THE GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH CARE FINANCE

ASSESSMENT INSTRUMENT

1. Name and Vital Information

|  |  |
| --- | --- |
| 1a. Last Name: | 1b. First Name: |
| 1c. Primary phone: 🞏 Home 🞏 Cell 🞏 Work  | 1d. Medicaid No.: |
| 1e. Other insurance coverage: |
| 1f. Additional phone: 🞏 Home 🞏 Cell 🞏 Work  | 1g. Email: |
| 1h. Medicare No.: | 1i. SSN: |
| 1j. Street Address: |
| 1k. City: | 1l. State: | 1m. ZIP: |
| 1n. Date of Birth: | 1o. Sex: 🞏 Male 🞏 Female 🞏 Unknown  |
| 1p. Marital Status: 🞏 Married 🞏 Widowed 🞏 Separated 🞏 Single 🞏 Unknown  |
| 1q. Preferred language:  | 1r. Interpreter needed? 🞏 Yes 🞏 No  |
| 1s. Race / ethnicity: |
| 1t. Lifetime occupation: |

1. Name and Vital Information, cont’d

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| 1aa. Individuals providing 🞏 Individual information for assessment If not individual, please write name(s) of any and all individual(s) contributing information and their relationship to the individual assessed: |
| 1ab. Name: | 1ac. Phone: | 1ad. Email: |
| 1ae. Relationship: 🞏 Spouse or partner 🞏 Non-minor child 🞏 Parent 🞏 Sibling or other relative  🞏 Unrelated person providing informal care 🞏 Unrelated person familiar with individual prior to assessment 🞏 Physician / Clinician familiar with individual prior to assessment  🞏 Physician / Clinician not familiar with individual prior to assessment |
| 1af. Name: | 1ag. Phone: | 1ah. Email: |
| 1ai. Relationship: 🞏 Spouse or partner 🞏 Non-minor child 🞏 Parent 🞏 Sibling or other relative  🞏 Unrelated person providing informal care 🞏 Unrelated person familiar with individual prior to assessment 🞏 Physician / Clinician familiar with individual prior to assessment  🞏 Physician / Clinician not familiar with individual prior to assessment |
| 1aj. Name: | 1ak. Phone: | 1al. Email: |
| 1am. Relationship: 🞏 Spouse or partner 🞏 Non-minor child 🞏 Parent 🞏 Sibling or other relative  🞏 Unrelated person providing informal care 🞏 Unrelated person familiar with individual prior to assessment 🞏 Physician / Clinician familiar with individual prior to assessment  🞏 Physician / Clinician not familiar with individual prior to assessment |
| 1an. Name: | 1ao. Phone: | 1ap. Email: |
| 1aq. Relationship: 🞏 Spouse or partner 🞏 Non-minor child 🞏 Parent 🞏 Sibling or other relative  🞏 Unrelated person providing informal care 🞏 Unrelated person familiar with individual prior to assessment 🞏 Physician / Clinician familiar with individual prior to assessment  🞏 Physician / Clinician not familiar with individual prior to assessment |
| 1ar. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

1. Emergency Points of Contact and Physicians

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| Primary Emergency Contact |
| 2a. Full Name: | 2b. Relationship:  |
| 2c. Address: | 2d. City, State, ZIP: |
| 2e. Phone: 🞏 Home 🞏 Cell 🞏 Work  | 2f. Secondary Phone: 🞏 Home 🞏 Cell 🞏 Work  |
| 2g. Email:  |
| Other Emergency Contact |
| 2h. Full Name: | 2i. Relationship:  |
| 2j. Address: | 2k. City, State, ZIP: |
| 2l. Phone: 🞏 Home 🞏 Cell 🞏 Work  | 2m. Secondary Phone: 🞏 Home 🞏 Cell 🞏 Work  |
| 2n. Email:  |
| Primary Care Physician |
| 2o. Full Name: |
| 2p. Address: | 2q. City, State, ZIP: |
| 2r. Phone: 🞏 Cell 🞏 Work | 2s. Fax:  | 2t. Email: |
| Other or Specialty Physician |
| 2u. Full Name: |
| 2v. Address: | 2w. City, State, ZIP: |
| 2x. Phone: 🞏 Cell 🞏 Work | 2y. Fax:  | 2z. Email: |
| Social Worker / Case Manager |
| 2aa. Full Name: | 2ab. Clinician Affiliation:  |
| 2ac. Address: | 2ad. City, State, ZIP: |
| 2ae. Phone: 🞏 Cell 🞏 Work | 2af. Fax:  | 2ag. Email: |
| 2ah. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

