                                |
|-----------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Current<br>Multi-Purpose Senior<br>Services Program<br>(MSSP) Client | <input type="checkbox"/> Regional<br>Center Client | <input type="checkbox"/> Eligible for<br>Specialty Mental<br>Health Services | <input type="checkbox"/> Eligible to receive<br>195 or more hours of<br>In-Home Supportive<br>Services (IHSS). |
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**B. Demonstration of Presumptive Eligibility Review**

Checked box indicates potential eligibility for CBAS. Onsite review to follow.

- Likely to meet NF-B level of care (Nursing Facility-B), 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.

**C. Eligibility Screening for CBAS: Non-Categorical or Non-Presumptively Eligible**

Individual is eligible for CBAS if meets one of the following four categories. Onsite review will confirm.

1. Meets NF-A level of care or above
2. Has diagnosis of organic, acquired or traumatic brain injury and/or chronic mental illness and needs supervision or assistance with at least one of the following (*circle or highlight all that apply*)
- Two of the following ADL/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management and hygiene
- OR**
- One ADL/IADL listed in (a) above and money management, accessing resources, meal preparation or transportation.
3. Has moderate to severe Alzheimer's disease or other dementia characterized by the descriptors of, or comparable to, Stages 5-7 Alzheimer's disease.
4. Has mild cognitive impairment or moderate Alzheimer's disease or other dementia characterized by the descriptors, or comparable to, Stage 4 Alzheimer disease
- AND**
- Needs supervision or assistance with (two) 2 of the following ADL/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management and hygiene. (*circle or highlight all that apply*)

*NOTE: Individuals with developmental disabilities who are current Regional Center clients are categorically eligible during this transition period.*

Participant Name: \_\_\_\_\_

Describe key findings to explain eligibility category selected.

Eligibility Description:

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**D. Eligibility Outcome, Center Information and Screener Identification**

- Per ADHC initial screening, participant meets eligibility criteria for CBAS.
- Per ADHC initial screening, participant does not meet eligibility criteria for CBAS.

Screener's Name: \_\_\_\_\_ Position: \_\_\_\_\_

Screener's Signature: \_\_\_\_\_ Date of Screening: \_\_\_\_\_

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_