MiChoice Home and Community Based Services Assessment

FS: Benefits & Insurance

Medicaid Status

○ Non-MA ○ MA Spend Down
○ MA Active ○ MA Inactive
○ MA Pending

Medicaid Effective From

Medicaid Effective To

Current Payment Sources

Medicaid	○ No	○ Yes
Medicare	○ No	○ Yes
Self or family pays for full cost	○ No	○ Yes
Medicare with Medicaid co-payment	○ No	○ Yes
Private Insurance	○ No	○ Yes
Employer/Union	○ No	○ Yes
Other, specify	○ No	○ Yes

Health Insurance (Person)

Company Name
Area Code
Phone Number
Address
Contract Number
Plan Code
Group #
Service Code

Health Insurance (Spouse)

Company Name
Area Code
Phone Number
Address
Contract Number
Plan Code
Group #
Service Code

Life Insurance (Person)

Company Name
Area Code
Phone Number
Address
Contract Number
Face Value
Cash Value

Term	○ No	○ Yes
Whole Life	○ No	○ Yes
Endowment	○ No	○ Yes

Life Insurance 2 (Person)

Company Name
Area Code
Phone Number
Address
Contract Number
Face Value
Cash Value

Term	○ No	○ Yes
Whole Life	○ No	○ Yes
Endowment	○ No	○ Yes

Life Insurance 3 (Spouse)

Company Name
Area Code
Phone Number
Address
Contract Number
Face Value
Cash Value

Term	○ No	○ Yes
Whole Life	○ No	○ Yes
Endowment	○ No	○ Yes

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified

If yes, briefly describe issue, if no, briefly indicate why.

FS: Financial Information

Gross Monthly Income (check box if Direct Deposit)

	Participant		Spouse	
Social Security	___,___	☐	___,___	☐
Railroad Retirement	___,___	☐	___,___	☐
VA Benefits	___,___	☐	___,___	☐
Pensions*	___,___	☐	___,___	☐
Alimony	___,___	☐	___,___	☐
Estate or Trust Fund	___,___	☐	___,___	☐
Interest Income	___,___	☐	___,___	☐
Dividends	___,___	☐	___,___	☐
Employment	___,___	☐	___,___	☐
SSI	___,___	☐	___,___	☐
Other Income 1 _____	___,___	☐	___,___	☐
Other Income 2 _____	___,___	☐	___,___	☐
Subtotals	___,___		___,___	

Total Gross Monthly Household Income ___,___

***Itemize source of pensions:**

Person is at or less than the special income limit ○ No ○ Yes

Person or representative is effectively managing financial affairs ○ No ○ Yes

	Participant	Spouse	Joint
DHS Irrevocable PPD Burial Accounts	___,___	___,___	
Assets — Savings	___,___	___,___	___,___
Checking	___,___	___,___	___,___
Equity Value/Real Estate	___,___	___,___	___,___
Stock/Securities	___,___	___,___	___,___
CD/IRA/Money Market	___,___	___,___	___,___
Cash Value Life Insurance	___,___	___,___	___,___
Trade-In Value 2nd Car	___,___	___,___	___,___
Other Asset 1 _____	___,___	___,___	___,___
Other Asset 2 _____	___,___	___,___	___,___
Other Asset 3 _____	___,___	___,___	___,___
Subtotals	___,___	___,___	___,___

Total Countable Assets
Includes Participant, Spouse and Joint ___,___

ASSETS - Names on joint account

Total assets are at or below the limit for an individual or for a person with a community spouse
○ No ○ Yes

Current Monthly Household Expenses

Rent / House	___,___	Property Tax	___,___
Heat	___,___	Charge Cards	___,___
Electricity	___,___	Water / Sewer	___,___
Telephone	___,___	Cable TV	___,___
Cell phone	___,___	Internet access	___,___
Food	___,___	Transp Expenses	___,___
Car Payment	___,___	Install Payments	___,___
Home Insurance	___,___	Other Expense 1 _____	
Car Insurance	___,___	Other Expense 2 _____	___,___
Life Insurance	___,___	Other Expense 3 _____	___,___
		_____	___,___

Total Household Expenses ☐☐☐,☐☐☐

Comments on Household Expenses

Monthly Medical Expenses

	Participant	Spouse
Prescriptions	___,___	___,___
Health Insurance	___,___	___,___
Medical Transport	___,___	___,___
Dr. Office	___,___	___,___
Personal Care	___,___	___,___
Over Counter Meds	___,___	___,___
DME	___,___	___,___
Medical Bills	___,___	___,___
Medicare Premium	___,___	___,___
Medicare D Premium	___,___	___,___
Other Medical Expense 1 _____ _____	___,___	___,___
Other Medical Expense 2 _____ _____	___,___	___,___
Medical Subtotal	___,___	___,___

Total Monthly Medical Expenses ☐☐☐,☐☐☐

Total Monthly Expenses ☐☐☐,☐☐☐
Includes Household and Medical

Variance
(Total Household Income - Total Monthly Expenses) ☐☐☐,☐☐☐

Comments on Expenses:

FS: Financial Information, continued

Income is adequate to meet expenses and needed purchases
○ No ○ Yes

Participant has excessive expenses ○ No ○ Yes
If Yes; explain

Participant has unaddressed debt ○ No ○ Yes
If yes, define:

Person who handles participant's finances:
Name:

Phone (☐☐☐) ☐☐☐ - ☐☐☐☐

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

SECTION A: Identifying Information - SW Assessment

Others Present:

Place of Assessment

- ○ Home
- ○ NH/Institution
- ○ Hospital
- ○ Adult Foster Care/Home for the Aged
- ○ Other, specify:

Assessment Reason

- ○ First assessment - An assessment that is done at the time of entry into the home care system, or when initially determining eligibility for home care/home health services.
- ○ Routine reassessment - A regularly scheduled follow-up assessment to ensure that the care plan is appropriate and current.
- ○ Return assessment - An assessment conducted when the person returns from the hospital, nursing facility or reenters the home care system after a planned absence.
- ○ Significant change in status reassessment - A comprehensive reassessment conducted at any time during the uninterrupted course of care because the person's status or condition has significantly changed. Code "return assessment" if the change in status is accompanied by a hospital stay.
- ○ Other (e.g. research) - Any assessment conducted outside of the established assessment schedule for reasons such as quality assurance, clinical research, confirmation of appropriateness of the current plan (not the routine "follow-up" assessment), development of acuity scale, community needs assessment, etc.

Reason for Late Assessment

- ○ Participant hospitalization
- ○ Agency scheduling issue
- ○ Participant choice/scheduling issue
- ○ Inclement weather
- ○ Other

Napis ID

Marital Status at this Assessment

- ○ Never Married
- ○ Married
- ○ Widowed
- ○ Separated
- ○ Divorced
- ○ Other
- ○ Partner/Significant Other

Residential/Living Status at Time of Assessment

- ○ Private home/apartment/rented room
- ○ Board and care
- ○ Assisted living or semi-independent living
- ○ Mental health residence (e.g., psychiatric group home)
- ○ Group home for persons with physical disability
- ○ Setting for persons with intellectual disability
- ○ Psychiatric hospital or unit
- ○ Homeless (with or without shelter)
- ○ Long term care facility (nursing home)
- ○ Rehabilitation hospital/unit
- ○ Hospice facility/palliative care unit
- ○ Acute care hospital
- ○ Correctional facility
- ○ Other

Who person lived with at time of referral (assessment) or currently lives with (reassessment)

- ○ Alone
- ○ With spouse/partner only
- ○ With spouse/partner and other(s)
- ○ With child (not spouse/partner)
- ○ With parent(s) or guardian(s)
- ○ With sibling(s)
- ○ With other relatives
- ○ With non-relative(s)

Is person primary caregiver for someone else?

○ No ○ Yes

Residential History
(Code for all settings person lived in during 5 YEARS prior to date case opened)

Long-term care facillity - e.g. nursing home	○ No	○ Yes
Mental health residence - e.g. psychiatric group home	○ No	○ Yes
Psychiatric hospital or unit	○ No	○ Yes
Board and care home, assisted living	○ No	○ Yes
Setting for persons with intellectual disability	○ No	○ Yes

Nursing Facility Admission Date ☐☐ / ☐☐ / ☐☐☐☐

About Me
Record strengths, abilities, desires, choices, interests, etc.

Person's Expressed Goals of Care

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

SECTION B: Social Functioning - SW Assessment

Social Relationships (Note: Whenever possible, ask person)

Codes: 0 = Never; 1 = More than 30 days ago; 2 = 8 to 30 days ago; 3 = 4 to 7 days ago; 4 = In last 3 days; 8 = Unable to determine

	0	1	2	3	4	8
Participation in social activities of long-standing interest	○	○	○	○	○	○
Visit by a long-standing social relation or family member	○	○	○	○	○	○
Other interaction with long-standing social relation or family member e.g., telephone, email	○	○	○	○	○	○
Conflict or anger with family or friends	○	○	○	○	○	○
Fearful of family member or close acquaintance	○	○	○	○	○	○
Neglected, abused, mistreated	○	○	○	○	○	○

Change in Social Activities in Last 90 Days (or since last assessment if less than 90 days)

Decline in level of participation in social, religious, occupational or other preferred activities. If there was a decline, person distressed by this fact:

- ○ No decline
- ○ Decline, not distressed
- ○ Decline, distressed

Isolation

Length of time person is alone during the day (morning and afternoon)

- ○ Less than 1 hour
- ○ 1 - 2 Hours
- ○ More than 2 hours but less than 8 hours
- ○ 8 hours or more

Person says or indicates that he/she feels lonely

○ No ○ Yes

Major Life Stressors in Last 90 Days

(e.g., episode of severe personal illness, death or severe illness of close family member/friend, loss of home, major loss of income/assets, victim of a crime such as robbery or assault, loss of driving license/car)

○ No ○ Yes

Prior Description of Conditions Noted Above:

Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified

If yes, briefly describe issue, if no, briefly indicate why.

SECTION C: Informal Support Services - SW Assessment

Informal Helper Status

Informal helper(s) unable to continue caring activities e.g., decline in health of helper makes it difficult to continue

○ No ○ Yes ○ No informal helper

Primary informal helper expresses feelings of distress, anger, or depression

○ No ○ Yes ○ No informal helper

Family or close friends report feeling overwhelmed by person's illness

○ No ○ Yes ○ No informal helper

Hours of Informal Care and Active Monitoring During Last 3 Days

For instrumental and personal activities of daily living in the LAST 3 DAYS, indicate the total number of hours of help received from all family, friends, and neighbors

Strong and Supportive Relationship with Family

○ No ○ Yes

Prior Description of Conditions Noted Above:

Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified

If yes, briefly describe issue, if no, briefly indicate why.