1. Initial Contact / Referral

|  |  |
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| 3a. Referral Source: | 3b. Relationship to Individual:  |
| 3c. Reason for Referral: | 3d. Phone: 🞏 Home 🞏 Cell 🞏 Work  |
| 3e. Assessment conducted in 🞏 Individual’s home 🞏 Other community setting 🞏 Nursing facility 🞏 Other health care setting 🞏 Hospital (indicate specialty if relevant: 🞏 Psychiatric 🞏 Rehab) |
| 3f. Assessment conducted by 🞏 licensed nurse 🞏 licensed social worker 🞏 Other clinician |
| 3g. Assessor Name:  | 3h. Phone:  | 3i. Email: |
| 3j. Individuals present for 🞏 Individual 🞏 Individual’s family members or legal guardian assessment 🞏 Clinicians currently providing care to individual |

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| 3k. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

1. Current Services

Please complete the following section to describe any services accessed by the individual within the last 30 days. For frequency, please provide information based on a typical day or week under ordinary circumstances.

| Indicate Any Services Currently Received by Individual |
| --- |
| Service | Currently Received? | If Yes, Indicate Provider Name | If Yes, Indicate Frequency  |
| 4aa – 4af. Personal Care Aide  | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4ba – 4bf. In-Home Nursing and/or Therapy  | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4ca – 4cf. Adult Day Health Care | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4da – 4df. Home-Delivered Meals | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4ea – 4ef. Congregate Meals / Senior Center | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4fa – 4ff. Financial Management or Counseling | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4ga – 4gf. Legal Services  | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4ha – 4hf. Housing Assistance | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4ia – 4if. Mental Health Services | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4ja – 4jf. Substance Abuse Services | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4ka – 4kf. Adult Protective Services | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4la – 4lf. Vocational Rehabilitation / Job Help | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4ma – 4mf. Transportation | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4na – 4nf. Other Medicaid HCBS waiver services not listed above (EPD or ID/DD) | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4oa – 4of. SNAP, Commodity Foods or other nutritional assistance not listed above | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4pa – 4pg. Case management / Social worker | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| Clinician affiliation (check only one): 🞏 DMH 🞏 DDS 🞏 Medicaid 🞏 Other  |
| 4qa – 4qf. PERS | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 4ra – 4rf. Other: | 🞏 Yes 🞏 No🞏 Unknown |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |

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| 4s. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

1. Guardianship and Power of Attorney

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| --- |
| Does anyone cash checks, pay bills, or otherwise manage financial affairs for the individual? |
| 5aa – 5ac. Legal Guardian | 🞏 Yes 🞏 No🞏 Unknown | Name:  | Phone: |
| 5ba – 5bc. Power of Attorney | 🞏 Yes 🞏 No🞏 Unknown | Name:  | Phone: |
| 5ca – 5cc. Representative Payee | 🞏 Yes 🞏 No🞏 Unknown | Name:  | Phone: |
| 5da – 5dc. Other: | 🞏 Yes 🞏 No🞏 Unknown | Name:  | Phone: |
| 5e. Would you like someone to help with these activities? 🞏 Yes 🞏 No |
| Does anyone assist in making medical decisions for the individual? |
| 5fa – 5fc. Legal Guardian | 🞏 Yes 🞏 No🞏 Unknown | Name:  | Phone: |
| 5ga – 5gc. Power of Attorney | 🞏 Yes 🞏 No🞏 Unknown | Name:  | Phone: |
| 5ha – 5hc. Other: | 🞏 Yes 🞏 No🞏 Unknown | Name:  | Phone: |
| 5i. Would you like someone to help with these activities? 🞏 Yes 🞏 No |

