



24 HOUR NURSING CARE DETERMINATION (DDPAS-4)

PLEASE TYPE OR PRINT

PAS AGENCY NAME: _____

Part I.

Person's Name: _____

Social Security #: _____ / _____ / _____

Part II. The data gathered during the assessment process, including any optional assessments and evaluations which were indicated, have been reviewed and interpreted in the following manner:

_____ The individual **does not need** 24 hour nursing care. **Provide justification for this determination.**

_____ The individual **does need** 24 hour nursing care. **Provide justification for this determination.**

Part III.

I have personally reviewed the information and data sources referenced in this document and certify that they are accurately described on this summary and that they are currently available in this record.

Signature of PAS QIDP: _____ / _____ (Date)



24 HOUR NURSING CARE DETERMINATION (DDPAS-4)

INSTRUCTIONS FOR COMPLETING DDPAS-4

PAS AGENCY: Enter the name of the PAS agency.

PART I.

NAME: Enter the legal name (last, first, and middle initial) of the individual.

SOCIAL SECURITY #: Enter the individual's 9 digit Social Security number.

PART II. Check whether the individual does or does not require 24-hour nursing level of care. Provide clear and concise justification for the determination. NOTE: An individual does not need nursing care if there is no need for a nurse to be available on a 24-hour basis, as evidenced by **all** of the following conditions: 1) the individual's medical and physical condition are stable; 2) the routine nature of the individual's medication, treatment, and care allows implementation by someone other than a nurse, possibly with the supervision of a nurse; 3) the individual needs only periodic nursing assistance, monitoring, or treatment which can be provided outside a nursing facility; and 4) the individual is able to comply with routine physical and medical care. Further, an individual does need nursing care if there is a need for the availability of nursing assessment, monitoring, intervention, and supervision of the individual's condition on a 24-hour basis. The individual could require this level of care if the judgment of a medical professional is required to assist and/or supervise in **any** of the following areas: 1) care of dressings and decubitus ulcers; 2) the monitoring of vital signs, blood chemistry, or urinalysis; 3) special feeding techniques, including tube feeding; 4) intense physical, occupational, or respiratory therapy; or 5) administration of intravenous care or other prescribed health care. It should not be presumed that the existence of any of these conditions alone categorically determines the need for nursing facility level of care.

Additional information that may be of assistance are: a summary of the individual's medical diagnosis, the date of onset of the individual's medical condition(s), and a description of what has been done in the past year to address the individual's medical condition(s). Attach supporting documentation, if necessary.

Individuals who are categorically eligible for a nursing facility level of care, without consideration of active treatment, are those who are comatose, are terminally ill with a life expectancy of six months or less (as certified by a physician), or have a diagnosis of dementia (of any type); for those individuals, indicate on the DDPAS-5 that Active Treatment is not needed due to the categorical need for a nursing facility level of care.

PART III. SIGNATURE: The PAS Agency QIDP must complete the form by supplying his/her name and date. Determination and signature by anyone other than a PAS Agency QIDP is invalid. The signature represents that the determination is accurately described and it is substantiated in the individual's record.