SECTION D: Environmental - SW Assessment

Home Environment

Code for any of the following that make home environment hazardous or uninhabitable (if temporarily in institution, base assessment on home visit)

Disrepair of the home (e.g. hazardous clutter; inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor; leaking pipes) ○ No ○ Yes

Squalid conditions (e.g. extremely dirty, infestation by rats or bugs) ○ No ○ Yes

Inadequate heating or cooling (e.g. too hot in summer, too cold in winter) ○ No ○ Yes

Lack of personal safety (e.g. fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street) ○ No ○ Yes

Limited access to home or rooms in home (e,g, difficulty entering or leaving home, unable to climb stairs, difficulty maneuvering within rooms, no railings although needed) ○ No ○ Yes

Living Arrangement

As compared to 90 days ago, person now lives with someone new (e.g., moved in with another person, other moved in) ○ No ○ Yes

Person or relative feels that person would be better off living elsewhere ○ No ○ Yes, other community residence ○ Yes, institution

Person chooses to live

Housing Assessment

Person lives in: ○ House ○ Residential group home ○ Apartment ○ Other, specify if applicable:

Person: ○ Owns ○ Rents ○ Other, specify if applicable:

Lives in apartment or house re-engineered accessible for persons with disabilities ○ No ○ Yes

Outside Environment

Availability of emergency assistance (e.g., telephone, alarm response system) ○ No ○ Yes

Accessibility to grocery store without assistance ○ No ○ Yes

Availability of home delivery of groceries ○ No ○ Yes

Finances

Because of limited funds, during the last 30 days made trade-offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care ○ No ○ Yes

Cooking facilities and refrigerator on premises ○ No ○ Yes

Microwave on premises ○ No ○ Yes

Telephone accessible and usable ○ No ○ Yes

Tub/shower/hot water accessible ○ No ○ Yes

Pets ○ No ○ Yes

Smoke detector ○ No ○ Yes

Washer/dryer accessible ○ No ○ Yes

Emergency plan in place ○ No ○ Yes

Will the person need assistance to evacuate in case of emergency ? ○ No ○ Yes

Are there other family members living in your home? ○ No ○ Yes

If yes, will any other family members in home need assistance to evacuate in case of emergency? ○ No ○ Yes

My Evacuation Plan

Home Safety

Is there safe entry/exit to the home? ○ No ○ Yes

Are there safe pathways in the home clear of obstruction? ○ No ○ Yes

Are there any stairs or steps in the house that the participant cannot safely negotiate? ○ No ○ Yes

Is there safe access to the bathroom? ○ No ○ Yes

Are there grab bars around tub and toilet? ○ No ○ Yes

Is participant able to use stove safely? ○ No ○ Yes

If not, what are the safeguards present:

Does the participant, or anyone in the household. smoke? ○ No ○ Yes

Educated participant on identified safety risks ○ No ○ Yes

Home Safety Notes:

Prior Description of Conditions Noted Above:

Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified

If yes, briefly describe issue, if no, briefly indicate why.

SECTION E: Cognitive Patterns - SW Assessment

Cognitive Skills for Daily Decision Making
Making decisions regarding tasks of daily life (e.g., when to get up or have meals, which clothes to wear, or activities to do)

- ○ Independent - Decisions consistant, reasonable, and safe
- ○ Modified independence - Some difficulty in new situations only
- ○ Minimally impaired - In specific recurring situations, decisions become poor or unsafe; cues/supervision necessary at those times
- ○ Moderately impaired - decisions consistently poor or unsafe; cues/supervision required at all times
- ○ Severly impaired - never/rarely made decisions
- ○ No Discernible consciousness, coma (Skip to Section G)

Memory/Recall Ability
Code for recall of what was learned or known

Short-term memory OK - seems/appears to recall after 5 minutes
○ Memory OK ○ Memory Problem

Procedural memory OK - can perform all or almost all steps in a multi-task sequence without cues
○ Memory OK ○ Memory Problem

Situational memory OK - Both recognizes caregivers' names/faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room)
○ Memory OK ○ Memory Problem

Periodic Disordered Thinking or Awareness
[Note: Accurate assessment requires conversations with staff, family, or others who have direct knowledge of the person's behavior over this time.]

Codes:
0 = Behavior not present
1 = Behavior present, consistent with usual functioning
2 = Behavior present, appears different from usual functioning (e.g., new onset or worsening, different from a few weeks ago)

	0	1	2
Easily distracted (e.g., episodes of difficulty paying attention, gets sidetracked)	○	○	○
Episodes of disorganized speech (e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)	○	○	○
Mental function varies over the course of the day (e.g., sometimes better, sometimes worse)	○	○	○

Acute Change in mental status from person's usual functioning (e.g., restlessness, lethargy, difficult to arouse, altered environmental perception)
○ No ○ Yes

Change in decision making as compared to 90 Days Ago (or since last assessment)

○ Improved ○ Declined
○ No change ○ Uncertain

Making Self Understood (Expression)
Expressing information content - both verbal and non-verbal

- ○ 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 AND prompting is usually required
- ○ Sometimes understood - Ability limited to making concrete requests
- ○ Rarely/never understood

Ability to Understand Others (Comprehension)
Understanding verbal information content (however able; with hearing appliance normally used)

- ○ Understands - Clear comprehension
- ○ Usually understands - Misses some part/intent of message, BUT comprehends most conversations
- ○ Often understands - Misses some part/intent of message, BUT with repetition or explanation can often comprehend conversation
- ○ Sometimes understands - Responds adequately to simple, direct communication only
- ○ Rarely or never understands

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified

If yes, briefly describe issue; If no, briefly indicate why.

SECTION G: Mood and Behavior Patterns - SW Assessment

Indicators of Possible Depression, Anxious, or Sad Mood
Code for indicators observed in last 3 days, irrespective of the assumed cause (Note: whenever possible, ask person)

0 = Not present 1 = Present but not exhibited in last 3 days 2 = Exhibited 1-2 of last 3 days 3 = Exhibited daily in last 3 days

	0	1	2	3
Made negative statements (e.g., "Nothing matters; Would rather be dead; What's the use; Regret having lived so long; Let me die")	○	○	○	○
Persistent anger with self or others (e.g., easily annoyed, anger at care received)	○	○	○	○
Expressions, including non-verbal, of what appear to be unrealistic fears (e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations)	○	○	○	○
Repetitive health complaints (e.g., persistently seeks medical attention, incessant concern with body functions)	○	○	○	○
Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationships	○	○	○	○
Sad, pained, or worried facial expressions (e.g., furrowed brow, constant frowning)	○	○	○	○
Crying, tearfulness	○	○	○	○
Recurrent statements that something terrible is about to happen (e.g., believes he or she is about to die, have a heart attack)	○	○	○	○
Withdrawal from activities of interest (e.g., long standing activities, being with family/friends)	○	○	○	○
Reduced social interactions	○	○	○	○
Expressions, including non-verbal, of a lack of any pleasure in life (anhedonia) (e.g., "I don't enjoy anything anymore")	○	○	○	○

Self-Reported Mood
Ask: "In the last 3 days, how often have you felt....."
0 = Not in last 3 days
1 = Not in last 3 days, but often feels that way
2 = In 1-2 days of last 3 days
3 = Daily in last 3 days
8 = Person could not (would not) respond

	0	1	2	3	8
Little interest or pleasure in things you normally enjoy?	○	○	○	○	○
Anxious, restless, or uneasy?	○	○	○	○	○
Sad, depressed, or hopeless?	○	○	○	○	○

Behavioral Symptoms
Code for indicators observed, irrespective of the assumed cause
0 = Not present
1 = Present but not exhibited in last 3 days
2 = Exhibited on 1-2 of last 3 days
3 = Exhibited daily in last 3 days

	0	1	2	3
Wandering (moved with no rational purpose, seemingly oblivious to needs or safety)	○	○	○	○
Verbal abuse (others were threatened, screamed at, cursed at)	○	○	○	○
Physical abuse (others were hit, shoved, scratched, sexually abused)	○	○	○	○
Socially inappropriate or disruptive behavior (e.g., made disruptive sounds or noises, screamed out, self-abusive acts, smeared or threw food or feces, hoarded, rummaged through others belongings)	○	○	○	○
Inappropriate public sexual behavior or public disrobing	○	○	○	○
Resists care (e.g., taking medications/ injections, ADL assistance, eating)	○	○	○	○

Changes in Behavioral Symptoms
Behavioral symptoms have become worse or are less well tolerated by family as compared to 30 days ago

○ No ○ Yes

Mental Health
0 = Not present
1 = Present but not exhibited in last 3 days
2 = Exhibited 1 of last 3 days
3 = Exhibited 2 of last 3 days
4 = Exhibited daily in last 3 days

	0	1	2	3	4
Delusions - Fixed false beliefs	○	○	○	○	○
Hallucinations - False sensory perception	○	○	○	○	○

Number of prior lifetime mental health admissions

○ None ○ 4 to 6

○ 1 to 3 ○ 7 or more

Self Injury
Self injurious attempt (code for most recent instance)

○ None (skip over next question to "Considered....")
○ Attempt(s) more than 12 months ago
○ Attempt in last 12 months

Intent of any self injurious attempt was to kill him/herself

○ No ○ Yes

Considered self-injurious behavior in last 30 days

○ No ○ Yes

Family/caregiver/friend/staff express concern that patient is at risk for self-injury

○ No ○ Yes

SECTION G: Mood and Behavior Patterns, continued

Tobacco and Alcohol

Smokes or chews tobacco daily

- ○ No
- ○ Not in last 3 days, but is usually a daily user
- ○ Yes

Has more than 3 drinks of beer/liquor/wine almost every day

○ No ○ Yes

Alcohol - Highest number of drinks in any "single sitting" in LAST 14 DAYS

○ None ○ 1 ○ 2 - 4 ○ 5 or more

In the last 90 days, peson felt the need or was told by others to cut down on drinking, or others were concerned with person's drinking

○ No ○ Yes

In the last 90 days, person had to have a drink first thing in the morning to steady nerves (i.e., an "eye opener") or has been in trouble because of drinking

○ No ○ Yes

Violence (Code for most recent instance)

0 = Never
1 = Any history more than 7 days ago
2 = In the last 7 days

	0	1	2
History of violence to others	○	○	○
Intimidation of others or threatened violence	○	○	○
Violent ideation	○	○	○
Police intervention for violent behavior	○	○	○
Sexual violence	○	○	○

Mental Health Interventions (Specify)

Developmental Disability ○ No ○ Yes

If Developmental Disability, Diagnosis ○ No ○ Yes

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

SECTION H: Summary - Social Worker

SC Certification I certify that based on the information obtained, observations made, and belief formed after reasonable inquiry, the statements and information contained in this document are true, accurate and complete. Check box to indicate your agreement with this statement.

