



Significant Change Form

Bureau of Long Term Care

Purpose

This form is required to be submitted for any Significant Change requests for participants receiving Aged and Disabled Services Waiver services and Personal Care Services. **Significant Change in Client's Condition** (IDAPA 16.03.23.010.06.) is defined as, A major change in the client's status that affects more than one area of the client's unmet need or available support and requires review or revision of the care plan or service agreement. For detailed information on Significant Change please review the Significant Change Form Instructions.

The Medicaid nurse reviewer will use this information to approve or deny significant change requests.

Participant Name				Medicaid #	
Provider Name				Provider #	
Date of Request		Date of Change		Anticipated Length of Change	
Justification	☐ Decrease in unmet need or available support ☐ Increase in unmet need or available support				
Overview Narrative for Change					

All areas of this form are required or this document may be returned as denied. Please specify details related to the cause of the change in status for each appropriate area. If there is no change in an area, please mark No Change box for that section. Attach additional documentation that supports your observations if applicable and available. This may include attendant progress notes, supervising visit notes, the physician's history and physical, or office visit notes. For full instructions for completing Significant Change/Modification Request Form, please refer to document Significant Change/Modification Request Form Instructions and Sample. This document will provide information on how to fill out the form, update relevant information related to a participant's functional abilities, supports and needs.

PREPARING MEALS	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
EATING MEALS	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
TOILETING	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		

Participant Name: _____

Medicaid#: _____

Provider Name: _____

Provider#: _____

MOBILITY	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
TRANSFERRING	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
PERSONAL HYGIENE	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
DRESSING	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
BATHING	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
ACCESS TO TRANSPORTATION	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
SHOPPING	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
LAUNDRY	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
HOUSEWORK	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		

Participant Name: _____

Medicaid#: _____

Provider Name: _____

Provider#: _____

NIGHT NEEDS	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
MEDICATION	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
PSYCHOLOGICAL / SOCIAL/ COGNITIVE FUNCTION	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
AREAS INCLUDE	Disorientation, Memory, Judgement, Hallucinations, Delusions, Anxiety, Depression, Wandering, Disruptive, Assaultive, Danger to Self, Alcohol/Drug Use, and/or Vulnerability.	
Detailed narrative for change in abilities		

Below area is reserved for significant changes for supplemental services (i.e.: Non-Medical Transportation, Chore Services, etc.)

Please specify the service in the top left box in addition to the available support and the detailed narrative. (See Significant Change Form Instructions for a full list of supplemental services)

OTHER (Please Specify):	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		
OTHER (Please Specify):	Available Support	☐ Circle all that apply: Family, Neighbor, Friend, Other: _____ ☐ No Support ☐ No Change
Detailed narrative for change in abilities		

Participant Signature		☐ Participant refused to sign	Date	
Provider Print Name		Provider Signature	Date	
RN Print Name		RN Signature	Date	

After form is complete, please fax form with cover sheet to:

Region1 (208)666-6856 - Region2 (208)799-5167 - Region3 (208)454-7625 –
 Region4 (208)334-0953 - Region5 (208)736-2116 - Regions6 (208)239-6269 - Region7 (208)528-5756



Significant Change Form Instructions

Bureau of Long Term Care

Purpose

These instructions are intended to assist our agencies providing A&D Waiver services and PCS to adults to identify significant changes in participant status that result in an increase or decrease in the UAI Unmet needs. IDAPA 16.03.23.010.06. Significant Change in Client's Condition. A major change in the client's status that affects more than one area of the client's unmet need or available support and requires review or revision of the care plan or service agreement.

Instructions

- 1) Verify the participant has had a change in functioning that is significant enough to warrant a change in the participant's amount of help they need in any areas listed below. Review the guideline definitions, and determine if there has been a change in any of the functioning areas.
- 2) Provider supervising personnel should visit the participant to assess what functioning areas have been impacted. Only in emergency situations will the regional reviewer consider a modification request without a provider visit to the participant's home.
- 3) If a change has occurred in any of the functioning areas, describe the participant's specific ability in the appropriate box. If there is no change in an area on this form, please mark the No Change box for that section.
- 4) Under "Justification Overview for Change" at the top of the form, please note what has caused the participant's change in functioning, when the change began, and the anticipated length of time the change in functioning will continue. Include in this area any changes to Available Supports when applicable.
- 5) If non-medical transportation services are approved, services will need to be specified in the care plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge or public transit provider will be utilized.
- 6) Attach additional documentation that supports your observations if applicable and available. This may include attendant progress notes, supervising visit notes, the physician's history and physical, or office visit notes.
- 7) The Provider Supervising personnel (if completed the request), Provider RN and the participant or the participant's representative must sign and date the request.
- 8) If the participant refuses to sign, the Agency will mark the box for refusal. The Agency RN or Supervising Personnel will sign and date where appropriate
- 9) If the change is approved by the BLTC Reviewer. The Plan of Care (Service Agreement) must be updated to reflect the change.
- 10) CFH ONLY: The updated Plan of Care does not need to be sent to the BLTC Reviewer for approval. The Significant Change Form attached to the approved Plan of Care (Service Agreement) will constitute the plan change approval.

