

Section I. CASE MANAGEMENT

Initial 6-Month Annual Post-Hospital Change in Needs

1. DEMOGRAPHICS

Last Name:		First Name:
DOB:	Date of Assessment:	Financial Eligibility Effective Date:
Current PAS Date:		Medical Reevaluation (at least 45 days prior to expiration of current PAS) Request due by:
Physical Address:		
City:	County:	Zip Code:
Mailing Address:		
City:	County:	Zip Code:
Home Phone:	Cell Phone:	Other Phone:
Detailed Directions to Member's Home:		

2. INSURANCE AND HEALTH CARE INFORMATION

Medicaid #:	Medicare#:	Other Health Insurance (Name and phone number)
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Medicare Information

	Yes	No	Name of Provider (some members may have an advantage plan like Highmark, Humana, etc.)	Phone Number of Provider
Do you have Part A?				
Do you have Part B?				
Do you have Part C?				
Do you have Part D?				

Check any that apply. A copy showing either the relationship or the document needs to be included in member's file. Member would not or could not provide a copy.

- | | | |
|----------------|-------------|--------------------|
| Legal Guardian | Durable POA | POST Form |
| Committee | Conservator | Document in Chart |
| Medical POA | DNR | Deemed Incompetent |
| Legal POA | Living Will | |

Name:

Phone Number:

**AGED AND DISABLED WAIVER PROGRAM
MEMBER ASSESSMENT**

Member Name

Date

3. GOALS AND CURRENT RESOURCES

What kinds of services and help are you expecting from this program?

Do you manage your finances (pay bills, go to bank, make purchases, balance checkbook, make simple purchases, handle money matters, etc.)? Yes No Comment:

If No do you need someone to assist you? Yes No

Do you currently have someone who assists you with activities such as bathing, grooming, preparing meals, etc.? Yes No

Name/Program Provider	Phone Number(s)	Service	Paid Support	Informal Support	Will support continue?

Comments:

4. ENVIRONMENTAL ASSESSMENT

Location:	Urban	Rural	
Type of Home: Check all that apply	Apartment	Mobile Home	House
	Multi-Family	Single Story	Two or more floors

Do you own, rent or live with someone who owns the house? Own Rent

Resides with:

If rented is this a HUD subsidy? Yes No If so who is the contact person and phone number

Who lives with you? No One

Name	Phone Number (s)	Relationship

**AGED AND DISABLED WAIVER PROGRAM
MEMBER ASSESSMENT**

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What changes to your home would make it easier for you to get in/out of the home or to do activities in your home (home modifications)?

Does your home have:	YES	NO	COMMENTS
Running water			
Adequate Heat			
Air Conditioning			
Working Cook Stove			
Working Refrigerator			
Telephone Access			
Pets (note any animals which may be a potential danger to a care giver.)			
Smoke Alarm			
Carbon Monoxide Alarm			
Structural or upkeep problems			
Barriers to Access inside or outside (like steps, narrow doorways, etc.)			
Plumbing Issues			
Electrical Hazards/Unsafe/Poor Lighting			
Scattered Floor Rugs			
Uneven Flooring			
Grab Bars in Bathroom, if needed			

Note any other safety and/or sanitation hazards found in the home such as insects/rodents present, no trash pickup, soiled living area, etc.

**AGED AND DISABLED WAIVER PROGRAM
MEMBER ASSESSMENT**

Member Name _____

Date _____

Do you ever have:	YES	NO	Comments
Is the home isolated (no visible neighbors) from other homes in the area.			
Unsafe feelings in Home			
Unsafe feelings in Neighborhood			
Trouble with neighbors/others in the household/landlord			

5. MEDICAL ASSESSMENT

PRIMARY CARE PHYSICIAN	
Name:	
Specialty:	
City/State:	Phone:
Frequency:	Last Visit:
<i>Other: Specialists; Physical, Speech, or Occupational Therapist; Counselors/Psychiatrist; Etc.</i>	
Name:	
Specialty:	
City/State:	Phone:
Frequency	Last Visit:

<i>Other: Specialists; Physical, Speech, or Occupational Therapist; Counselors/Psychiatrist; Etc.</i>	
Name:	
Specialty:	
City/State:	Phone:
Frequency	Last Visit:
<i>Other: Specialists; Physical, Speech, or Occupational Therapist; Counselors/Psychiatrist; Etc.</i>	
Name:	
Specialty:	
City/State:	Phone:
Frequency:	Last Visit:

***If needed add another sheet with physician information.**

What do you think your most serious medical conditions are? Do you feel like these conditions limit you in any way?

Do you feel like you need to see a specialist, receive physical, speech or occupational therapy, tests or bloodwork, or any other medical service (Example: Dentist, podiatrist, optometrist, or audiologist)?

Do you need assistance in making an appointment for these services? Yes No
If so, who currently helps you?