Agree ☐

Supports Coordinator Name:_____

SW Summary
Additional comments not documented elsewhere in Assessment:

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

END SW ASSESSMENT

Caregiver - Basic

Caregiver

First Name: _____

Last Name: _____

Date of Birth: _____

Status ○ Active ○ Not Active

Helper Type

○ Primary Helper ○ Secondary Helper ○ Other Helper

Relationship to Person:

○ Child or child-in-law ○ Sibling

○ Spouse ○ Other relative

○ Partner/significant other ○ Friend

○ Parent / guardian ○ Neighbor

Relationship Other/ Non-relative specify: _____

Lives with person

○ No

○ Yes, 6 months or less

○ Yes, more than 6 months

Address Line 1: _____

Address Line 2: _____

City: _____ **State:**_____

Zip: _____ **Zip Plus 4:**_____

County: _____ **Township Code:**_____

Country: _____ **Province:**_____

Email Address: _____

Phone Numbers:

Main phone : Area Code_____

Main Phone:_____

Mobile phone : Area Code_____

Mobile Phone:_____

Work phone : Area Code_____

Work Phone:_____

Contacts

Emergency Contact*	○ No	○ Yes
Family Contact*	○ No	○ Yes
Billing Contact*	○ No	○ Yes
Plan of Care Participant	○ No	○ Yes

Legal Relationship with Person

Guardian	○ No	○ Yes	○ Pending
Durable Power of Attorney	○ No	○ Yes	○ Pending
Conservator	○ No	○ Yes	○ Pending
Representative Payee	○ No	○ Yes	○ Pending
Advanced Medical Directives	○ No	○ Yes	○ Pending
Living Will	○ No	○ Yes	○ Pending

Area of informal help during last 3 days

IADL Help	○ No	○ Yes	○ No informal helper
ADL Help	○ No	○ Yes	○ No informal helper
Advice or emotional support	○ No	○ Yes	○ No informal helper

If needed, willingness (with ability) to increase help

IADL Help	○ No ○ 1-2 hours/day ○ More than 2 hours/day
ADL Help	○ No ○ 1-2 hours/day ○ More than 2 hours/day
Advice or emotional support	○ No ○ 1-2 hours/day ○ More than 2 hours/day

Tasks

Include frequency and duration if known

Do you want this person to receive a copy of the back-up plan and person-centered service plan?

○ No ○ Yes

Comments:

Caregiver - Basic

Caregiver

First Name: _____

Last Name: _____

Date of Birth: _____

Status: ○ Active ○ Not Active

Helper Type

○ Primary Helper ○ Secondary Helper ○ Other Helper

Relationship to Person:

○ Child or child-in-law ○ Sibling

○ Spouse ○ Other relative

○ Partner/significant other ○ Friend

○ Parent / guardian ○ Neighbor

Relationship Other/ Non-relative specify: _____

Lives with person

○ No

○ Yes, 6 months or less

○ Yes, more than 6 months

Address Line 1: _____

Address Line 2: _____

City: _____ **State:**_____

Zip: _____ **Zip Plus 4:**_____

County: _____ **Township Code:**_____

Country: _____ **Province:**_____

Email Address: _____

Phone Numbers:

Main phone : Area Code_____

Main Phone:_____

Mobile phone : Area Code_____

Mobile Phone:_____

Work phone : Area Code_____

Work Phone:_____

Contacts

Emergency Contact*	○ No	○ Yes
Family Contact*	○ No	○ Yes
Billing Contact*	○ No	○ Yes
Plan of Care Participant	○ No	○ Yes

Legal Relationship with Person

Guardian	○ No	○ Yes	○ Pending
Durable Power of Attorney	○ No	○ Yes	○ Pending
Conservator	○ No	○ Yes	○ Pending
Representative Payee	○ No	○ Yes	○ Pending
Advanced Medical Directives	○ No	○ Yes	○ Pending
Living Will	○ No	○ Yes	○ Pending

Area of informal help during last 3 days

IADL Help	○ No	○ Yes	○ No informal helper
ADL Help	○ No	○ Yes	○ No informal helper
Advice or emotional support	○ No	○ Yes	○ No informal helper

If needed, willingness (with ability) to increase help

IADL Help	○ No ○ 1-2 hours/day ○ More than 2 hours/day
ADL Help	○ No ○ 1-2 hours/day ○ More than 2 hours/day
Advice or emotional support	○ No ○ 1-2 hours/day ○ More than 2 hours/day

Tasks

Include frequency and duration if known

Do you want this person to receive a copy of the back-up plan and person-centered service plan?

○ No ○ Yes

Comments:

Caregiver - Basic

Caregiver
First Name: _____

Last Name: _____

Date of Birth: _____

Status ○ Active ○ Not Active

Helper Type
○ Primary Helper ○ Secondary Helper ○ Other Helper

Relationship to Person:

○ Child or child-in-law ○ Sibling

○ Spouse ○ Other relative

○ Partner/significant other ○ Friend

○ Parent / guardian ○ Neighbor

Relationship Other/ Non-relative specify: _____

Lives with person
○ No
○ Yes, 6 months or less
○ Yes, more than 6 months

Address Line 1: _____

Address Line 2: _____

City: _____ **State:**_____

Zip: _____ **Zip Plus 4:**_____

County: _____ **Township Code:**_____

Country: _____ **Province:**_____

Email Address: _____

Phone Numbers:

Main phone : Area Code_____

Main Phone:_____

Mobile phone : Area Code_____

Mobile Phone:_____

Work phone : Area Code_____

Work Phone:_____

Contacts

Emergency Contact*	○ No	○ Yes
Family Contact*	○ No	○ Yes
Billing Contact*	○ No	○ Yes
Plan of Care Participant	○ No	○ Yes

Legal Relationship with Person

Guardian	○ No	○ Yes	○ Pending
Durable Power of Attorney	○ No	○ Yes	○ Pending
Conservator	○ No	○ Yes	○ Pending
Representative Payee	○ No	○ Yes	○ Pending
Advanced Medical Directives	○ No	○ Yes	○ Pending
Living Will	○ No	○ Yes	○ Pending

Area of informal help during last 3 days

IADL Help	○ No	○ Yes	○ No informal helper
ADL Help	○ No	○ Yes	○ No informal helper
Advice or emotional support	○ No	○ Yes	○ No informal helper

If needed, willingness (with ability) to increase help

IADL Help	○ No ○ 1-2 hours/day ○ More than 2 hours/day
ADL Help	○ No ○ 1-2 hours/day ○ More than 2 hours/day
Advice or emotional support	○ No ○ 1-2 hours/day ○ More than 2 hours/day

Tasks
Include frequency and duration if known

Do you want this person to receive a copy of the back-up plan and person-centered service plan?
○ No ○ Yes

Comments:

Caregiver - Primary Only

Caregiver Social Security Number: _____

Caregiver Gender ○ Male ○ Female

Lives Alone ○ No ○ Yes

Income status: monthly income below the poverty level?
○ No ○ Yes

Race
○ White
○ Black
○ Asian/Pacific Islander
○ American Indian/Eskimo/Aleut

Is caregiver Hispanic? ○ No ○ Yes

Multi-racial status ○ No ○ Yes
○ White
○ Black
○ Asian/Pacific Islander
○ American Indian/Eskimo/Aleut

Counseling Services

Individual Counseling ○ No ○ Yes
Start Date:_____

Support Group ○ No ○ Yes
Start Date:_____

Caregiver Training ○ No ○ Yes
Start Date:_____

Other Counseling, Specify: ○ No ○ Yes
Start Date:_____

Respite Care Services

In home respite ○ No ○ Yes
Start Date:_____

Chore ○ No ○ Yes
Start Date:_____

Homemaker ○ No ○ Yes
Start Date:_____

Home Delivered Meals ○ No ○ Yes
Start Date:_____

Home Health Aide ○ No ○ Yes
Start Date:_____

Kinship ○ No ○ Yes
Start Date:_____

Overnight ○ No ○ Yes
Start Date:_____

Respite Care Services, continued

Personal Care ○ No ○ Yes
Start Date:_____

Specialized ○ No ○ Yes
Start Date:_____

Volunteer Respite ○ No ○ Yes
Start Date:_____

Adult Day Care ○ No ○ Yes
Start Date:_____

Direct Payment ○ No ○ Yes
Start Date:_____

Other ○ No ○ Yes

Specify "other", if applicable_____

Start Date:_____

Defined Supplemental Services

Caregiver Supplemental ○ No ○ Yes
Start Date:_____

Direct Payment ○ No ○ Yes
Start Date:_____

Other service ○ No ○ Yes
Specify "other", if applicable
○ Home modification
○ PERS
○ Medical Equip/Supplies

Start Date:_____

Non-registered Caregiver Services

○ Case management ○ Nutrition education
○ Nutrition counseling ○ Transportation
○ Health education ○ Outreach
○ Information & assistance ○ Other, Specify:

Caregiver - Primary Only, continued

Answer the next two questions for caregivers receiving any form of respite care or defined supplemental service

Does care recipient need assistance with 2 or more activites of daily living?
○ No ○ Yes

Does care recipient have a cognitive impairment?
○ No ○ Yes

How did caregiver hear about this program (referral source)?

○ Newspaper
○ Television
○ Brochure
○ Friend
○ Agency
○ Web site
○ Physician
○ Health care provider
○ Other

How long has caregiver provided care?

○ 0 - 6 months
○ 7 - 12 months
○ 13 - 36 months
○ 37 + months

How long does it take caregiver to get to care recipient's home?

