

PERSONAL CARE
MEMBER ASSESSMENT

Member Name: _____

Date: _____

<input type="checkbox"/> Initial <input type="checkbox"/> 6-Month <input type="checkbox"/> Annual			
1. DEMOGRAPHICS			
Last Name:		First Name:	
DOB:	Date of Assessment:	Financial Eligibility Effective Date:	
Current PAS Date:		Anchor Date:	
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. LEGAL REPRESENTATIVE INFORMATION			
Check any that apply. A copy showing either the relationship or the document needs to be included in the member's file.			
<input type="checkbox"/> Member would not or could not provide a copy.			
<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Durable POA	<input type="checkbox"/> POST Form	
<input type="checkbox"/> Committee	<input type="checkbox"/> Conservator	<input type="checkbox"/> Document in Chart	
<input type="checkbox"/> Medical POA	<input type="checkbox"/> DNR	<input type="checkbox"/> Deemed Incompetent	
Name:		Phone Number:	
3. ENVIRONMENTAL ASSESSMENT			
Location:	Urban <input type="checkbox"/>	Rural <input type="checkbox"/>	
Type of Home: Check all that apply	Apartment <input type="checkbox"/>	Mobile Home <input type="checkbox"/>	House <input type="checkbox"/>
	Multi-Family <input type="checkbox"/>	Single Story <input type="checkbox"/>	Two or more floors <input type="checkbox"/>
Who lives with you? No One <input type="checkbox"/>			
Name	Phone Number (s)	Relationship	

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4. REVIEW OF SYSTEMS

NEUROMUSCULAR (Check Findings)

Level of Consciousness:	<input type="checkbox"/> Alert <input type="checkbox"/> Disoriented <input type="checkbox"/> Lethargic <input type="checkbox"/> Stuporous Comments: _____
Oriented to:	<input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time Comments: _____
Challenging Behaviors	<input type="checkbox"/> N/A <input type="checkbox"/> Physically <input type="checkbox"/> Verbally <input type="checkbox"/> Socially inappropriate/Disruptive Comments: _____
Communication:	<input type="checkbox"/> Verbal <input type="checkbox"/> Writes Messages <input type="checkbox"/> American Sign Language <input type="checkbox"/> Braille <input type="checkbox"/> Signs, Gestures, or Sounds <input type="checkbox"/> Communication Board or Device Comments: _____
Speech:	<input type="checkbox"/> Clear <input type="checkbox"/> Unclear <input type="checkbox"/> Aphasic Comments: _____
Vision:	<input type="checkbox"/> WNL <input type="checkbox"/> Contacts <input type="checkbox"/> Eye Glasses <input type="checkbox"/> Corrective Lenses for Reading Only <input type="checkbox"/> Needs large Print <input type="checkbox"/> Sees Objects <input type="checkbox"/> Sees Shadows <input type="checkbox"/> No Vision Comments: _____
Hearing:	<input type="checkbox"/> WNL <input type="checkbox"/> Requires Repeats Deaf: <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> Total <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Implants Comments: _____
Neurological:	<input type="checkbox"/> WNL <input type="checkbox"/> Difficulty with Receptive Language <input type="checkbox"/> Difficulty with Expressive Language <input type="checkbox"/> Seizures: Type: _____ Date of Last Seizure: _____ (Frequency) _____ <input type="checkbox"/> Memory <input type="checkbox"/> Confusion <input type="checkbox"/> Disorientation Comments: _____
Sensation:	<input type="checkbox"/> WNL <input type="checkbox"/> Pain <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness Location: _____ Comments: _____
Strength:	<input type="checkbox"/> WNL <input type="checkbox"/> Paralysis <input type="checkbox"/> Weakness <input type="checkbox"/> Location: _____ Comments: _____
Posture:	<input type="checkbox"/> Upright <input type="checkbox"/> Bent Forward <input type="checkbox"/> Scoliosis Comments: _____
Gait:	<input type="checkbox"/> Steady <input type="checkbox"/> Unsteady <input type="checkbox"/> 1 or <input type="checkbox"/> 2 Person Assist Comments: _____

CARDIO-PULMONARY (Check Findings)

Respiratory:	<input type="checkbox"/> WNL Shortness of Breath: <input type="checkbox"/> Rest or <input type="checkbox"/> Exertion <input type="checkbox"/> Labored Coughing: <input type="checkbox"/> Productive <input type="checkbox"/> Non-Productive <input type="checkbox"/> Wheezing
Respiratory Equipment and Treatment:	<input type="checkbox"/> N/A <input type="checkbox"/> Oxygen _____L/Min <input type="checkbox"/> Ventilator <input type="checkbox"/> C-PAP <input type="checkbox"/> BI-PAP <input type="checkbox"/> Inhalers <input type="checkbox"/> Nebulizer <input type="checkbox"/> Tracheostomy Care Comments: _____
Cardiac:	<input type="checkbox"/> Chest Discomfort <input type="checkbox"/> Palpitations <input type="checkbox"/> Lips/nail beds dusky Comments: _____
Cardiac Devices:	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Defibrillator <input type="checkbox"/> Date Inserted: _____ How often checked _____ Who Checks It _____ Comments _____