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| Does the individual have any advanced directives? |
| 5ja – 5jb. Living Will | 🞏 Yes 🞏 No🞏 Unknown | Location held: |
| 5ka – 5kb. Do-Not-Resuscitate orders | 🞏 Yes 🞏 No🞏 Unknown | Location held: |
| 5la – 5lb. Comfort Care orders | 🞏 Yes 🞏 No🞏 Unknown | Location held: |
| 5ma – 5mb. Other | 🞏 Yes 🞏 No🞏 Unknown | Location held: |
| 5n. If **yes** is checked for any of the four items in this section, please ask individual or another respondent to attest they are able to provide documentation for any and all advanced directives.  🞏 Yes, they so attest 🞏 No, they do not so attest |

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| 5o. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

1. Physical Environment

For the following section, please indicate the type of residence where the individual lives, others who also live there, and any relevant information regarding community residential facilities. For potential problems with the physical space where the individual resides, please provide detailed comments where indicated. The information contained in this section is not used to determine eligibility for Medicaid services but instead designed to provide information about the individual to potential providers after eligibility has been determined.

|  |
| --- |
| Describe the home where the individual currently resides. |
| 6a. Type of home: 🞏 Self-owned house/condo 🞏 Family-owned (not self-owned) house/condo  🞏 Rented house / apartment 🞏 Rented room  |
| 6b. Individual lives: 🞏 Alone 🞏 With one other person  🞏 With two or more other individuals |
| For individuals living in any subsidized or publicly financed housing arrangement (including, for example: community residential facilities, group homes, assisted living facilities): |
| 6ca. Name of Provider: | 6cb. First date of residence: |
| 6cc. Address: | 6cd. City, State, ZIP: |

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| 6d. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

1. Physical Environment, Continued

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| --- |
| Indicate and describe any problems that apply to the physical space where the individual resides. |
| 6ea – 6eb. Home is accessible to individual  | 🞏 Yes 🞏 No🞏 Unknown | If no, describe: |
| 6fa – 6fb. Electrical hazards | 🞏 Yes 🞏 No🞏 Unknown | If yes, describe: |
| 6ga – 6gb. Adequate fire safety devices | 🞏 Yes 🞏 No🞏 Unknown | If no, describe: |
| 6ha – 6hb. Adequate heat / AC | 🞏 Yes 🞏 No🞏 Unknown | If no, describe: |
| 6ia – 6ib. Adequate water / hot water | 🞏 Yes 🞏 No🞏 Unknown | If no, describe: |
| 6ja – 6jb. Adequate toilet facilities | 🞏 Yes 🞏 No🞏 Unknown | If no, describe: |
| 6ka – 6kb. Operable kitchen appliances | 🞏 Yes 🞏 No🞏 Unknown | If no, describe: |
| 6la – 6lb. Operable laundry appliances | 🞏 Yes 🞏 No🞏 Unknown | If no, describe: |
| 6ma – 6mb. Furniture in good condition | 🞏 Yes 🞏 No🞏 Unknown | If no, describe: |
| 6na – 6nb. Adequate bathing facilities | 🞏 Yes 🞏 No🞏 Unknown | If no, describe: |
| 6oa – 6ob. Structural problems | 🞏 Yes 🞏 No🞏 Unknown | If yes, describe: |
| 6pa – 6pb. Operable telephone  | 🞏 Yes 🞏 No🞏 Unknown | If no, describe: |
| 6qa – 6qb. Adequate lighting | 🞏 Yes 🞏 No🞏 Unknown | If no, describe: |
| 6ra – 6rb. Unsanitary conditions, including rodent or insect infestation | 🞏 Yes 🞏 No🞏 Unknown | If yes, describe: |
| 6sa – 6sb. Other: | 🞏 Yes 🞏 No🞏 Unknown | Describe: |

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| 6t. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

1. Functional Assessment

Describe the type of assistance and the frequency of assistance required for the individual for each activity based on typical experience under ordinary circumstances within the last seven days prior to assessment. Use the frequency to indicate variations within a week (e.g., for a person whose needs vary by the location where they reside, use “sometimes” to indicate needs they have only in a location where they reside only a minority of the time). Minutes per occurrence, times per day, and days per week information will be used in developing a care plan. Base these responses on typical experience under ordinary circumstances. Check only one box within each activity.