○ Less than 1 hour
○ 1 - 3 hours
○ More than 3 hours
○ NA: Caregiver lives with care recipient

Caregiver provides care:

○ Daily
○ Several times a week
○ Weekly
○ Less than 1 day per week
○ Monthly
○ Occasionally

Does caregiver provide hands-on care?
○ No ○ Yes

If yes, hands-on care is provided:

Number of hours
○ Less than 1 hour
○ 1 - 3 hours
○ More than 3 hours

Frequency
○ Per day
○ Per week
○ Per month

Caregiver employment status
○ Full time
○ Part time
○ Not employed

Caregiver health status
○ Excellent
○ Good
○ Fair
○ Poor

Are other friends or family members willing and capable to help with care?
○ No
○ Yes

How many care recipients does caregiver care for: _____

For how many is caregiver the primary caregiver:_____

How many dependents does caregiver have

Under age 19: _____

Age 19 to 59: _____

Over age 59: _____

Is this a Kinship Care family/situation?
○ No
○ Yes

Caregiver - Self -Determination

Is this Caregiver a Self-Determination employee?

○ No ○ Yes

Active/Inactive status:

○ Active ○ Not Active

Hours per Week Employed by Participant: _____

Indicate Part Time Status if Less than 18 hours per Week/Full Time Status if More than 18 Hours per Week.

○ Part Time ○ Full Time

Start Date of Self-Determination Employment: _____

End Date of Self-Determination Employment: _____

Fiscal Intermediary Utilized: _____
(Choices found in dropdown menu)

Was Training Packet Received?	○ No	○ Yes
Was Training Completed?	○ No	○ Yes
Has Agency received the Training Record?	○ No	○ Yes
Has Agency Recorded and Billed the Training Record?	○ No	○ Yes
Has Background Check been received?	○ No	○ Yes

Community Supports				
Name				
Phone				
Description				
Frequency/Duration				
Tasks				
Do you want this person to receive a copy of the back up plan and person-centered service plan?	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes
Is this person part of the back-up plan?	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes

Community Supports				
Name				
Phone				
Description				
Tasks				
Do you want this person to receive a copy of the back up plan and person-centered service plan?	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes
Is this person part of the back-up plan?	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes

SECTION I: Disease Diagnoses, Disabilities - RN Assessment

Previous Reminder
Note: This is prefilled with reminder notes from a prior assessment (unless this is a first assessment)

Next Reminder
Enter any reminders related to the next assessment with this person

Most Recent Hospitalization
Hospital Name: _____

Hospital Use, Emergency Room Use, Physician Visit
Code for number of times during the LAST 90 DAYS (or since last assessment if less than 90 days)

Inpatient acute hospital with overnight stay ☐
Emergency room visit (not counting overnight stay) ☐
Physician visit (or authorized assistant or practitioner) ☐

Time Since Last Hospital Stay
Code for most recent instance in last 90 days

○ No hospitalization within 90 days
○ 31 to 90 days ago
○ 15 to 30 days ago
○ 8 to14 days ago
○ In the last 7 days
○ Now in hospital

Disease Diagnoses

0 = Not Present
2 = Diagnosis present, receiving active treatment
3 = Diagnosis present, monitored but no active treatment

	0	2	3
Cardiac or Pulmonary			
Congestive heart failure	○	○	○
Coronary heart disease	○	○	○
Chronic Obstructive Pulmonary Disease (COPD)	○	○	○
Hypertension	○	○	○
Peripheral vascular disease	○	○	○
Musculoskeletal			
Arthritis	○	○	○
Hip fracture during last 30 days (or since last assessment if less than 30 days)	○	○	○
Osteoporosis	○	○	○
Other fracture during last 30 days (or since last assessment if less than 30 days)	○	○	○

Disease Diagnoses, continued

0 = Not Present
2 = Diagnosis present, receiving active treatment
3 = Diagnosis present, monitored but no active treatment

	0	2	3
Neurological			
Alzheimers disease	○	○	○
Dementia (other than Alzheimers disease)	○	○	○
Cerebral palsy	○	○	○
Hemiplegia	○	○	○
Multiple sclerosis	○	○	○
Paraplegia	○	○	○
Parkinson's disease	○	○	○
Quadriplegia	○	○	○
Seizure disorder	○	○	○
Stroke/CVA	○	○	○
Transient Ischemic Attack (TIA)	○	○	○
Traumatic Brain Injury (TBI)	○	○	○
Psychiatric/Mood			
Anxiety	○	○	○
Depression	○	○	○
Bi-polar disorder	○	○	○
Schizophrenia	○	○	○
Other			
Renal failure	○	○	○
Cancer	○	○	○
Diabetes mellitus	○	○	○
Infections			
Antibiotic resistant infection (e.g., Methicillin resistant staph)	○	○	○
Pneumonia	○	○	○
Urinary tract infection in last 30 days	○	○	○

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

SECTION J: Health Conditions and Preventive Health Measures - RN Assessment

Prevention

Blood pressure measured in LAST YEAR	○ No	○ Yes
Colonoscopy test in LAST 5 YEARS	○ No	○ Yes
Pneumovax vaccine in LAST 5 YEARS or after age 65	○ No	○ Yes
Influenza vaccine in LAST YEAR	○ No	○ Yes
If Male, Prostate exam	○ No	○ Yes
If Male, Testicular exam (self or health provider)	○ No	○ Yes
If Male, PSA blood test (Prostate Specific Antigen)	○ No	○ Yes
If Female, Mammogram or breast exam in LAST 2 YEARS	○ No	○ Yes

Falls

- ○ No fall in last 90 days
- ○ No fall in last 30 days, but fell 31-90 days ago
- ○ One fall in last 30 days
- ○ Two or more falls in last 30 days

Recent Falls

(Skip if last assesssed more than 30 days ago or if this is first assessment)

- ○ Not applicable (First assesssment, or more than 30 days since last assessment)
- ○ No fall in last 30 days
- ○ Yes, fall in last 30 days

Problem Frequency

0 = Not present
1 = Present but not exhibited in last 3 days
2 = Exhibited on 1 of last 3 days
3 = Exhibited on 2 of last 3 days
4 = Exhibited daily in last 3 days

	0	1	2	3	4
Balance					
Difficult or unable to move self to standing position unassisted	○	○	○	○	○
Difficult or unable to turn self around and face the opposite direction when standing	○	○	○	○	○
Dizziness	○	○	○	○	○
Unsteady Gait	○	○	○	○	○
Cardiac or Pulmonary					
Chest pain	○	○	○	○	○
Difficulty clearing airway secretions	○	○	○	○	○
Psychiatric					
Abnormal thought process (e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality)	○	○	○	○	○
Neurological					
Aphasia	○	○	○	○	○
GI Status					
Acid Reflux	○	○	○	○	○
Constipation - No bowel movement in 3 days or difficult passage of hard stool	○	○	○	○	○
Diarrhea	○	○	○	○	○
Vomiting	○	○	○	○	○
Difficulty urinating or urinating 3 or more times at night	○	○	○	○	○
Sleep Problems					
Difficulty falling asleep or staying asleep; waking too early; restlessness; non-restful sleep	○	○	○	○	○
Too much sleep - Excessive amount of sleep that interferes with person's normal functioning	○	○	○	○	○

Problem Frequency, continued

0 = Not present
1 = Present but not exhibited in last 3 days
2 = Exhibited on 1 of last 3 days
3 = Exhibited on 2 of last 3 days
4 = Exhibited daily in last 3 days

Other Problems	0	1	2	3	4
Aspiration	○	○	○	○	○
Fever	○	○	○	○	○
GI or GU bleeding	○	○	○	○	○
Peripheral Edema	○	○	○	○	○

Dyspnea (Shortness of breath)

- ○ Absence of symptom
- ○ Absent at rest, but present when performed moderate activities
- ○ Absent at rest, but present when performed normal day-to-day activities
- ○ Present at rest

Fatigue

Inability to complete normal daily activities (e.g., ADLs, IADLs)

- ○ None
- ○ Minimal - Diminished energy but completes normal day-to-day activities
- ○ Moderate - Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
- ○ Severe - Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
- ○ Unable to commence any normal day-to-day activities - Due to diminished energy

Self-Reported Health

Ask: "In general, how would you rate your health?"

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor
- ○ Could not (would not) respond

Instability of Conditions

Conditions/diseases make cognitive, ADL, mood, or behavior patterns unstable (fluctuating, precarious, or deteriorating)	○ No	○ Yes
Experiencing an acute episode, or a flare-up of a recurrent or chronic problem	○ No	○ Yes
End-stage disease, 6 or fewer months to live	○ No	○ Yes

Pain Scale

Number from 0 to 10 that best describes pain on scale where:
0 = No pain 5 = Distressing pain 10 = Unbearable pain

☐

Notes about pain:

SECTION J: Health Conditions and Preventive Health Measures, continued - RN Assessment

Pain Symptoms
[Note: Always ask person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]

Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other non-verbal signs suggesting pain)

- ○ No pain
- ○ Present but not exhibited in last 3 days
- ○ Exhibited on 1 - 2 of last 3 days
- ○ Exhibited daily of last 3 days

Intensity of Highest Level of Pain Present

- ○ No pain
- ○ Mild
- ○ Moderate
- ○ Severe
- ○ Times when pain is horrible or excruciating

Consistency of Pain

- ○ No pain
- ○ Single episode during last 3 days
- ○ Intermittent
- ○ Constant

Breakthrough pain - Times in LAST 3 DAYS when person experienced sudden, acute flare-ups of pain

- ○ No ○ Yes

Pain Control - Adequacy of current therapeutic regimen to control pain (from person's point of view)

- ○ No issue of pain
- ○ Pain intensity acceptable to person; no treatment regimen or change in regimen required
- ○ Controlled adequately by therapeutic regimen
- ○ Controlled when therapeutic regimen followed, but not always followed as ordered
- ○ Therapeutic regimen followed, but pain control not adequate
- ○ No therapeutic regimen being followed for pain; pain not adequately controlled

Other Status Indicators

Hygiene - Usually poor hygiene, unkempt, disheveled

- ○ Not Present
- ○ Present but not exhibited in last 3 days
- ○ Exhibited on 1 of last 3 days
- ○ Exhibited on 2 of last 3 days
- ○ Exhibited daily in last 3 days

Physically restrained (e.g., limbs restrained, used bed rails, restrained to chair when sitting)

- ○ No ○ Yes

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

SECTION J: Pain Supplement - RN Assessment

Description of Primary Pain

- ○ Aching
- ○ Crushing
- ○ Sharp
- ○ Tender
- ○ Burning
- ○ Dull
- ○ Stabbing
- ○ Shooting
- ○ Numbness
- ○ Throbbing
- ○ Cramping
- ○ Pins/needles
- ○ Nagging
- ○ Other - Describe:

Site of Primary Pain

- ○ Back
- ○ Bone
- ○ Chest - while doing usual activities
- ○ Headache
- ○ Hip
- ○ Joint (other than hip)
- ○ Incisional
- ○ Soft tissue (e.g. lesion, muscle)
- ○ Stomach
- ○ Other - Describe:

Primary Pain Comments:

Describe Other, Non-Primary Pain:

Type of Pain Scale Used
○ Wong-Baker ○ FLACC ○ Other:

Pain Scale Comments:

Worst Pain in last 7 days (Wong-Baker Scale 0 - 10) _____

Least Pain in last 7 days (Wong-Baker Scale 0 - 10) _____

FLACC Scores: 0, 1, 2 (at time of assessment)

Face Score: _____
Legs Score: _____
Activity Score: _____
Cry Score: _____
Consolability Score: _____
FLACC Total Score: _____

SECTION J: Pain Supplement , continued - RN Assessment

Alternative Pain Management Techniques, if used

Person's Satisfaction with Pain Management

- ○ Satisfied with current pain management
- ○ Not satisfied with current pain management
- ○ Other, Specify:

Additional Pain Management Options Discussed

○ No ○ Yes

Pain Management Assistance

- ○ Person desires assistance with pain management
- ○ Person does not desire/refuses assistance with pain management

Additional Information Provided to Person

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue; If no, briefly indicate why.