6. SOCIAL ASSESSMENT

How often are you able to leave your home? Daily 1 to 6 times a week Monthly
2 to 3 times a month Rarely Never Other:

What prevents you from leaving your home? Get out as I choose Do not want to
Physically unable to do so No access to transportation Other:

How do you spend your days?

What types of activities do you enjoy, such as shopping, playing cards, reading, etc.?

Are there activities you enjoy but you have not been able to do?

Activity	Barrier(s) to participating in activity	Would you be interested in participating if barrier(s) can be removed?

Comments:

Education/Training/Work History

Describe any work history, education, or training that is important to know about you.

7. EMOTIONAL ASSESSMENT

Emotion	Yes	No	Is Doctor Aware?		Any Treatment?	
			Yes	No	Yes	No
Any major changes or losses in the past year? (death of a loved one/pet; divorce, illness, etc.)						
Do you have trouble going to sleep?						
Do you have trouble staying asleep?						
Do you nap during the day? (If so, note below how often during the day)						
Do you feel you cannot think clearly?						
Do you ever cry and not understand why?						

**AGED AND DISABLED WAIVER PROGRAM
MEMBER ASSESSMENT**

Member Name

Date

How many hours do you usually sleep at night?

How often during the day do you nap?

What makes you feel happy?

Case Manager Observations/Comments:

8. RISK ASSESSMENT

MEDICAL Mark any areas yes, if identified as a risk:	YES	NO	COMMENTS
Oxygen			
Smoking			
Alcohol and Substance Abuse			
Morbid Obesity as R/T Mobility and Transport			
Other			
FALL RISKS Does the member have:	YES	NO	COMMENTS
Outside/Inside Stairs			
Ambulation Equipment			
Inability to evacuate the home			
Cluttered living environment and/or numerous throw rugs.			

Fall Risks	YES	NO	Is Doctor aware?	Are you being treating for?
History of falls				
Vertigo, dizziness, numbness, or tingling				
Unsteady Gait				
BEHAVIORAL Does the member exhibit the following:	YES	NO	Is Doctor aware?	Are you being treating for?
Wandering				
Resistance to care				
Changes in behavior (describe)				

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BEHAVIORAL Does the member exhibit the following:	YES	NO	Is Doctor aware?	Are you being treating for?
Depression or suicidal thoughts				
Noncompliance with medications, nutrition				
Confusion				
Cognitive Impairment				
Challenging physical or verbal behaviors				

Are there any other issues you feel may be a risk to your health or safety?

9. Identified Member Needs:

Housing	Legal Services	Medical Appointments
Hearing Aids	Utility Assistance	Debit Counseling
Home Modifications	Food Stamps	Weatherization
Advanced Directives Provider & Phone #		
Personal Emergency Response System Provider & Phone #		
Home Delivered Meals Provider & Phone #		
Eye Glasses Provider & Phone #		
Dentures Provider & Phone #		
Incontinent Supplies Provider & Phone #		
Durable Medical Equipment Provider & Phone #		
Assistive Technology Provider & Phone #		
Therapy	Other	Other

Comments:

Who was present during the assessment?

Name	Relationship

AGED AND DISABLED WAIVER PROGRAM
MEMBER ASSESSMENT

Member Name
Date

Comments:

By signing, I certify that the reported information is complete and accurate. I understand that payment for the services certified on this form will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under Medicaid Fraud.

Member/Legal Representative Signature

Date

Case Manager Signature

Date

Copy of the Assessment was provided to member on _____
(Date)

Copy of the Assessment was provided to the Personal Assistance/Homemaker Agency on _____
(Date)

Section II. PERSONAL ASSISTANCE/HOMEMAKER RN

Initial 6-Month Annual Post-Hospital Change in Needs

Last Name:	First Name:
Date of Assessment:	Current PAS Date:

1. REVIEW OF SYSTEMS

NEUROMUSCULAR (Circle/Check findings)	
Level of Consciousness:	Alert Disoriented Lethargic Obtunded Stuporous Comments:
Oriented to:	Person Place Time Comments:
Challenging Behaviors:	N/A Physically Verbally Socially Inappropriate/Disruptive Comments:
Communication:	Verbal Writes Messages American Sign Language Braille Signs, Gestures, or Sounds Communication Board or Device Comments:
Speech:	Clear Unclear Aphasic Comments:
Vision:	WNL Contacts Eye Glasses Corrective Lenses for Reading Only Needs Large Print Sees Objects Sees Shadows No Vision Comments:
Hearing:	WNL Requires Repeats Deaf: right left total Hearing Aids Implants Comments:
Neurological:	WNL Difficulty with Receptive Language Difficulty with Expressive Language Seizures: Type: _____ Date of Last Seizure: _____ (Frequency) _____ Memory Confusion Disorientation Comments:
Sensation:	WNL Pain Tingling Numbness Location: Comments:
Strength:	WNL Paralysis Weakness Location: _____ Comments:
Posture:	Upright Bent Forward Scoliosis Comments:
Gait:	Steady Unsteady 1 or 2 Person Assist Comments:
CARDIO-PULMONARY (Circle/Check findings)	
Respiratory:	WNL Shortness of Breath with Rest or Exertion Labored Coughing Productive Non-Productive Wheezing Comments:
Respiratory Equipment and Treatments:	N/A Oxygen: _____ L/min Ventilator C-PAP BI-PAP Inhalers Nebulizer Tracheostomy Care Comments:
Cardiac:	Chest Discomfort Palpitations Lips/nail beds dusky Comments:
Cardiac Devices:	Pacemaker Defibrillator Date Inserted: How Often Checked _____ Who Checks It _____ Comments:

**AGED AND DISABLED WAIVER PROGRAM
MEMBER ASSESSMENT**

Member Name

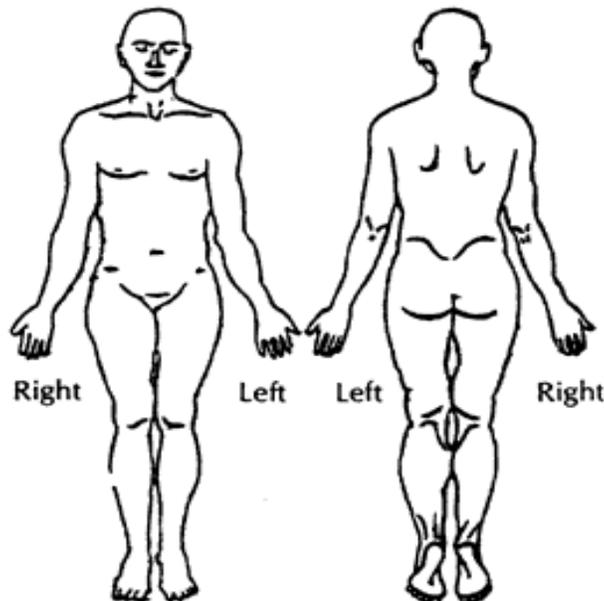
Date

GI/GU (Circle/Check findings)

Intake:	Difficulty Chewing Difficulty Swallowing History of Choking Appetite: Good Fair Poor Comments:
Dental:	Caries Teeth: Loose Broken Dental Prosthesis Edentulous Comments:
Diet:	Normal Note if a Special diet: Dietary Supplements (Type) Tube feeding Comments:
Bowel:	Normal Diarrhea Constipation Incontinent: Partial Total Ostomy Supplies Used: Comments:
Urinary:	Normal Incontinent: Partial Total Catheter: Foley Texas Dialysis: shunt port Ostomy Supplies Used: Comments:
Recent Weight Change:	N/A Weight Gain Since Previous Assessment : Amount Weight Loss Since Previous Assessment: Amount Comments:

INTEGUMENTARY (Circle/Check Findings)

Skin Color:	WNL Pale Jaundice Cyanotic Ruddy/Red Comments:
Skin:	Warm/Dry Rash Pressure Ulcers Stasis Ulcers Abrasions Burns Bruises Open Lesions Cuts Surgical Wounds Skin Desensitized to: Pain Pressure Unexplained injury to skin describe: Protective/Preventive Foot Care describe:



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Describe any other treatments and/or health care provided for the member.

Medical Equipment in the home: (check all that apply)

Ramp Hoyer Lift Walker Cane Crutches Wheelchair Bedside Commode
 Elevated Commode Seat Scooter Chair Lift Chair Hand Held Shower Shower chair
 Glucometer Hospital bed Other:

Needed Medical Equipment:

2. MEMBER ACTIVITIES

I = Independent S = Supervision P = Partial T =Total

Activity	Level of Assist	Comments
Bathing		
Grooming		
Dressing		
Ambulation		
Transfer/Repositioning		
Toileting		
Medication Prompting		
Meal Preparation		
Laundry		
Environmental (housekeeping dishes, trash, etc.)		
Transportation for:		
Essential Errands: Describe in comment section		
Community Activities: Describe in comment section		

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MEMBER ASSESSMENT

Member Name _____

Date _____

Yes No Member referred for physician examination at: office, emergency room, clinic, other

Has the member's needs for assistance changed since the last completed PAS? (Please include any hospitalizations since last assessment.)

Comments:

Arrival Time:	Departure Time:	Total Time:
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By signing, I certify that the reported information is complete and accurate. I understand that payment for the services certified on this form will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under Medicaid Fraud.

Member/Legal Representative Signature

Date

Personal Assistance/Homemaker RN Signature

Date

Copy of the Assessment was provided to member on _____
(Date)

Copy of the Assessment was provided to the Case Manager on _____
(Date)

