Upper Peninsula Health Plan MI Health Link Personal Care Assessment Tool

Member Name: _____ Date of Birth: _____ Date of Assessment: _____

SECTION 1 Check score boxes based on member's ability to complete Activities of Daily Living (ADL's)

ADL's	No assistance needed	Verbal assistance or prompting, cueing and reminding needed	Minimal hands-on assistance or assistive technology needed	Direct hands-on assistance needed for most activities	Totally dependent on others
Score	**1**	**2**	**3**	**4**	**5**
Eating	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐
Mobility	☐	☐	☐	☐	☐

DETERMINATION: Does member score 3 or greater in at least one ADL. *Check only one box below*

☐ NO – Member **IS NOT** eligible for personal care services, **STOP** assessment.

☐ YES – Scores 3 or greater in an ADL. Member **IS** eligible for personal care services, **CONTINUE** assessment.

Does member require complex care needs for their ADL's? *Check only one box below*

☐ YES, complete Section 2

☐ NO, skip to Section 3

SECTION 2 Complete Reasonable Time Schedule (RTS) based on the members complex care need

Upper Peninsula Health Plan MI Health Link Personal Care Assessment Tool

Activity	Complex Care Needs	Yes	No
Eating	**1.Eating or Feeding Assistance**		
	Blended meals and throat massage-45 minutes/meal x 3 (68 hours/month)	☐	☐
	Feeding tube or supplemental food bag: if 20 minutes each x 4 in a 24 hour period (40 hours/month)	☐	☐
	Feeding tube or supplemental food bag: if 20 minutes each x 6 in a 24 hour period (60 hours/month)	☐	☐
Toileting	**2.Catheters or Leg Bags**		
	In-dwelling (Foley) 10 minutes every 4 hours (30 hours/month)	☐	☐
	Intermittent, 15 minutes every 4 hours (45 hours/month)	☐	☐
Toileting	**3.Colostomy Care**		
	If 20 minutes once a day (10 hours/month)	☐	☐
	If 20 minutes twice a day (20 hours/month)	☐	☐
	Use the hours in numbers **2 and 3 in ADLs in** place of toileting if both a catheter and colostomy care is needed. If only one is needed then some toileting hours may be included in the regular reasonable time schedule REFER TO SECTION 5		
Toileting	**4. Bowel Program** (used mainly for quadriplegics) (30 hours/month)	☐	☐
Eating	**5. Suctioning**		
	During meals or as needed-Minimum 10 minutes every 2 hours (60 hours/month)	☐	☐
Transferring	**6. Specialized Skin Care/Wound Care**		
	Turning at night-10 minutes every 2 hours for 10 hours (25 hours/month)	☐	☐
	Massage to prevent decubital ulcers-15 minutes per day (8 hours/month)	☐	☐
Mobility	**7. Range of Motion Exercises**		
	If 30 minutes once a day (15 hours/month)	☐	☐
	If 30 minutes twice a day (30 hours/month)	☐	☐

SECTION 3 Check score boxes based on member's ability to complete Instrumental Activities of Daily Living (IADL)

IADL	No assistance needed	Verbal assistance or prompting, cuing and reminding needed	Minimal hands-on assistance or assistive technology needed	Direct hands-on assistance needed for most activities	Totally dependent on others
Score	**1**	**2**	**3**	**4**	**5**
Medication	☐	☐	☐	☐	☐
Meal Prep	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐
Laundry	☐	☐	☐	☐	☐
Housework	☐	☐	☐	☐	☐

Upper Peninsula Health Plan MI Health Link Personal Care Assessment Tool

Does member live in a shared living arrangement? *Check only one box below*

☐ **YES**, lives with spouse

Is the spouse unavailable or unable to help the member with tasks? (Choose one option only)

☐ Spouse is unavailable/unable to help

Document Reason: _____

Are all the IADL tasks for the member completed separate from others living in the home?

☐ Yes – all tasks are completed separate (IADL's would not be halved for time)

☐ No – all or some IADL's are completed together (half IADL's where tasks are not separate except for travel time)

☐ Spouse is available/able to help

☐ **YES**, lives with non-spouse

Are all the IADL tasks for the member completed separate from others living in the home?

☐ Yes – all tasks are completed separate (IADL's would not be halved for time)

☐ No – all or some IADL's are completed together (half IADL's where tasks are not separate except for travel time)

☐ **NO**, lives alone, skip to section 4

Does member have a service animal? *Check only one box below*

☐ YES, complete section 4

☐ NO, Skip to section 5

SECTION 4

Service Animal Assessment	**Yes**	**No**
Does the member qualify for personal care services?	☐	☐
Is the service animal a dog or miniature horse?	☐	☐
Is the member certified disabled due to a specific condition?	☐	☐
Is the service animal trained to meet specific needs of the member relative to their disability? (Do not request demonstration of tasks)	☐	☐
Is the animal performing personal care tasks for the member other than providing comfort or emotional support?	☐	☐
IF YES TO ALL OF THE ABOVE, THE MEMBER QUALIFIES FOR THE MONTHLY STIPEND		

SECTION 5 ADL RTS

Upper Peninsula Health Plan MI Health Link Personal Care Assessment Tool

Activity	Rank	Reasonable Time Schedule in Hours per Month	Actual Time Needed in Hours per Month	Total Complex Care in Hours per Month	Combined Time Needed and Complex Care in Hours per Month	Documentation If time required to complete ADL varies from the RTS, document details under each ADL
Eating	3	22				
	4	25				
	5	28				
Toileting	3	11				
	4	13				
	5	14				
Bathing	3	8				
	4	9				
	5	11				
Grooming	3	4				
	4	5				
	5	6				
Dressing	3	7				
	4	8				
	5	9				
Transferring	3	3				
	4	4				
	5	5				
Mobility	3	7				
	4	8				
	5	9				
Total All ADL Hours (including Complex Care hours if applicable) per Month						

SECTION 6 IADL RTS

Did section 3 indicate IADL time needs to be prorated by one half? *Check only one box below*

- ☐ YES, split IADL time in half **DO NOT SPLIT TRAVEL TIME OR MEDICATON TME IN HALF**
- ☐ NO, continue

Upper Peninsula Health Plan MI Health Link Personal Care Assessment Tool

Activity	Rank	Max Hours Allowed per Month	Actual Time Needed in Hours per Month	Total Travel Time in Hours per Month (Max round trips 2 times per week)	Combined Hours per Month Needed and Travel Time in Hours per Month	Documentation If time required to complete IADL varies from the RTS, document details under each IADL
Medications	3-5	There is no time limit		N/A		
Meal Preparation/ Clean-up	3-5	25		N/A		
Shopping for Food/ Medications	3-5	5				
Laundry	3-5	7				
House Work	3-5	6		N/A		
Total All IADL Hours per Month						

Total ADL Hours per Month	+	Total IADL Hours per Month	=	Total Hours per Month

SECTION 7 SELF DETERMINATION/PROVIDER INFO

☐ Member already established with:

- ☐ Community Agency
  - Name of Agency: _____
- ☐ Northern Home Care
- ☐ GT Independence

☐ Member needs assistance arranging services

- ☐ Community Agency
  - Name of Agency: _____
- ☐ Northern Home Care
  - ☐ Northern Home Care Employment Packet Provided
  - ☐ Northern Home Care Employment Packet Needed
- ☐ GT Independence

Name of worker: _____

Address: _____

Phone Number: _____