SECTION K: Nutritional / Hydration Status - RN Assessment

Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS ○ No ○ Yes

Weight Change - Pounds

Unintended weight loss of 10 pounds in last 6 months ○ No ○ Yes

Unintended weight gain of 10 pounds in last 6 months ○ No ○ Yes

Consumption

In at least 4 of last 7 days, person ate one or fewer meals a day ○ No ○ Yes

Eats less than 2 meals per day ○ No ○ Yes

Eats few fruits/vegetables/milk products ○ No ○ Yes

Has illness/condition that changes the kind or amount of food eaten ○ No ○ Yes

Able to chew, swallow foods prepared/presented ○ No ○ Yes

Dietary supplement between meals (in last 7 days) ○ No ○ Yes

Dehydrated ○ No ○ Yes

Fluid intake less than 1,000 cc per day (less than four 8 oz cups/day) ○ No ○ Yes

Mode of nutritional intake

- ○ Normal - swallows all types of food
- ○ Modified independent - e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
- ○ Requires diet modification to swallow solid food -e.g., mechanical diet (puree, minced, etc.) or only able to ingest specific foods
- ○ Requires modification to swallow liquid - e.g., thickened liquids
- ○ Can swallow only pureed solids AND thickened liquids
- ○ Combined oral and parenteral or tube feeding
- ○ Nasogastric tube feeding only
- ○ Abdominal feeding tube - e.g., PEG tube
- ○ Parenteral feeding only - Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
- ○ Activity did not occur - during entire period

Type of Diet

- ○ Regular
- ○ Sodium Restricted
- ○ Fat Controlled
- ○ Diabetic
- ○ Mechanical Soft
- ○ Bland Low Residue
- ○ Calorie Restricted

Diet Comments:

Physically capable to purchase or attain ample food/fluids to meet dietary needs: (e.g. issues of transportation, mobility, mental functioning, distance to store, etc.) ○ No ○ Yes

Always has enough money to buy food ○ No ○ Yes

Eats alone most of the time ○ No ○ Yes

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

SECTION L: Dental or Oral - RN Assessment

DENTAL or ORAL

Dental exam in LAST YEAR	○ No ○ Yes
Reports difficulty chewing	○ No ○ Yes
Reports having dry mouth	○ No ○ Yes
Has broken, fragmented, loose, or otherwise non-intact natural teeth	○ No ○ Yes
Person needs dental care	○ No ○ Yes
Wears a denture (removable prosthesis)	○ No ○ Yes

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

SECTION M: Hearing and Vision - RN Assessment

HEARING

Ability to hear
(with hearing appliance normally used)

- ○ Adequate - No difficulty in normal conversation, social interaction, listening to TV
- ○ Minimal difficulty - Difficulty in some environments (e.g., when participant speaks softly or is more than 6 ft away
- ○ Moderate difficulty - Problem hearing normal conversation, requires quiet setting to hear well
- ○ Severe difficulty - Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or partipant reports that all speech is mumbled)
- ○ No Hearing

Hearing Aid

- ○ Uses reliably
- ○ Does not use reliably
- ○ Needed, but not available
- ○ Does not need/want

Hearing Exam in LAST 2 YEARS ○ No ○ Yes

VISION

Ability to see in adequate light
(with glasses or any other visual appliance normally used)

- ○ Adequate - sees fine detail, including regular print in newspapers/books
- ○ Minimal difficulty - sees large print, but not regular print in newspapers/books
- ○ Moderate difficulty - limited vision; not able to see newspaper headlines, but can identify objects
- ○ Severe difficulty - object identification in question, but eyes appear to follow objects; sees only light, color, shapes
- ○ No vision

Eye Exam in LAST YEAR ○ No ○ Yes

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue; if no, briefly indicate why:

SECTION N: Skin Condition - RN Assessment

Major Skin Problems
(e.g., lesions, 2nd or 3rd degree burns, healing surgical wounds)

○ No ○ Yes

Most Severe Pressure Ulcer

- ○ No pressure ulcer
- ○ Any area of persistent skin redness
- ○ Partial loss of skin layers
- ○ Deep craters in the skin
- ○ Breaks in skin exposing muscle or bone
- ○ Not codeable e.g., necrotic eschar predominant

Prior Pressure Ulcer ○ No ○ Yes

Presence of Skin Ulcer Other Than Pressure Ulcer
(e.g., venous ulcer, arterial ulcer, mixed venous-arterial ulcer, diabetic foot ulcer)

○ No ○ Yes

Skin Tears or Cuts (other than surgery)

○ No ○ Yes

Other skin conditions or changes in skin condition
(e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema)

○ No ○ Yes

Foot Problems
(e.g., bunions, hammer toes, overlapping toes, structural problems, ulcers)

- ○ No foot problems
- ○ Foot problems, no limitation in walking
- ○ Foot problems limit walking
- ○ Foot problems prevent walking
- ○ Foot problems, does not walk for other reasons

Who Performs Foot Care

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

SECTION O: Continence - RN Assessment

Bladder Continence

- ○ Continent - Complete control: DOES NOT use any type of catheter or other urinary collection device
- ○ Complete control with any catheter or ostomy over LAST 3 days
- ○ Infrequently incontinent - Not incontinent over last 3 days but does have incontinent episodes
- ○ Occasionally incontinent - Less than daily
- ○ Frequently incontinent - Daily, but some control present
- ○ Incontinent - No control present
- ○ Did not occur - No urine output from bladder in last 3 days

Urinary Collection Device (exclude pads/briefs)

- ○ None
- ○ External (condom) catheter
- ○ Indwelling catheter
- ○ Cystostomy, nephrostomy, ureterostomy

Bowel Continence

- ○ Continent - Complete control; DOES NOT USE any type ostomy device.
- ○ Control with ostomy - Control with ostomy device over last 3 days
- ○ Infrequently incontinent - Not incontinent over last 3 days, but does have incontinent episodes
- ○ Occasionally incontinent - Less than daily
- ○ Frequently incontinent - Daily, but some control present
- ○ Incontinent - No control present
- ○ Did not occur - No bowel movement in last 3 days

Pads or Briefs Worn ○ No ○ Yes

Ostomy Care

- ○ Ostomy (self care)
- ○ Ostomy (not self care)
- ○ No Ostomy

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

SECTION P: Physical Functioning - RN Assessment

IADL Self Performance and Capacity

Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0 = Independent - No help, setup, or supervision
1 = Setup help only
2 = Supervision - Oversight/cuing
3 = Limited assistance - Help on some occasions
4 = Extensive assistance - Help throughout task, but performs 50% or more of task on own
5 = Maximal assistance - Help throughout task, but performs less than 50% of task on own
6 = Total dependence - Full performance by others during entire period
8 = Activity did not occur - During entire period (NOT USED FOR CAPACITY)

	PERFORMANCE	CAPACITY
	0 1 2 3 4 5 6 8	0 1 2 3 4 5 6
Meal preparation - How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food, and utensils)	○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○ ○ ○ ○ ○
Ordinary Housework - How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)	○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○ ○ ○ ○ ○
Managing Finances - How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored	○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○ ○ ○ ○ ○
Managing Medications - How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)	○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○ ○ ○ ○ ○
Phone Use - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)	○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○ ○ ○ ○ ○
Stairs - How full flight of stairs is managed (12-14 stairs)	○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○ ○ ○ ○ ○
Shopping - How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION	○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○ ○ ○ ○ ○
Transportation - How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)	○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○ ○ ○ ○ ○

ADL Self-Performance - Consider all episodes over 3-day period.

0 = Independent - No physical assistance, setup, or supervision in any episode
1 = Independent setup help only - Article or device provided or placed within reach, no physical assistance or supervision in any episode
2 = Supervision - Oversight/cuing
3 = Limited assistance - Guided maneuvering of limbs, physical guidance without taking weight
4 = Extensive assistance - Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
5 = Maximal assistance - Weight-bearing support (including lifting limbs) by 2+ helpers -OR- weight-bearing support for more than 50% of subtasks
6 = Total dependence - Full performance by others during all episodes
8 = Activity did not occur during entire period

	0 1 2 3 4 5 6 8
Bed Mobility - How moves to/from lying position, turns from side to side, and positions body while in bed	○ ○ ○ ○ ○ ○ ○ ○
Transferring - Including moving to and between surfaces - to/from bed, chair, wheelchair, standing position NOTE: Exclude to/from bath/toilet	○ ○ ○ ○ ○ ○ ○ ○
Transfer toilet - How moves on and off toilet or commode	○ ○ ○ ○ ○ ○ ○ ○
Locomotion - How moves between locations on same floor (walking or wheeling). NOTE: If in wheelchair, self-sufficiency once in chair	○ ○ ○ ○ ○ ○ ○ ○
Dressing lower body - How dresses and undresses (street clothes, underwear) from the waist down, including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.	○ ○ ○ ○ ○ ○ ○ ○
Dressing upper body - How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.	○ ○ ○ ○ ○ ○ ○ ○
Eating - How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	○ ○ ○ ○ ○ ○ ○ ○
Toilet Use - How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET	○ ○ ○ ○ ○ ○ ○ ○
Personal Hygiene - How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS	○ ○ ○ ○ ○ ○ ○ ○
Bathing - How takes a full-body bath/shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. EXCLUDE WASHING OF BACK AND HAIR	○ ○ ○ ○ ○ ○ ○ ○
Walking - How walks between locations on same floor indoors	○ ○ ○ ○ ○ ○ ○ ○

SECTION P: Physical Functioning, continued - RN Assessment

Locomotion/Walking

Primary Mode of Locomotion

- ○ Walking, no assistive device
- ○ Walking, uses assistive device (e.g., cane, walker, crutch, pushing wheelchair)
- ○ Wheelchair, scooter
- ○ Bedbound

Timed 13-foot Walk

Lay out straight unobstructed course. Have person stand in a still position, feet just touching start line. Then say: "When I tell you, begin to walk at a normal pace (with cane/walker if used). This is not a test of how fast you can walk. Stop when I tell you to stop. Is this clear?" Assessor may demonstrate test. Then say: "Begin to walk now". Start stop watch (or can count seconds) when first foot falls. End count when foot falls beyond 13 foot mark. Then say: "You may stop now."