Type of assistance required

* Cueing or supervision: the individual can physically perform the task alone but requires another individual to provide cueing or supervisory guidance in order to complete the task.
* Mechanical assistance only: the individual can physically perform the task alone, provided the individual has access to a piece of necessary equipment, such as a rolling shower, a wheelchair, cane or walker, adult urinary supplies, or other adaptive equipment .
* One-to-one physical assistance: the person cannot perform the task alone, but may complete the task with physical assistance from another person, such as assistance with lifting, movement, or physical guidance. This individual requires *assistance* with the activity and is not totally dependent on others for the performance of the task.
* Two-to-one physical assistance: the person cannot perform the task alone, but may complete the task with physical assistance from two other persons, such as assistance with lifting, movement, or physical guidance. This individual requires *assistance* with the activity and is not totally dependent on others for the performance of the task.
* Totally dependent on another person: this person is unable to perform or assist in the performance of the task and the task must be completed in whole by another person or persons.

Frequency of assistance:

* Never: The individual never requires assistance, whether mechanical or from another person
* Sometimes: The individual requires assistance, whether mechanical or from another person, occasionally or in limited circumstances
* Usually: The individual generally requires assistance, whether mechanical or from another person, under routine or normal circumstances, but in limited circumstances may not require such assistance
* Always: The individual does not perform the task without assistance, whether mechanical or from another person; the task would not be completed without such assistance
1. Functional Assessment, Continued

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| Describe the type of assistance of frequency of assistance required for the individual for each activity. Check only one box within each activity. |

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| --- |
| 1. **BATHING**
 |
| 7aa – 7ad. How frequently is this activity required and for what duration?  |  | Minutes per occurrence | = minutes per week  |
|  | Times per day |
|  | Days per week |
| 7ba. Type of assistance required | Required Frequency of Assistance | Bathing Score (7bb): |
| Never | Sometimes | Usually | Always |
| Cueing or supervision | *(0)* | *(0)* | *(1)* | *(2)* |
| Mechanical assistance only | *(0)* | *(0)* | *(1)* | *(1)* |
| 1:1 person physical assist | *(0)* | *(1)* | *(2)* | *(3)* |
| Totally dependent on another person | *(0)* | *(2)* | *(3)* | *(4)* |
| **7c. Observations:** |

|  |
| --- |
| 1. **DRESSING**
 |
| 7da – 7dd. How frequently is this activity required and for what duration?  |  | Minutes per occurrence | = minutes per week  |
|  | Times per day |
|  | Days per week |
| 7ea. Type of assistance required | Required Frequency of Assistance | Dressing Score (7eb): |
| Never | Sometimes | Usually | Always |
| Cueing or supervision | *(0)* | *(0)* | *(1)* | *(2)* |
| Mechanical assistance only | *(0)* | *(0)* | *(1)* | *(1)* |
| 1:1 person physical assist | *(0)* | *(1)* | *(2)* | *(3)* |
| Totally dependent on another person | *(0)* | *(2)* | *(3)* | *(4)* |
| **7f. Observations:** |

1. Functional Assessment, Continued

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| --- |
| 1. **EATING / FEEDING**
 |
| 7ga – 7gd. How frequently is this activity required and for what duration?  |  | Minutes per occurrence | = minutes per week  |
|  | Times per day |
|  | Days per week |
| 7ha. Type of assistance required | Required Frequency of Assistance | Eating Score (7hb): |
| Never | Sometimes | Usually | Always |
| Cueing or supervision | *(0)* | *(0)* | *(1)* | *(3)* |
| Mechanical assistance only | *(0)* | *(0)* | *(1)* | *(1)* |
| 1:1 person physical assist | *(0)* | *(1)* | *(3)* | *(4)* |
| Totally dependent on another person | *(0)* | *(1)* | *(4)* | *(4)* |
| **7i. Observations:** |

1. Functional Assessment, Continued

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| --- |
| 1. **TRANSFER**
 |
| 7ja – 7jd. How frequently are these activities (#4-5) required and for what duration?  |  | Minutes per occurrence | = minutes per week  |
|  | Times per day |
|  | Days per week |
| 7ka. Type of assistance required | Required Frequency of Assistance | Highest of Transfer or Mobility Scores (7kc): |
| Never | Sometimes | Usually | Always |
| Cueing or supervision | *(0)* | *(0)* | *(1)* | *(3)* |
| Mechanical assistance only | *(0)* | *(0)* | *(1)* | *(1)* |
| 1:1 person physical assist | *(0)* | *(1)* | *(3)* | *(4)* |
| 2:1 person physical assist | *(0)* | *(1)* | *(3)* | *(4)* |
| Totally dependent on another person | *(0)* | *(1)* | *(4)* | *(4)* |
| 1. **MOBILITY**
 |
| 7kb. Type of assistance required | Required Frequency of Assistance |
| Never | Sometimes | Usually | Always |
| Cueing or supervision | *(0)* | *(0)* | *(1)* | *(2)* |
| Mechanical assistance only | *(0)* | *(0)* | *(1)* | *(1)* |
| 1:1 person physical assist | *(0)* | *(1)* | *(2)* | *(3)* |
| 2:1 person physical assist | *(0)* | *(1)* | *(2)* | *(3)* |
| Totally dependent on another person | *(0)* | *(2)* | *(3)* | *(4)* |
| **7l. Observations:** |

