ADW Participant's Name: _____ Date of Assessment: _____

SECTION I. CASE MANAGEMENT

Initial	☐	6 Month	☐	Annual	☐	Change in Needs/ Level of Service	☐	Dual Services	☐

1. DEMOGRAPHICS

Last Name:		**First Name:**
DOB:	**Current Anchor Date:**	**Financial Eligibility Effective Date:**
Current PAS Date:		**Medical Reevaluation** ***(Request Due By:*** *Up to 90 days before and no later than 45 days prior to the anchor date):*
Physical Address: **City:** **State** **Zip Code** **County**		
Mailing Address: **City:** **State** **Zip Code** **County**		
Home Phone:	**Cell Phone:**	**Other Phone:**
Detailed Directions to Home:		

2. HEALTHCARE AND INSURANCE INFORMATION

Medicaid #:	**Medicare #** *Document if participant has Part A, B, C, D; provider name (Highmark, Humana, etc.; phone*			**Other Health Insurance:**	
	Type	**Name**	**Phone**	**Name**	**Phone**
	A				
	B				
	C				
	D				

When present, place an X in the column below marked "yes". A copy verifying relationship, decision or decision making authority must be included in the participant's ADW file. Please indicate if the ADW participant would not provide a copy of _____.

Yes	**Type**	**Yes**	**Type**	**Yes**	**Type**
☐	Legal Guardian	☐	Durable POA	☐	POST Form
☐	Medical POA	☐	Conservator	☐	Document in Chart
☐	Legal POA	☐	DNR	☐	Deemed Incompetent
☐	Healthcare Surrogate	☐	Living Will	☐	Deemed Incapacitated
Person(s) with Legal Representation (Example: MPOA):				**Phone(s):**	

ADW Participant's Name: _____ Date of Assessment: _____

MEDICAL EQUIPMENT: *(What does the person currently have in place? Check all that apply)*

☐	**Ramp**	☐	**Wheelchair (manual or power)**	☐	**Lift Chair**
☐	**Hoyer Lift**	☐	**Bedside Commode**	☐	**Hand Held Shower**
☐	**Walker**	☐	**Elevated Commode Seat**	☐	**Shower Chair**
☐	**Crutches**	☐	**Scooter Chair**	☐	**Glucometer**
☐	**Hospital Bed**	☐	**Oxygen**	☐	**Other:**

Needed Medical Equipment *(What does the person not have now or what needs replaced?)*

Who is responsible for cleaning equipment?

3. GOALS AND CURRENT RESOURCES: *Tell me what you would prefer and need.*

GOAL(S): *What kinds of services and help are you expecting from this program (document in the ADW person's words.)?*	**FINANCE:** *Do you manage your own finances (bill payment, banking, purchases, etc.)?* ☐ *Yes* ☐ *No* *Do you need assistance with these activities?*
INFORMAL SUPPORT: *Do you currently have someone who assists you with bathing, dressing, etc.?* ☐ *Yes* ☐ *No* *If so, who?* *Phone:*	***FORMAL SUPPORT:*** *Do you have an agency or service helping you with activities such as bathing, dressing or meals?* ☐ *Yes* ☐ *No* *If so, what agency or company?* *Phone:*

4. ENVIRONMENTAL: *Tell me about your home and neighborhood.*

Home Location	Type of Home			Own or Rent
☐ Rural ☐ Urban	☐ Apartment	☐ House	☐ Single Story	☐ Own Your Home
	☐ Mobile Home	☐ Multi Family	☐ 2 or More Floors	☐ Live with Home Owner
				☐ Rent
				☐ HUD Subsidy

Who Lives in the Home?	Phone	Relationship
No One		
Name:		
Name:		
Name:		

ADW Participant's Name: _____ Date of Assessment: _____

5. RISKS *Answer yes or no, note if no plan needed and reason. Note additional information.*

Home/Neighborhood Risks	**Yes**	**No**	**No Plan Needed**	**Comments** *Describe why plan is not needed or comment on the issue. Example: Years in neighborhood. Does not want to move.*
Is the home isolated from other homes in the area (no visible neighbors)?	☐	☐	☐	
Unsafe feelings in the home	☐	☐	☐	
Unsafe feelings in neighborhood	☐	☐	☐	
Trouble with neighbors/others in the household/landlord	☐	☐	☐	
In-Home Risks	**Yes**	**No**	**No Plan Needed**	*Describe why plan is not needed or comment on the issue. Example: Daughter carries in water for no running water.*
Running Water	☐	☐	☐	
Adequate Heat/Air	☐	☐	☐	
Working Cook Stove	☐	☐	☐	
Working Refrigerator	☐	☐	☐	
Pets (animals which may be a potential danger to a worker)	☐	☐	☐	
Alarms (Smoke or Carbon Monoxide)	☐	☐	☐	
Firearms not locked up	☐	☐	☐	
Structural or Upkeep Problems	☐	☐	☐	
Barriers to Access Inside or Outside (like steps, narrow doorways, etc.)	☐	☐	☐	
Plumbing Issues	☐	☐	☐	
Electrical Hazards/Unsafe/Pour Lighting	☐	☐	☐	
Scattered Floor Rugs	☐	☐	☐	
Uneven Flooring	☐	☐	☐	
Grab Bar in Bathroom, if needed	☐	☐	☐	
Other Safety/Sanitation Hazards (insects, rodents, no trash pickup, soiled living area, etc.)	☐	☐	☐	
Medical Risks				*Example: Educated regarding smoking. Not interested.*
Oxygen	☐	☐	☐	
Smoking	☐	☐	☐	
Alcohol or Substance Abuse	☐	☐	☐	
Morbid Obesity as R/T Mobility and Transport	☐	☐	☐	
Other	☐	☐	☐	