- ○ Unable to create 13-foot course
- ○ Stopped before test complete
- ○ Refused to do the test
- ○ Not tested - e.g., does not walk on own
- ○ Test Completed

If timed walk completed enter the number of seconds. Enter 30 if more than 30 seconds [ ][ ]

Distance Walked

Farthest distance walked at one time without sitting down in the LAST 3 DAYS (with support as needed)

- ○ Did not walk
- ○ Less than 15 feet
- ○ 15 to 149 feet
- ○ 150 to 299 feet
- ○ 300+ feet
- ○ 1/2 mile or more

Distance Wheeled Self

Farthest distance wheeled self at one time in the LAST 3 DAYS (include independent use of motorized wheelchair)

- ○ Wheeled by others
- ○ Used motorized wheelchair/scooter
- ○ Wheeled self less than 15 feet
- ○ Wheeled self 15 -149 feet
- ○ Wheeled self 150-299 feet
- ○ Wheeled self 300+ feet
- ○ Did not use wheelchair

Change in ADL Status

As compared with 90 days ago (or since last assessment if less than 90 days ago)

- ○ Improved
- ○ No change
- ○ Declined
- ○ Uncertain

Overall Self-Sufficiency

Has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days ago)

- ○ Improved
- ○ No change
- ○ Deteriorated

Driving

Drove car (vehicle) in the LAST 90 DAYS

- ○ No or does not drive
- ○ Yes

If drove in LAST 90 DAYS, assessor is aware that someone has suggested that person limits OR stops driving

- ○ No or does not drive
- ○ Yes

Activity Level

In the LAST 3 DAYS, number of days went out of the house or building in which he/she resides (no matter how short the period)

- ○ No days out
- ○ Did not go out in last 3 days, but usually goes out over a 3-day period
- ○ 1 to 2 days
- ○ 3 days

Total hours of exercise or physical activity in LAST 3 DAYS (e.g., walking)

- ○ None
- ○ Less than 1 hour
- ○ 1 to 2 hours
- ○ 3 to 4 hours
- ○ More than 4 hours

Physical Function Improvement Potential

Person believes he/she is capable of improved performance in physical function

- ○ No
- ○ Yes

Care professional believes person is capable of improved performance in physical function

- ○ No
- ○ Yes

Prior Description of Conditions Noted Above:

Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified

If yes, briefly describe issue, if no, briefly indicate why.

SECTION Q: Service Utilization-Formal Care - RN Assessment

Formal Care - Days and Total Minutes of Care in Last 7 Days
Extent of care/treatment in LAST 7 DAYS (or since last assessment or admission if less than 7 days) involving:

	# Days	Total Minutes in Last Week
Personal assistants/aides	☐	☐☐☐
Home nurse	☐	☐☐☐
Homemaking services	☐	☐☐☐
Meals	☐	N / A
Physical Therapy	☐	☐☐☐
Occupational Therapy	☐	☐☐☐
Speech-language pathology and audiology services	☐	☐☐☐
Day care or day hospital	☐	☐☐☐
Social Worker in home	☐	☐☐☐
Psychological therapy (by any licensed mental health professional) *	☐	☐☐☐

I want an alternate caregiver to provide services if my regularly scheduled person is not available. ○ No ○ Yes

My Back-Up Plan for Care Is:

Back-Up Plan Reviewed ○ No ○ Yes

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

SECTION Q: Service Utilization-Treatments and Programs - RN

Treatment or Programs Received or Scheduled in Last 3 Days
(Or since last assessment if less than 3 days)

0 = Not ordered AND did not occur
1 = Ordered, not implemented
2 = 1 or 2 days of last 3 days
3 = Daily in last 3 days

	0	1	2	3
Transfusion	○	○	○	○
Chemotherapy	○	○	○	○
Dialysis	○	○	○	○
IV medication	○	○	○	○
Oxygen therapy	○	○	○	○
Radiation	○	○	○	○
Tracheostomy care	○	○	○	○
Ventilator or respirator	○	○	○	○
Infection control (e.g. isloation, quarantine)	○	○	○	○
Suctioning	○	○	○	○
Wound care	○	○	○	○
Palliative care program	○	○	○	○
Scheduled toileting program	○	○	○	○
Turning/repositioning program	○	○	○	○
Medical alert bracelet or electronic security alert	○	○	○	○

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

SECTION Q: Service Utilization-Equipment/other

Management of Equipment (in last 14 days)

0 = Not Used
1 = Managed on own
2 = Managed on own if laid out or with verbal reminders
3 = Partially performed by others
4 = Fully performed by others

	0	1	2	3	4
Oxygen	○	○	○	○	○
IV	○	○	○	○	○
Catheter	○	○	○	○	○
Other	○	○	○	○	○

Does person use medical equipment that relies on power?
i.e., ventilation equipment, oxygen therapy, oxygen tank, IV therapy, TPN
○ No ○ Yes ○ Not Applicable

If yes, is there a back-up system in case of power failure?
○ No ○ Yes

What is back-up system?
○ Battery
○ Generator
○ Participant chooses not to have a backup system

How many hours will back-up system operate? ☐☐☐

If participant uses oxygen, are there back-up oxygen tanks present?
○ No ○ Yes

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

SECTION R: Medication Use - RN Assessment

My Medication List is located:_____

Adherent with Medications Prescribed by Physician

- ○ Always adherent
- ○ Adherent 80% of time or more
- ○ Adherent less than 80% of time, including failure to purchase prescribed medications
- ○ No medications prescribed

Person needs reminding several times a day to take medications ○ No ○ Yes

Preparation of medications needed ○ No ○ Yes

Medications must be administered to person ○ No ○ Yes

Allergy to Any Drug ○ No known drug allergies ○ Yes

Allergies/Sensitivities, Specify - include reaction

Pharmaceutical :

Environmental :

Food :

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue; If no, briefly indicate why.

SECTION S: Vitals - RN Assessment

Vital Signs

Temperature (F) ☐☐☐.☐

Pulse-Radial ☐☐☐ **Pulse-Apical** ☐☐☐

Respiration ☐☐☐ **Lung Sounds Left:** **Right:**

Blood Pressure (sitting)

BP (systolic) Left arm ☐☐☐ / ☐☐☐ **BP (systolic) Right arm** ☐☐☐ / ☐☐☐

BP (diastolic) Left arm ☐☐☐ / ☐☐☐ **BP (diastolic) Right arm** ☐☐☐ / ☐☐☐

Height ☐☐ **Feet** ☐☐ **Inches**

Weight (Base weight on most recent measure in LAST 30 DAYS) ☐☐☐ **Pounds**

○ **Unable to weigh**

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue; If no, briefly indicate why.

SECTION T: Nursing Notes - RN Assessment

SC Certification: I certify that based on the information obtained, observations made, and belief formed after reasonable inquiry, the statements and information contained in this document are true, accurate and complete. Check box to indicate your agreement with this statement.

○ Agree

Supports Coordinator Name:_____

Service Need Level

- ○ 1A **This means you cannot be left alone. If your services are not delivered as planned, your backup plan needs to start immediately.**
- ○ 1B **This means you cannot be left alone. If your services are not delivered as planned, your family/friends needs to be contacted immediately.**
- ○ 1C **This means you cannot be left alone. Staff at your place of residence must be available to you as planned or follow established emergency procedures.**
- ○ 2A **This means you can be left alone for a short period of time. If your services are not delivered as planned, your backup plan needs to start within 12 hours.**
- ○ 2B **This means you can be left alone for a short period of time. If your services are not delivered as planned, your family/friends need to be contacted within 12 hours.**
- ○ 2C **This means you can be left alone for a short period of time. Staff at your place of residence must be available to you periodically each day. Follow established emergency procedures if no staff are available.**
- ○ 3A **This means you can be left alone for a day or two. If your services are not delivered as planned, your backup plan needs to start within a couple days.**
- ○ 3B **This means you can be left alone for a day or two. If your services are not delivered as planned, your family/friends need to be contacted within a couple days.**

Emergency Rating _____

High intensity person ○ No ○ Yes

Discussed the internal grievance and external appeals process ○ No ○ Yes

Person rights and responsibilities explained ○ No ○ Yes

Agency folder was provided and reviewed with participant ○ No ○ Yes

SECTION T: Nursing Notes, continued - RN Assessment

Person is/remains medically eligible under Door _____

Drop down choices:

Not medically eligibile	Door 5
Door 1	Door 6
Door 2	Door 7
Door 3	Door 8
Door 4	MPRO Exception

Prior Description of Conditions Noted Above:
Note: This is prefilled with prior assessment notes (unless this is a first assessment)

Description of Conditions Noted Above:

RN Summary: Additional comments not documented elsewhere in Assessment

Include in PCSP? ○ Yes ○ No ○ No issues identified
If yes, briefly describe issue, if no, briefly indicate why.