1. Functional Assessment, Continued

|  |
| --- |
| 1. **MANAGEMENT OF MEDICATIONS**
 |
| 7ma – 7md. How frequently is this activity required and for what duration?  |  | Minutes per occurrence | = minutes per week |
|  | Times per day |
|  | Days per week |
| 7na. Type of assistance required | Required Frequency of Assistance | Med Score (7nb): |
| Never | Sometimes | Usually | Always |
| Cueing or supervision | *(0)* | *(0)* | *(1)* | *(2)* |
| Self-manages but requires assistance with administration | *(0)* | *(1)* | *(2)* | *(3)* |
| Another person assists with management and administration | *(0)* | *(1)* | *(2)* | *(3)* |
| Totally dependent on another person | *(0)* | *(2)* | *(3)* | *(3)* |
| **7o. Observations:** |

1. Functional Assessment, Continued

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| 1. **TOILETING**
 |
| 7pa – 7pd. How frequently are these activities (#5-7) required and for what duration?  |  | Minutes per occurrence | = minutes per week |
|  | Times per day |
|  | Days per week |
| 7qa. Type of assistance required | Required Frequency of Assistance | Highest of Toilets, Urinary or Bowel Score (7qd): |
| Never | Sometimes | Usually | Always |
| Cueing or supervision | *(0)* | *(0)* | *(1)* | *(1)* |
| Mechanical assistance only | *(0)* | *(1)* | *(1)* | *(1)* |
| 1:1 person physical assist | *(0)* | *(1)* | *(2)* | *(3)* |
| 2:1 person physical assist | *(0)* | *(2)* | *(3)* | *(4)* |
| Totally dependent on another person | *(0)* | *(3)* | *(3)* | *(4)* |
| 1. **URINARY CONTINENCE AND CATHETER CARE**
 |
| 7qb. Type of assistance required | Required Frequency of Assistance |
| Never | Sometimes | Usually | Always |
| Individual is urinary-continent | *(0)* | *(0)* | *(0)* | *(0)* |
| Cueing or supervision | *(0)* | *(0)* | *(1)* | *(1)* |
| 1:1 person assist | *(0)* | *(1)* | *(2)* | *(3)* |
| 2:1 person physical assist | *(0)* | *(2)* | *(3)* | *(3)* |
| Totally dependent on another person | *(0)* | *(3)* | *(3)* | *(4)* |
| 1. **BOWEL CONTINENCE AND OSTOMY CARE**
 |
| 7qc. Type of assistance required | Required Frequency of Assistance |
| Never | Sometimes | Usually | Always |
| Individual is bowel-continent | *(0)* | *(0)* | *(0)* | *(0)* |
| Cueing or supervision | *(0)* | *(0)* | *(1)* | *(2)* |
| 1:1 person assist | *(0)* | *(1)* | *(2)* | *(3)* |
| 2:1 person physical assist | *(0)* | *(2)* | *(3)* | *(3)* |
| Totally dependent on another person | *(0)* | *(3)* | *(3)* | *(4)* |
| **7r. Observations:** |

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| --- |
| 7s. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