ADW Participant's Name: _____ Date of Assessment: _____

Fall Risks				*Example: Home cluttered. Does not want to de-clutter.*
Outside/Inside Stairs	☐	☐	☐	
Ambulation Equipment	☐	☐	☐	
Inability to evacuate the home	☐	☐	☐	
Cluttered living environment and/or numerous throw rugs	☐	☐	☐	
History of falls	☐	☐	☐	
Vertigo, dizziness, numbness, tingling	☐	☐	☐	
Unsteady gait	☐	☐	☐	
Behavioral Risks				*If yes in this area, must address risk.*
Wandering	☐	☐	☐	
Resistance to care	☐	☐	☐	
Changes in behavior (describe)				
Emotional Risks	**Yes**	**No**	**No Plan Needed**	*If yes in this area, must address risk.*
Have you experienced a major loss that has had a big impact on you?	☐	☐	☐	
Within the last year, are you experiencing feelings of depression, overwhelmed, crying or trouble sleeping which was not there before?	☐	☐	☐	
Do you feel that you are not thinking as clearly or you feel confused?	☐	☐	☐	
Do you feel depressed and think about hurting yourself?	☐	☐	☐	
Do you have trouble taking medication as prescribed or eating when you are supposed to do so?	☐	☐	☐	
Please describe any cognitive impairment (change in memory, concentration or attention span).	☐	☐	☐	
Do you get frustrated, angry and lose control of your actions? (verbal or physical threats)	☐	☐	☐	
Other:	☐	☐	☐	

ADW Participant's Name: _____ Date of Assessment: _____

6. MEDICAL: *(If needed, add another sheet with physician/specialist information)*

Primary Care Physician			**Other:** ***Specialists, Physical, Speech or Occupational Therapist, Counselors/Psychiatrist, etc.***	
Name:			Name:	
Frequency:	Last Visit:	Phone:	Specialty:	Phone:
Name:			Name:	
Specialty:		Phone:	Specialty:	Phone:
Name:			Name:	
Specialty:		Phone:	Specialty:	Phone:
Name:			Name:	
Specialty:		Phone:	Specialty:	Phone:
Name:			Name:	
Specialty:		Phone:	Specialty:	Phone:
Name:			Name:	
Specialty:		Phone:	Specialty:	Phone:

COORDINATION OF HEALTH CARE: *Complete this area in full.* ***It is a part of provider monitoring.***

- Do you have a Primary Care Physician who coordinates your healthcare? ☐ Yes ☐ No
- Do you think you need referrals to physicians, specialists or medical testing? ☐ Yes ☐ No
- Do you need assistance with making medical appointments? ☐ Yes ☐ No

7. SOCIAL: *Tell me about yourself. Who you are and what you do is important to your services.*

Are you able to leave your home? How often?	
Do you have the chance to interact with others outside the home?	
What community activities do you enjoy?	
What type of work, education or training did you have in the past?	

ADW Participant's Name: _____ Date of Assessment: _____

8. IDENTIFIED SERVICE/RESOURCE NEEDS: *Check box or List Provider Name and Phone Number Below.*

☐	**Housing**	☐	**Food Stamps**	☐	**Utility Assistance**
☐	**Hearing Aids**	☐	**Medical Appointments**	☐	**Weatherization**
☐	**Home Modifications**	☐	**Debit Counseling**	☐	**Legal Services**

Advanced Directives Provider and Phone #	
Personal Emergency Response System and Phone #	
Home Delivered Meals Provider and Phone #	
Eye Glasses Provider and Phone #	
Dentures Provider and Phone #	
Incontinent Supply Provider and Phone #	
Durable Medical Equipment Provider and Phone #	
Assistive Technology Provider and Phone #	
Therapy Provider and Phone #	
Nursing (ADW Skilled Nursing or Home Health Skilled Nursing)	
Hospice	
Transportation (ADW Transportation or Nonemergency Medical Transportation, NEMT, Community Transportation Resources)	
Personal Attendant Services (ADW or DRS)	
Dual Services (Personal Care Services)	
Other	
Other	

ADW Participant's Name: _____ Date of Assessment: _____

List of Those Present During Assessment	Relationship to ADW Participant

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.