SECTION U: Person Location/Status - RN Assessment

CM Recommends
○ Community based care
○ Institutional care

Person Choice
○ Community based care
○ Institutional care

Confirm person medically eligible for MI-Choice
○ No
○ Yes

Description of Conditions Noted Above:

Other or Primary Diseases

List of All Diagnoses

Disease Diagnosis	ICD Code	Disease Code
		○ Not Present ○ Primary diagnosis/diagnoses ○ Diagnosis present, receiving active treatment ○ Diagnosis present, monitored but no active treatment
		○ Not Present ○ Primary diagnosis/diagnoses ○ Diagnosis present, receiving active treatment ○ Diagnosis present, monitored but no active treatment
		○ Not Present ○ Primary diagnosis/diagnoses ○ Diagnosis present, receiving active treatment ○ Diagnosis present, monitored but no active treatment
		○ Not Present ○ Primary diagnosis/diagnoses ○ Diagnosis present, receiving active treatment ○ Diagnosis present, monitored but no active treatment
		○ Not Present ○ Primary diagnosis/diagnoses ○ Diagnosis present, receiving active treatment ○ Diagnosis present, monitored but no active treatment
		○ Not Present ○ Primary diagnosis/diagnoses ○ Diagnosis present, receiving active treatment ○ Diagnosis present, monitored but no active treatment
		○ Not Present ○ Primary diagnosis/diagnoses ○ Diagnosis present, receiving active treatment ○ Diagnosis present, monitored but no active treatment
		○ Not Present ○ Primary diagnosis/diagnoses ○ Diagnosis present, receiving active treatment ○ Diagnosis present, monitored but no active treatment
		○ Not Present ○ Primary diagnosis/diagnoses ○ Diagnosis present, receiving active treatment ○ Diagnosis present, monitored but no active treatment
		○ Not Present ○ Primary diagnosis/diagnoses ○ Diagnosis present, receiving active treatment ○ Diagnosis present, monitored but no active treatment
		○ Not Present ○ Primary diagnosis/diagnoses ○ Diagnosis present, receiving active treatment ○ Diagnosis present, monitored but no active treatment

List of Medications
List all active prescriptions and any non-prescribed (over the counter) medications **taken in the LAST 3 DAYS**

Strength/Dose		Route Codes:		Frequency Codes:		
Positive number, such as 0.5, 5, 150		PO (By mouth/oral)	TOP (Topical)	Q1H (Every Hour)	BID (2 times daily)	4W (4 times weekly)
		SL (Sublingual)	IH (Inhalation)	Q2H (Every 2 Hours)	TID (3 times daily)	QIW (4 times weekly)
gtts (drops)	mg (milligram)	IM (Intramuscular)	NAS (Nasal)	Q3H (Every 3 Hours)	QID (4 times daily)	5W (5 times weekly)
gm (gram)	ml (milliliter)	IV (Intravenous)	ET (Enteral tube)	Q4H (Every 4 hours)	5D (5 times daily)	6W (6 times weekl
L (liter)	oz (ounce)	Sub-Q (Subcutaneous)	TD (Transdermal)	Q6H (Every 6 hours)	QOD (Every other day)	1M (Monthly)
mcg (microgram)	OTH (other)	REC (Rectal)	EYE (Eye)	Q8H (Every 8 hours)	Q2D (Every other day)	QM (Monthly)
mEq (milli-equiv)	Puffs		Other	Q12H (Every 12 hours)	Q3D (Every three days)	2M (Twice each month)
	% percentage			QD (Daily)	QW (Weekly)	OTH (other)
	units			BED (Bedtime)	2W (2 times weekly)	
				QHS (Hours of sleep)	BIW (2 times weekly)	
					3W (3 times weekly)	
					TIW (3 times weekly)	

Medication Name	Strength/Dose	Route	Frequency	PRN	Purpose
				○ No ○ Yes	
Prescribed by	**Start Date**		**Reviewed this Visit**		**Notes**
	Stop Date		○ No ○ Yes		

Medication Name	Strength/Dose	Route	Frequency	PRN	Purpose
				○ No ○ Yes	
Prescribed by	**Start Date**		**Reviewed this Visit**		**Notes**
	Stop Date		○ No ○ Yes		

Medication Name	Strength/Dose	Route	Frequency	PRN	Purpose
				○ No ○ Yes	
Prescribed by	**Start Date**		**Reviewed this Visit**		**Notes**
	Stop Date		○ No ○ Yes		

Medication Name	Strength/Dose	Route	Frequency	PRN	Purpose
				○ No ○ Yes	
Prescribed by	**Start Date**		**Reviewed this Visit**		**Notes**
	Stop Date		○ No ○ Yes		

Medication Name	Strength/Dose	Route	Frequency	PRN	Purpose
				○ No ○ Yes	
Prescribed by	**Start Date**		**Reviewed this Visit**		**Notes**
	Stop Date		○ No ○ Yes		

Medication Name	Strength/Dose	Route	Frequency	PRN	Purpose
				○ No ○ Yes	
Prescribed by	**Start Date**		**Reviewed this Visit**		**Notes**
	Stop Date		○ No ○ Yes		

Medication Name	Strength/Dose	Route	Frequency	PRN	Purpose
				○ No ○ Yes	
Prescribed by	**Start Date**		**Reviewed this Visit**		**Notes**
	Stop Date		○ No ○ Yes		

Medical Providers

Provider Name (i.e., Westside Medical Center, Smith Podiatry, etc.)

Credentials
(MD, DO, DDS, DPM, NP, PA, DC, OD, PHD, other)

Specialty
(Anesthesiologist, Cardiologist, Chiropractor, Dentist, Dermatologist, Endocrinologist, ENT, Family Practice, Gastroenterologist, General Practitioner, Geriatrician, Hematologist, Internal Medicine, Nephrologist, Neurologist, Oncologist, Opthalmologist, Optometrist, Orthopedist, Physiatrist, Plastic Surgeon, Podiatrist, Proctologist, Psychiatrist, Pulmonologist, Referring Physician, Rehab & Physical Therapy, Rheumatologist, Urologist, Wound Care, Other)

Address 1

Address 2

City/State/Zip

County

Country

Province

Email Address

Phone Numbers
Business Phone: Area Code Number

Mobile Phone: Area Code Number

Fax Phone: Area Code
Mobile Phone: Area Code

Primary Care Physician ○ No ○ Yes

Date Last Seen

Special Notes Related to this case
i.e., Parkinson Specialist, NH Doctor

Provider Name (i.e., Westside Medical Center, Smith Podiatry, etc.)

Credentials
(MD, DO, DDS, DPM, NP, PA, DC, OD, PHD, other)

Specialty
(Anesthesiologist, Cardiologist, Chiropractor, Dentist, Dermatologist, Endocrinologist, ENT, Family Practice, Gastroenterologist, General Practitioner, Geriatrician, Hematologist, Internal Medicine, Nephrologist, Neurologist, Oncologist, Opthalmologist, Optometrist, Orthopedist, Physiatrist, Plastic Surgeon, Podiatrist, Proctologist, Psychiatrist, Pulmonologist, Referring Physician, Rehab & Physical Therapy, Rheumatologist, Urologist, Wound Care, Other)

Address 1

Address 2

City/State/Zip

County

Country

Province

Email Address

Phone Numbers
Business Phone: Area Code Number

Mobile Phone: Area Code Number

Fax Phone: Area Code
Mobile Phone: Area Code

Primary Care Physician ○ No ○ Yes

Date Last Seen

Special Notes Related to this case
i.e., Parkinson Specialist, NH Doctor

Medical Providers, continued

Provider Name (i.e., Westside Medical Center, Smith Podiatry, etc.)

Credentials
(MD, DO, DDS, DPM, NP, PA, DC, OD, PHD, other)

Specialty
(Anesthesiologist, Cardiologist, Chiropractor, Dentist, Dermatologist, Endocrinologist, ENT, Family Practice, Gastroenterologist, General Practitioner, Geriatrician, Hematologist, Internal Medicine, Nephrologist, Neurologist, Oncologist, Opthalmologist, Optometrist, Orthopedist, Physiatrist, Plastic Surgeon, Podiatrist, Proctologist, Psychiatrist, Pulmonologist, Referring Physician, Rehab & Physical Therapy, Rheumatologist, Urologist, Wound Care, Other)

Address 1

Address 2

City/State/Zip

County

Country

Province

Email Address

Phone Numbers
Business Phone: Area Code Number

Mobile Phone: Area Code Number

Fax Phone: Area Code Number

Primary Care Physician ○ No ○ Yes

Date Last Seen

Special Notes Related to this case
i.e., Parkinson Specialist, NH Doctor

Provider Name (i.e., Westside Medical Center, Smith Podiatry, etc.)

Credentials
(MD, DO, DDS, DPM, NP, PA, DC, OD, PHD, other)

Specialty
(Anesthesiologist, Cardiologist, Chiropractor, Dentist, Dermatologist, Endocrinologist, ENT, Family Practice, Gastroenterologist, General Practitioner, Geriatrician, Hematologist, Internal Medicine, Nephrologist, Neurologist, Oncologist, Opthalmologist, Optometrist, Orthopedist, Physiatrist, Plastic Surgeon, Podiatrist, Proctologist, Psychiatrist, Pulmonologist, Referring Physician, Rehab & Physical Therapy, Rheumatologist, Urologist, Wound Care, Other)

Address 1

Address 2

City/State/Zip

County

Country

Province

Email Address

Phone Numbers
Business Phone: Area Code Number

Mobile Phone: Area Code Number

Fax Phone: Area Code Number

Primary Care Physician ○ No ○ Yes

Date Last Seen

Special Notes Related to this case
i.e., Parkinson Specialist, NH Doctor

Pharmacies

Provider **Note: When entering, select pharmacy (from drop down list) with same address, or add new.** **Address 1** **Address 2** **City / State / Zip** **Phone** **Special Notes Related to This Case:**	**Provider** **Note: When entering, select pharmacy (from drop down list) with same address, or add new.** **Address 1** **Address 2** **City / State / Zip** **Phone** **Special Notes Related to This Case:**
Provider **Note: When entering, select pharmacy (from drop down list) with same address, or add new.** **Address 1** **Address 2** **City / State / Zip** **Phone** **Special Notes Related to This Case:**	**Provider** **Note: When entering, select pharmacy (from drop down list) with same address, or add new.** **Address 1** **Address 2** **City / State / Zip** **Phone** **Special Notes Related to This Case:**
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Durable Medical Equipment

Durable Medical Equipment Item
Note: When entering, choose from drop down list or add new

Durable Medical Equipment Provider
Note: When entering, choose from drop down list or add new

Additional description/details

When acquired

Payor Source
- ○ Medicare
- ○ Medicaid
- ○ Care Management
- ○ Private Pay
- ○ Private/other insurance
- ○ On loan
- ○ Other payor

Comment

Durable Medical Equipment Item
Note: When entering, choose from drop down list or add new

Durable Medical Equipment Provider
Note: When entering, choose from drop down list or add new

Additional description/details

When acquired

Payor Source
- ○ Medicare
- ○ Medicaid
- ○ Care Management
- ○ Private Pay
- ○ Private/other insurance
- ○ On loan
- ○ Other payor