VIII. Physical Assessment

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| --- |
| Recent Professional / Hospital Care  |
| 8aa- 8ae. | Name of Doctor or Facility:Provider is a 🞏 Physician 🞏 Hospital 🞏 Nursing facility | Date of last visit:  |
| Phone: | Reason for visit: |
| 8ba- 8be. | Name of Doctor or Facility:Provider is a 🞏 Physician 🞏 Hospital 🞏 Nursing facility | Date of last visit:  |
| Phone: | Reason for visit: |
| 8ca- 8ce. | Name of Doctor or Facility:Provider is a 🞏 Physician 🞏 Hospital 🞏 Nursing facility | Date of last visit:  |
| Phone: | Reason for visit: |
| 8da- 8de. | Name of Doctor or Facility:Provider is a 🞏 Physician 🞏 Hospital 🞏 Nursing facility | Date of last visit:  |
| Phone: | Reason for visit: |
| 8ea- 8ee. | Name of Doctor or Facility:Provider is a 🞏 Physician 🞏 Hospital 🞏 Nursing facility | Date of last visit:  |
| Phone: | Reason for visit: |

VIII. Physical Assessment, Continued

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| --- |
| Individual’s Diagnosis Profile (include all diagnoses, including mental health or ID/DD diagnoses) |
|  | Diagnosis | Currently See a Provider for Care of this Condition | Date of Onset |
| 8fa. – 8fc. |  | 🞏 Yes 🞏 No |  |
| 8ga. – 8gc. |  | 🞏 Yes 🞏 No |  |
| 8ha. – 8hc. |  | 🞏 Yes 🞏 No |  |
| 8fi. – 8ic. |  | 🞏 Yes 🞏 No |  |
| 8ja. – 8jc. |  | 🞏 Yes 🞏 No |  |
| 8ka. – 8kc. |  | 🞏 Yes 🞏 No |  |
| 8la. – 8lc. |  | 🞏 Yes 🞏 No |  |
| 8ma. – 8mc. |  | 🞏 Yes 🞏 No |  |
| 8na. – 8nc. |  | 🞏 Yes 🞏 No |  |
| 8oa. – 8oc. |  | 🞏 Yes 🞏 No |  |

|  |
| --- |
| Individual’s Medication Profile (include all medications, irrespective of condition treated) |
|  | Medication Name | Reason Prescribed | Dose | Frequency | Route |
| 8pa. – 8pc. |  |  |  |  |  |
| 8qa. – 8qc. |  |  |  |  |  |
| 8ra. – 8rc. |  |  |  |  |  |
| 8sa. – 8sc. |  |  |  |  |  |
| 8ta. – 8tc. |  |  |  |  |  |
| 8ua. – 8uc. |  |  |  |  |  |
| 8va. – 8vc. |  |  |  |  |  |
| 8wa. – 8wc. |  |  |  |  |  |
| 8xa. – 8xc. |  |  |  |  |  |
| 8ya. – 8yc. |  |  |  |  |  |

1. Physical Assessment, Continued

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| 8z. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

VIII. Physical Assessment, Continued

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| Vital signs □ Not Taken |
| 8aaa. Blood Pressure: / mm Hg | 8aab. Pulse: bpm | 8aac. Pulse saturation: % |
| 8aad. Temperature:  º F | 8aae. Respiratory rate:  | 8aaf. Blood sugar: mg/dL |

|  |
| --- |
| Allergies |
| 8aba – 8abd. Food allergies | 🞏 Yes 🞏 No🞏 Unknown | Please list allergens: |  |
|  |
|  |
| 8aca – 8acd. Medication allergies | 🞏 Yes 🞏 No🞏 Unknown | Please list allergens: |  |
|  |
|  |
| 8ada – 8add. Environmental allergies | 🞏 Yes 🞏 No🞏 Unknown | Please list allergens: |  |
|  |
|  |

|  |
| --- |
| Nutritional assessment |
| 8aea. Est. Height (inches): | 8aeb. Weight (lbs.): | 8aec. Recent weight gain / loss: 🞏 Yes 🞏 No |
| 8aed – 8aem. Special diet  | 🞏 None 🞏 Low fat / cholesterol 🞏 No / low salt 🞏 No / low sugar 🞏 No meat / no pork / no beef 🞏 Vegetarian diet 🞏 Liquid or soft diet only 🞏 Doctor-recommended caloric intake🞏 Combination of the above🞏 Other (specify) (Choose all that apply) |
| 8aen. Dietary supplements | 🞏 None 🞏 Occasionally 🞏 Daily, not primary source 🞏 Daily, primary source 🞏 Daily, sole source |
| 8aeo – 8aet. Other dietary considerations  | 🞏 Inadequate food 🞏 Nausea / vomiting / diarrhea (Choose all that apply)🞏 Taste problems 🞏 Problems swallowing 🞏 Tooth or mouth problems 🞏 Problems following special diet 🞏 None |

