

Name: Member Assessment, Section I Case Management (CM)
(Policy Reference: 501.7)

Purpose: A face-to-face in home interview with the ADW member/legal representative in order to identify the member's abilities, needs, preferences, and supports; determine needed services or resources; and provide a sound basis for developing the Service Plan and Plan of Care. A Secondary purpose is to provide the member a good understanding of the program, services," and expectations. There are 2 components to the Member Assessment ***whenever possible*** both of these assessments should be scheduled to be conducted at the same time.

Note: Complete all areas of the Member Assessment leaving no blanks:

Section I Case Management

- Document member's name and date at the top of each page.
- Select the type of Assessment:
 - Initial
 - 6-month
 - Annual
 - Post-Hospital
 - Change in Needs

1. Demographics document member's

- Last and First Name.
- Date of Birth (DOB)
- Date of the Assessment
- Financial Eligibility Effective Date
- Current PAS Date
- Medical Reevaluation request by date ***(at least 45 days prior to expiration of current PAS)***
- Physical Address: city, County and Zip Code
- Mailing Address: city, County and Zip Code
- Home Phone, Cell Phone, and Other Phone
- Detailed directions to the member's home.

2. Insurance and Health Care Information:

- Enter Medicaid, and Medicare Number (if applicable if not put NA)
- Enter Other Insurance including name and phone number.
- Complete **Medicare Information** if applicable.
- Check all boxes if apply: Member has legal guardian, Committee, MPOA, Legal POA, Durable POA, Conservator, DNR, Living Will, POST Form, Document in Chart, Deemed Incompetent. Document name and phone number.
- Request a copy of legal representative documentation for member file. Check the appropriate box if the member would not or could not provide a copy.

3. Goals and Current Resources:

- Ask the member “what kinds of services and help he/she expects from the program?”
- Check yes or no to the question “Do you manage your finances?”
 - If no ask if the member needs someone to assist with finances and document response.
- Document any informal or formal supports currently in place to assist member with activities of daily living, transportation, environmental tasks, home health etc.,
 - Document:
 - i. Agency or person’s name providing the service.
 - ii. Agency or person’s phone number.
 - iii. The Service being provided.
 - iv. Note if the service paid or informal support.
 - v. Mark yes or no to the question “will support continue once ADW services start?”

4. Environmental Assessment

- Check the location.

- Check the type of home (*check all that apply*).
- Ask the member “Do you own, rent or live with someone who owns the house?” If residing with someone else document the person’s name.
- If renting ask if it is a HUD subsidy and mark yes or no”
 - If yes it is a HUD subsidy document the name and phone number of the contact person.
- Ask the member “Who lives with you?”
 - If the answer is **No one** check the box and move onto the next question.
 - If the answer yes document the name, phone number and relationship of all those who live with the member.
- Ask the member “What he/she would need in the home to make it easier to get in/out of the home or to do activities in the home?” Document member’s response.
- Ask the member “Does your home have?” **review each area listed here and check yes or no to each and note any comments you or the member may have. LEAVE NO BLANKS! Make sure you address any issues of safety and/or sanitation hazards listed.**
- Note any other safety and/or sanitation hazards found in the home such as insects/rodents present, not trash pickup, soiled living area, etc.
- Ask the member “Do you ever have?” **Document member’s response by checking yes or no to each area and any comments you or the member may have. LEAVE NO BLANKS! Make sure you address any issues of safety and/or sanitation hazards listed.**

5. Medical Assessment

- Document names of all member physicians, their specialty, city/state, phone number, frequency of member visit and date of last visit. Use “**Additional Physician Information**” Form if needed.
- Ask the member if he/she feels the need to see a medical specialist, receive PT, OT or ST, tests or blood work, or any other medical service; and

If need assistance in making appointments for any of the services. If assistance is required ask who is currently helping the member make appointments and document the response.

6. Social Assessment

- Document how often member is able to leave their home and what prevents you from leaving your home.
- Ask “how do you spend your days?” Document member’s response.
- Ask “what activities the member enjoys?” within home or outside of home.
- Ask “Are there activities you enjoy but you have not been able to do?”
 - Document the activity.
 - Document the barrier(s) to participating in activity.
 - Document if he/she “would you be interested in participating if the barrier(s) can be removed?”
- Note any comments.
- Ask the member to describe any work history, education, or training that is important to know and document member’s response.

7. Emotional Assessment:

- Ask each question listed in this area as yes or no.
 - If the answer to a question is “**yes**” document **yes** or **no** to the following questions:
 - i. Is Doctor Aware?
 - ii. Any Treatment?
- Ask the member “how many hours do you usually sleep at night?” Document the member’s response.
- Ask the member “how often during the day do you nap?” Document the member’s response.
- Ask the member “what makes you feel happy?” Document the member’s response.
- Document specific problem’s /plans regarding the Emotional Assessment under “**Case Manager observations/comments**”.

8. Risk Assessment

- Under section **Medical** mark any areas **“yes” if identified as a risk** noting any comments. Mark areas **“no”** if no identified risk.
- Under section **Fall Risks** answer the question **“Does the member have”** to each of the areas in this section starting with **“Outside/Inside Stairs”**. Note any comments in the comments section. If the answer is **no** to the question **“Does the member have”** then mark **“no”**.
- Under section **Fall Risks** mark **yes or no** to each item listed in this area.
 - If answered **“yes”** document **yes** or **no** the following questions:
 - i. Is Doctor Aware?
 - ii. Are you being treated for?
- Under section **Behavioral** answer the question **“Does the member exhibit the following” yes or no**.
 - If answered **“yes”** document **yes** or **no** the following questions:
 - i. Is Doctor Aware?
 - ii. Are you being treated for?
- Ask the Member **“Are there any other issues you feel may be a risk to your health or safety?”** Document the members answer in this area.

9. **Identified Member Needs: Check each area determined as an Identified member need.** Address all needs identified in the section on the Service Plan with documentation specifying **“who”** will be responsible to assist the member to meet the member needs. Specifically address the issue of transportation with the member who will take them to the doctor, grocery shopping, etc. Member/legal representative and family need to be aware that transportation by the Personal Assistant/Homemaker is a last resort. **(Example: CM will assist with ensuring adequate incontinence supplies. Jane Doe, family will assist member with making medical appointment)**. Note any comments regarding the member needs in the Comment section.

10. Document the names of all present during the assessment, including their relationship to the member.

11. Note any other comments in the comment section.

Once the assessment is **completed** it must be **signed and dated** by the following:

- Member/legal representative
- Case Manager completing the assessment.

The Case Manager **must** also provide a copy of this assessment to the member/legal representative and the PA/HM agency as soon as possible and document the date the copies were provided.