Comment

Durable Medical Equipment Item
Note: When entering, choose from drop down list or add

Durable Medical Equipment Provider
Note: When entering. choose from drop down list or add

Additional description/details

When acquired

Payor Source
- ○ Medicare
- ○ Medicaid
- ○ Care Management
- ○ Private Pay
- ○ Private/other insurance
- ○ On loan
- ○ Other payor

Comment

Durable Medical Equipment Item Drop Down List

- No DME Required
- Air conditioner
- Bed/Chair alarm
- Bed pan
- Bed Rails
- BiPaP machine
- Blood pressure cuff
- Brace
- Cane
- Catheter supplies
- Coagulation tester
- Colostomy supplies
- Commode
- C-PAP machine
- Crutches
- Diabetic footware
- Diabetic supplies
- Dressing aids
- Eating aids/utensils
- Emergency pull cords
- Enteral Formulae
- Feeding pump
- Gait belt
- Gel cushions/pads
- Geri chair
- Glucometer
- Grab bar
- Hospital bed
- Hoyer lift
- Incontinence supplies
- Lifeline/PERS
- Lift Chair
- Mattress-air/egg crate
- Medical Supplies
- Medication dispenser
- Nebulizer
- Oxygen
- Prosthesis
- Pulse oximeter
- Ramp
- Reacher
- Scale
- Sharps container
- Shower-bench/chair
- Shower-handheld wand
- Shower-other bathing aids
- Sit-to-stand device
- Stair lift
- Suction machine
- Table-bedside/overbed
- TENS unit
- Toilet seat-bars
- Toilet seat-raised
- Transfer bench
- Transfer lift
- Trapeze
- Urinal
- Van lift
- Ventilator
- Versaframe
- Walker
- Wheelchair-electric, manual
- Wounds supplies
- Wound Vac
- Other - 1, Other - 2
- Other - 3, Other - 4

PCSP Interventions

Purchased WA

Intervention (see selections on last page)

Intended Start

Intervention Description (for Supports Coordination Intervention only)

Resolved Date

Issues Addressed - Assessment Sections with Issues

Issues Descriptions

Participant Preference (EXCLUDE Days/Times)

Communication Plan (for Supports Coordination Intervention only)

How often should the SC contact you? (number of days)

How often should the SC assess you? (number of days)

How often should the SC have a person-centered planning meeting? (number of days)

Who would you prefer that the SC communicate with about your services & supports, if anyone, other than you? Leave blank if no one else.

Would you like a copy of your PCSP mailed to your primary physician? ○ No ○ Yes

Would you like a copy of your PCSP mailed to any of your other physicians? If yes, who? ○ No ○ Yes

Other preferences regarding communications

Purchased Other

Intervention (see selections on last page)

Intended Start

Intervention Description (for Supports Coordination Intervention only)

Resolved Date

Issues Addressed - Assessment Sections with Issues

Issues Descriptions

Participant Preference

Communication Plan (for Supports Coordination Intervention only)

How often should the SC contact you? (number of days)

How often should the SC assess you? (number of days)

How often should the SC have a person-centered planning meeting? (number of days)

Who would you prefer that the SC communicate with about your services & supports, if anyone, other than you? Leave blank if no one else.

Would you like a copy of your PCSP mailed to your primary physician? ○ No ○ Yes

Would you like a copy of your PCSP mailed to any of your other physicians? If yes, who? ○ No ○ Yes

Other preferences regarding communications

PCSP Interventions, continued

Informal

Provider Type ○ Caregiver ○ Community Supports

Provider

Issues Addressed - Assessment Sections with Issues

○ B: Social Functioning
○ E: Cognitive
○ G: Mood/Behavior
○ J: Health Conditions
○ K: Nutrition/Hydration
○ M: Hearing and Vision
○ O: Continence
○ P: Physical Function
○ Q: Svc Util - Formal Care
○ Q: Svc Util - Treatments

Issues Descriptions

Provider Phone Number

Tasks (Include frequency and duration if known)

Start Date:

Stop Date:

Informal

Provider Type ○ Caregiver ○ Community Supports

Provider

Issues Addressed - Assessment Sections with Issues

○ B: Social Functioning
○ E: Cognitive
○ G: Mood/Behavior
○ J: Health Conditions
○ K: Nutrition/Hydration
○ M: Hearing and Vision
○ O: Continence
○ P: Physical Function
○ Q: Svc Util - Formal Care
○ Q: Svc Util - Treatments

Issues Descriptions

Provider Phone Number

Tasks (Include frequency and duration if known)

Start Date:

Stop Date:

Self Intervention

Intervention

Intervention Description

Issues Addressed - Assessment Sections with Issues

○ B: Social Functioning
○ E: Cognitive
○ G: Mood/Behavior
○ J: Health Conditions
○ K: Nutrition/Hydration
○ M: Hearing and Vision
○ O: Continence
○ P: Physical Function
○ Q: Svc Util - Formal Care
○ Q: Svc Util - Treatments

Issues Descriptions

Intended Start Date

Resolved Date

Self Intervention

Intervention

Intervention Description

Issues Addressed - Assessment Sections with Issues

○ B: Social Functioning
○ E: Cognitive
○ G: Mood/Behavior
○ J: Health Conditions
○ K: Nutrition/Hydration
○ M: Hearing and Vision
○ O: Continence
○ P: Physical Function
○ Q: Svc Util - Formal Care
○ Q: Svc Util - Treatments

Issues Descriptions

Intended Start Date

Resolved Date

PCSP Interventions, continued

Arranged	Arranged
Intervention (see selections on last page)	**Intervention** (see selections on last page)
Additional Description	**Additional Description**
Intervention Description - include frequency and tasks if known	**Intervention Description -** include frequency and tasks if known
Issues Addressed - Assessment Sections with Issues	**Issues Addressed - Assessment Sections with Issues**
○ B: Social Functioning ○ M: Hearing and Vision	○ B: Social Functioning ○ M: Hearing and Vision
○ E: Cognitive ○ O: Continence	○ E: Cognitive ○ O: Continence
○ G: Mood/Behavior ○ P: Physical Function	○ G: Mood/Behavior ○ P: Physical Function
○ J: Health Conditions ○ Q: Svc Util - Formal Care	○ J: Health Conditions ○ Q: Svc Util - Formal Care
○ K: Nutrition/Hydration ○ Q: Svc Util - Treatments	○ K: Nutrition/Hydration ○ Q: Svc Util - Treatments
Issues Descriptions	**Issues Descriptions**
Provider Type ○ Service Provider ○ Medical Provider ○ Pharmacy Provider ○ DME Provider ○ Other	**Provider Type** ○ Service Provider ○ Medical Provider ○ Pharmacy Provider ○ DME Provider ○ Other
Provider	**Provider**
Provider Phone Number	**Provider Phone Number**
Start Date:	**Start Date:**
Stop Date:	**Stop Date:**

PCSP Goals

Goal - Participant/Supports Coordinator identified desire

Desired Outcomes - Why do you have this goal?

Issues Addressed - Assessment Sections with Issues

- ○ B: Social Functioning
- ○ E: Cognitive
- ○ G: Mood/Behavior
- ○ J: Health Conditions
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- ○ M: Hearing and Vision
- ○ O: Continence
- ○ P: Physical Function
- ○ Q: Svc Util - Formal Care
- ○ Q: Svc Util - Treatments

Issues Descriptions

Priority - This goal is important to me

○ Less important ○ Important ○ More Important

Start Date:

Goal Review - Update progress of goal and have expectations been met

Resolved Date:

PCSP Goals

Goal - Participant/Supports Coordinator identified desire

Desired Outcomes - Why do you have this goal?

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- ○ B: Social Functioning
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PCSP Goals

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- ○ P: Physical Function
- ○ Q: Svc Util - Formal Care
- ○ Q: Svc Util - Treatments

Issues Descriptions

Priority - This goal is important to me

○ Less important ○ Important ○ More Important

Start Date:

Goal Review - Update progress of goal and have expectations been met

Resolved Date:

Intervention Drop Down Choices

Purchased WA

9ADC - Adult Day Care
Chore - Chore Services
CLS - Community Living Supports
CTS-NFT - Community Transition Services - NFT
Community Transportation
CNSL - Counseling
EAA - Environmental Accessibility Adaptations
FI - Fiscal Intermediary Services
G-S - Goods & Services
HDM - Home Delivered Meals
Nsg - Nursing
PERS - Personal Emergency Response System
PDN - Private Duty Nursing
Respite - Respite
SME - Specialized Medical Equipment and Supplies
SC - Supports Coordination
Trng - Training

Purchased Other

ADC - Adult Day Care
Chore - Chore Services
CLS - Community Living Supports
CTS-NFT - Community Transition Services - NFT
Community Transportation
CNSL - Counseling
EAA - Environmental Accessibility Adaptations
FI - Fiscal Intermediary Services
Ft Care - Foot Care
G-S - Goods & Services
HDM - Home Delivered Meals
HMK - Homemaking
Med Mgmt - Medication Management
Nsg - Nursing
Other - Other Services
PC - Personal Care
PERS - Personal Emergency Response System
PDN - Private Duty Nursing
Respite - Respite
SCP - Senior Companion
SME - Specialized Medical Equipment and Supplies
SC - Supports Coordination
Trng - Training

Arranged

Community-based Food Assistance - Food
Disease Specific Support or Advocacy - Disease specific
Durable Medical Equipment
Faith/Religion Based Services and Support - Faith
Hearing Services and Supports - Hearing
Health Insurance or Benefit Assistance Services (ie MMAP) - Health ins/benefit
Home Health Aide Services - HHA
Hospice Services & Support - Hospice
Housing Assistance, Service or Support - Housing
Incontinence Supplies - Incontinence
Independent Living Services
Legal Services - Legal
Low cost or free Community Based Services - Low cost CBS
Mental Health Services - Mental health
Non-Emergency Medical Transportation - NEMT
Occupational Therapy - OT
Other - Other
Other - Physician
Palliative Care
Pharmacy
Primary Physician
Physical Therapy Service - PT
Prescription Assistance Services - Prescription
Services & Supports for the Aged - Aged
Services & Supports for the Blind - Blind
Skilled Care
Skilled Nursing Services - Skilled Nursing
Social Workers Services - SW
Speech Language Pathology Therapy Services - Speech
State Emergency Relief Services - SER
Supplemental Nutrition Assistance Program - SNAP
Tribal Services
Veterans Supports & Services - Veterans
Vision Services - Vision