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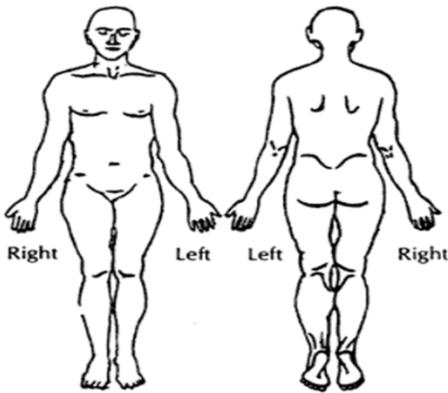
GI/GU (Check Findings)	
Intake:	<input type="checkbox"/> Difficulty Chewing <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> History of Choking Appetite <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Comments: _____
Dental:	<input type="checkbox"/> Carries Teeth: <input type="checkbox"/> Loose <input type="checkbox"/> Broken <input type="checkbox"/> Dental Prosthesis <input type="checkbox"/> Edentulous Comments: _____
Diet:	<input type="checkbox"/> Normal <input type="checkbox"/> Special Diet: _____ <input type="checkbox"/> Dietary Supplements (Type) _____ <input type="checkbox"/> Feeding Tube Comments: _____
Bowel:	<input type="checkbox"/> Normal <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation Incontinent Ostomy: <input type="checkbox"/> N/A <input type="checkbox"/> Partial <input type="checkbox"/> Total Supplies Used: _____ Comments: _____
Urinary:	<input type="checkbox"/> Normal Incontinent: <input type="checkbox"/> Partial <input type="checkbox"/> Total Catheter: <input type="checkbox"/> Foley <input type="checkbox"/> Texas Dialysis: <input type="checkbox"/> Shunt <input type="checkbox"/> Port <input type="checkbox"/> Ostomy Supplies Used: _____ Comments: _____
Recent Weight Change:	<input type="checkbox"/> N/A <input type="checkbox"/> Weight Gain Since Previous Assessment Amount: _____ <input type="checkbox"/> Weight Loss Since Previous Assessment Amount: _____ Comments: _____

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INTEGUMENTARY (Check Findings)	
Skin Color:	<input type="checkbox"/> WNL <input type="checkbox"/> Pale <input type="checkbox"/> Jaundice <input type="checkbox"/> Cyanotic <input type="checkbox"/> Ruddy/Red Comments: _____
Skin:	<input type="checkbox"/> Warm/Dry <input type="checkbox"/> Rash <input type="checkbox"/> Pressure Ulcers <input type="checkbox"/> Stasis Ulcers <input type="checkbox"/> Abrasions <input type="checkbox"/> Burns <input type="checkbox"/> Bruises <input type="checkbox"/> Open Lesions <input type="checkbox"/> Cuts <input type="checkbox"/> Surgical Wounds <input type="checkbox"/> Skin Desensitized to <input type="checkbox"/> Pain <input type="checkbox"/> Pressure <input type="checkbox"/> Unexplained injury to skin: (describe) _____ <input type="checkbox"/> Protective/Preventive Foot Care: (describe) _____



Describe any other treatments and/or healthcare provided for the member:

<p>Medical Equipment in the home: (check all that apply)</p> <p>Ramp <input type="checkbox"/> Hoyer Lift <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedside Commode <input type="checkbox"/> Elevated Commode Seat <input type="checkbox"/> Scooter Chair <input type="checkbox"/> Lift Chair <input type="checkbox"/> Hand Held Shower <input type="checkbox"/> Shower Chair <input type="checkbox"/> Glucometer <input type="checkbox"/> Hospital Bed <input type="checkbox"/> Other: _____</p> <hr/> <p>Needed Medical Equipment: _____</p>

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5. MEMBER ACTIVITIES

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

Activity	Level of Assist	Comments
Personal Care Tasks		
Bath:		
Skin Care:		
Hair:		
Nails:		
Mouth Care:		
Dressing:		
Ambulation:		
Transfer:		
Toileting:		
Position: Turn Every ____ Hr(s)		
Assistance with Medications:		
Meals: <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D Snacks Diet: Special Directions:		
Environmental Tasks cannot be more than one-third (1/3) of total time.		
Bed Making:		
Laundry:		
Vacuum/Sweep		
Mop:		
Dishwashing:		
Dust:		
Straighten:		
Other:		
Essential Errands:		
Community Activities: Describe PC services needed during community activities		

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

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Comments:

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Who was present during the assessment?

Name	Relationship

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 Care RN Signature

Date

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