PREPARING MEALS	Identify the participant's ability to prepare own food. Consider safety issues such as whether burners are left on. None: No help or caregiver support needed. Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance. Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity. Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support. Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.
EATING MEALS	Identify the level of assistance needed to perform the activity of feeding and eating with special equipment if regularly used or special tray setup. None: No help or caregiver support needed. Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance. Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity. Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support. Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.
TOILETING	Identify the participant's ability to get to and from the toilet (including commode, bedpan, and urinal), manage colostomy or other devices, to cleanse after eliminating, and to adjust clothing. None: No help or caregiver support needed.

	Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance. Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity. Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support. Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.
MOBILITY	Identify the participant's physical ability to get around both inside and outside, using mechanical aids if needed. None: No help or caregiver support needed. Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance. Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity. Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support. Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.
TRANSFERRING	Identify the participant's ability to transfer when in bed or wheelchair. None: No help or caregiver support needed. Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance. Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity. Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support. Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.
PERSONAL HYGIENE	Identify the participant's ability to shave, care for mouth and comb hair. None: No help or caregiver support needed. Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance. Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity. Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support. Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.
DRESSING	Identify the participant's ability to dress and undress, including selection of clean clothing or appropriate seasonal clothing. None: No help or caregiver support needed. Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance. Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity. Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support. Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.
BATHING	Identify the participant's ability to bathe and wash hair. None: No help or caregiver support needed. Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance. Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity. Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support.

	Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.
ACCESS TO TRANSPORTATION	Identify the participant's ability to get to and from stores, medical facilities, and other community activities, considering the ability both to access and use transportation. None: No help or caregiver support needed. Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance. Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity. Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support. Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.
SHOPPING	Identify the participant's ability to shop for food and personal items. None: No help or caregiver support needed. Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance. Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity. Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support. Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.
LAUNDRY	Identify the participant's ability to do own laundry either at home or at laundromat. None: No help or caregiver support needed. Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance. Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity. Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support. Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.
HOUSEWORK	Identify the participant's ability to clean surfaces and furnishing in his/her living quarters, including dishes, floors and bathroom fixtures and disposing of household garbage. None: No help or caregiver support needed. Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance. Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity. Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support. Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.
NIGHT NEEDS	Identify the participant's need for assistance during the night. **See additional information table below for guidelines
MEDICATION	Identify the participant's ability/willingness to administer his/her own medication. **See additional information table below for guidelines
Psych/Socio	Identify the participant's ability to manage his/her life, including needs and activities. **See additional information table below

Below list of services are for supplemental services. If there are any significant changes regarding below services, please use the "Other" tables on the significant change form and specify the service requiring change in addition to the available support as well as the detailed narrative.

EMERGENCY RESPONSE	Identify the participant's ability to recognize the need for and to seek emergency help. None: No help or caregiver support needed. Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance.
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	Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity. Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support. Total: Incapable of completing any part of the activity, the caregiver or support must complete all of the activity.
SPECIALIZED MEDICAL EQUIPMENT/ SUPPLIES	Specialized medical equipment and supplies include: Devices, controls, or appliances that enable a participant to increase his abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which he lives; and Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State plan and exclude those items that are not of direct medical or remedial benefit to the participant.
SKILLED NURSING	Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit.
ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS	Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participant's principal residence, and is owned by the participant or the participant's non-paid family. c. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department.
PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)	PERS is an electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service is limited to participants who: Rent or own a home, or live with unpaid caregivers, are alone for significant parts of the day, have no caregiver for extended periods of time and would otherwise require extensive, routine supervision. Authorization Information: PERS Installation includes the install and first month's rent.
CONSULTATION	Consultation services are services to a participant or family member. Services are provided by a Personal Assistance Agency to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self-reliance possible for the participant and the participant's family. Services include consulting with the participant and family to gain a better understanding of the special needs of the participant and the role of the caregiver.
HOME DELIVERED MEALS	Home delivered meals are meals that are delivered to the participant's home to promote adequate participant nutrition. One (1) to two (2) meals per day may be provided to a participant who: Rents or owns a home, is alone for a significant part of the day, has no caregiver for extended periods of time and is unable to prepare a meal without assistance.
CHORE SERVICES	Chore services include the following services when necessary to maintain the functional use of the home, or to provide a clean, sanitary, and safe environment. Intermittent assistance may include the following; Yard maintenance, minor home repair, heavy housework, sidewalk maintenance, trash removal to assist the participant to remain in the home. Chore activities may include the following; washing windows, moving heavy furniture, shoveling snow, chopping wood when wood is the participant's primary source of heat and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them or is responsible for their provision. In the case of rental property, the landlord's

	responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant.
ADULT DAY HEALTH	Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. Authorization Information: 14 hours per day is the maximum amount to be authorized
RESPIRE	Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments. Respite care services may be provided in the participant's residence, a certified family home, a developmental disabilities agency, a residential care or assisted living facility, or an adult day health facility.
COMPANTION SERVICES	Companion services include non-medical care, supervision, and socialization provided to a functionally impaired adult. Companion services are in-home services to ensure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider, who may live with the participant, may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. However, the primary responsibility is to provide companionship and be there in case they are needed.
SUPPORTED EMPLOYMENT	Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work.
COMMUNITY SUPPORT/ BEHAVIOR MANAGEMENT	Use of community services such as day treatment, workshop programs, financial or legal services, vocational training, case management, targeted service coordination, transportation, etc. Please include family support, physicians, attorneys, social workers, etc.
HABILITATION	Habilitation services assist the participant to reside as independently as possible in the community, or maintain family unity. Residential habilitation a. Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in certified family homes. The services and supports that may be furnished consist of the following: Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; or Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic

	programs. Personal assistance services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the person or the person's primary caregiver(s) are unable to accomplish on his or her own behalf. Personal assistance activities include direct assistance with grooming, bathing, and eating, assistance with medications that are ordinarily self-administered, supervision, communication assistance, reporting changes in the waiver participant's condition and needs, household tasks essential to health care at home to include general cleaning of the home, laundry, meal planning and preparation, shopping, and correspondence. Day habilitation b. Day habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day habilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.
NON-MEDICAL TRANSPORTATION	Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources. This service is limited to 1800 miles per year. a. Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it. b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge, or public transit providers will be utilized.

All Functional Areas except Night Needs and Medications

None: No help or caregiver support needed.

Minimal: Capable of participating in the activity with caregiver support, oversight, encouragement, cueing, or standby assistance.

Moderate: Capable of participating in the activity, but limited hands-on caregiver support needed to complete the activity.

Extensive: Capable of minimal participation in the activity; only able to complete the activity with hands-on or weight bearing assistance from the caregiver or support.

Total: Incapable of completing any part of the activity, the caregiver or support must complete all the activity.

Functional Areas for Night Needs **Requires documentation for approval.

None: Needs no assistance from another person during the night.

Minimal: Requires hands on or standby assistance 1-2 times per night for care.

Moderate: Requires hands on or standby assistance 3-4 times per night for care.

Extensive: Requires hands on or standby assistance 5 or more times per night for care.

Total: Requires continuous hands on or standby assistance throughout the night for care.

Functional Areas for Medication

None: Can self-administer medication without assistance.

Minimal: Requires minimal assistance (i.e. open containers or use a mediset); understands medication routine.

Moderate: Requires occasional assistance or cueing to follow medication routine or timely medication refills.

Extensive: Requires daily assistance or cueing; must be reminded to take medications; does not know medication routine; may not remember if took medications.

Total: Requires licensed nurse to administer and/or assess the amount, frequency, or response to medication or treatment. A treatment is defined as an in home skilled nursing treatment.

Psychological/Social/Cognitive Function

Psychological/Social/Cognitive areas are based on the following areas:

Disorientation Delusions Disruptive Vulnerability

Memory Anxiety Assaultive

Judgement Depression Danger to Self

Hallucinations Wandering Alcohol/Drug

If you have any questions, concerns or need assistance with this form please call, fax or email and our staff will assist you.



Region Contact Information and Map

Region 1- Coeur d' Alene

Phone (208) 769-1567

Fax (208)666-6856

Email BLTCRegI@dhw.idaho.gov

Region 2- Lewiston

Phone (208) 799-4430

Fax (208)799-5167

Email BLTCRegII@dhw.idaho.gov

Region 3- Caldwell

Phone (208) 455-7150

Fax (208)454-7625

Email BLTCRegIII@dhw.idaho.gov

Region 4- Boise

Phone (208) 344-0960

Fax (208)334-0953

Email BLTCRegIV@dhw.idaho.gov

Region 5- Twin Falls

Phone (208) 736-3024

Fax (208)736-2116

Email BLTCRegV@dhw.idaho.gov

Region 6- Pocatello

Phone (208) 239-6260

Fax (208)239-6269

Email BLTCRegVI@dhw.idaho.gov

Region 7- Idaho Falls

Phone (208) 528-5750

Fax (208)528-5756

Email BLTCRegVII@dhw.idaho.gov