_____ _____

ADW Participant/Legal Representative Signature **Date**

_____ _____

Case Manager Signature **Date**

ADW Participant's Name: _____ Date of Assessment: _____

Copy of the assessment was provided to the ADW participant and Personal Attendant Agency on:

_____

SECTION II. PERSONAL ATTENDANT RN

Initial	6 Month	Annual	Post Hospital	Change in Needs
☐	☐	☐	☐	☐

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

1. **NURSING ASSESSMENT** ***Conditions:*** *Mark an X in the box for all that applies.* ***Specific Status:*** *For specifics, describe the status of the condition. Example: If you marked tremors, you could describe "hand tremors."*

Nursing Assessment	Condition(s)				Specific Status
NEUROMUSCULAR *Musculoskeletal, Neurological, Orientation, Mobility/Posture/Gait* ☐ ***No Problem***	☐	Language- Expressive	☐	Language-Receptive	
	☐	No communication	☐	Weakness	
	☐	Intellectual or developmental delay	☐	Paralysis	
	☐	Orientation/Memory	☐	Tremors	
	☐	Tingling, Pain, Numbness, Neuropathy	☐	Unsteady Gait, Mobility	
	☐	Other:	☐	Seizures	
CARDIO-PULMONARY *Cardiovascular, Respiratory* ☐ ***No Problem***	☐	Shortness of breath	☐	C-Pap, Bi-Pap	
	☐	Chest discomfort	☐	Oxygen	
	☐	Inhaler, Nebulizer	☐	Ventilator	
	☐	Edema: (describe location)	☐	Other:	
GI/GU *Gastrointestinal, Renal, Incontinence (Bowel/Bladder), Diet, Weight Change* ☐ ***No Problem***	☐	Appetite (Good, Fair, Poor)	☐	Difficulty chewing	
	☐	Special diet- Type:	☐	Difficulty swallowing	
	☐	Total Incontinence	☐	History of choking	
	☐	Partial incontinence	☐	Weight gain	
	☐	Catheter	☐	Weight loss	
	☐	Dialysis, port, shunt	☐	Dental- carries, lost or broken teeth, dental prosthesis	
	☐	Ostomy	☐	Other:	
Integumentary *Skin, Sensory, Dental* ☐ ***No Problem***	☐	Pale	☐	Jaundice	*Describe type, drainage and location of any decubitus, skin or foot care.*
	☐	Cyanotic	☐	Ruddy/Red	
	☐	Warm/Dry	☐	Decubitus (describe in specific status)	
	☐	Rash	☐	Cuts	
	☐	Surgical wounds	☐	Pain or Pressure	
	☐	Protective or preventive foot care	☐	Other:	
Other *Hearing, Vision, Mental Health, Substance Abuse, Challenging Behaviors* ☐ ***No Problem***	☐	Hearing	☐	Vision	
	☐	Substance Abuse (describe in specific status)	☐	Mental Illness (describe in specific status)	
	☐	Challenging behaviors (describe in specific status)	☐	Other:	

ADW Participant's Name: _____ Date of Assessment: _____

Comments:

2. FUNCTIONAL ASSESSMENT *(Based upon what I am able to do, how do I need the PA to assist me?) Levels of Assistance: I = Independent; S = Supervision; P = Partial; T = Total*

Functional Assessment	Level of Assist	Describe Any Specific Directions for the Personal Assistant
Bathing		
Grooming		
Dressing		
Ambulation		
Transfer/Repositioning		
Toileting		
Medication Prompting		
Meal Preparation *Special Directions:*		
Laundry		
Environmental (housekeeping, dishes, trash, etc.)		
Transportation For:		
Essential Errands: Describe in Comment Section		
Community Activities: Describe in Comment Section		
Comments:		
Describe any other treatments and/or healthcare provided for the ADW participant.		
Describe any RN recommendations based upon findings from the Nursing Assessment *(referrals to physicians, home health services, etc.):*		

ADW Participant's Name: _____ Date of Assessment: _____

3. **CHANGES IN NEEDS** *(Reminder: Document changes in needs below when requesting a change in level of service. RN Contact Form may include additional information for changes in levels of service).*

Has the ADW participant's needs for assistance changed since the last completed PAS? (Please include any hospitalizations, nursing home admissions, respite admissions, etc. Since last assessment).

Arrival Time:	**Departure Time:**	**Total Time:**

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.

_____ _____

ADW Participant/Legal Representative Signature **Date**

_____ _____

Personal Assistant RN Signature **Date**

Comments: (Example: Justification of personal assistant hours such as a person with shortness of breath will take longer for an activity or a higher acuity level).

ADW Participant's Name: _____ Date of Assessment: _____

Copy of the assessment was provided to the ADW participant and Case Management Agency on: _____