VIII. Physical Assessment, Continued

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| Hearing and vision assessment |
| Hearing | 8afa. Ability to hear (with aid or device if normally used): 🞏 Adequate 🞏 Minimal difficulty 🞏 Moderate difficulty 🞏 Highly impaired  |
| 8afb. Hearing aid or other appliance required: 🞏 Yes 🞏 No |
| Vision | 8afc. Ability to see in adequate light (with glasses or other appliance if normally used): 🞏 Adequate 🞏 Impaired 🞏 Moderately impaired 🞏 Highly impaired 🞏 Severely impaired  |
| 8afd. Corrective lenses (glasses, contacts, or magnifying lens) used: 🞏 Yes 🞏 No  |

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| Does the individual have any paralysis, joint or bone problems, amputated or missing limbs? |
| 8aga. Joint motion | 🞏 Normal or correctable 🞏 Limited motion 🞏 Immobile or uncorrected instability |
| 8agb – 8age. Paralysis / Paresis | 🞏 None 🞏 Partial 🞏 Total | Onset: 🞏 1 year or less 🞏 More than 1 year  |
| Describe paralysis / paresis: |
| Previous rehabilitation: 🞏 Yes 🞏 No / Not completed  |
| 8agf – 8agh. Amputated or Missing Limbs | 🞏 None 🞏 Fingers / Toes 🞏 Arm(s) 🞏 Leg(s) 🞏 Combination |
| Date of Amputation / Loss: 🞏 1 year or less 🞏 More than 1 year  |
| Previous rehabilitation: 🞏 Yes 🞏 No / Not completed  |

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| Does the individual experience any pain? |
| 8aha. 🞏 No pain reported 🞏 Pain reported on scale from 1 to 10 (please describe below)  🞏 Pain reported by non-verbal individual (describe below and indicate scale used)  |
|  | Location of pain | Individual’s rating of pain | Length of time experienced |
| 8ahb – 8ahd. |  |  |  |
| 8ahe – 8ahg. |  |  |  |
| 8ahh – 8ahj. |  |  |  |
| 8ahk. Scale used for non-verbal reporting:  |

VIII. Physical Assessment, Continued

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| 8aia. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

1. Skilled Care Assessment

**Notes -** 30-day information will be used for informational purposes; 7-day info for scoring

| Detailed skilled nursing and therapies required by individual (please identify in prior section regarding existing services first) |
| --- |
| Service | Currently received | If Yes, Indicate Provider Name | If Yes, Indicate Frequency  |
| 9aa – 9af. Occupational therapy *(1-2)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9ba – 9bf. Physical therapy *(1-2)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9ca – 9cf. Respiratory therapy *(1-2)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9da – 9df. Speech therapy *(1-2)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9ea – 9ef. Ventilator care *(5)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9fa – 9ff. Tracheal suctioning or tracheostomy care *(3-4)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9ga – 9gf. Total parenteral nutrition *(3)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9ha – 9hf. Complex wound care *(3)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9ia – 9if. Wound care, moderate complexity *(2)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9ja – 9jf. Wound care, early or preventive *(1)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9ka – 9kf. Hemodialysis *(2)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9la – 9lf. Peritoneal dialysis *(2)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9ma – 9mf. Enteral tube feeding *(2)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9na – 9nf. IV fluid or medication administration *(1-2)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9oa – 9of. Intramuscular or subcutaneous injections *(1-2)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9pa – 9pf. Isolation precautions *(1)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |
| 9qa – 9qf. PCA pump *(1)* | 🞏 Yes, within last 7 days🞏 Yes, within last 30 days🞏 No / Not known |  | 🞏 Hours or 🞏 Times per day:🞏 Days or 🞏 Times per week: |

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| 9r. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

1. Cognitive and Behavioral Assessment

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| Previously identified SMI / ID/DD |
| 10a. Has the individual been evaluated by another screen and determined to have a serious mental illness or intellectual disability? | 🞏 No such screen completed 🞏 Screening performed, no such determination 🞏 Screening performed, SMI identified 🞏 Screening performed, ID/DD identified  |
| Receptive and expressive communication |
| 10b. Ability to make self understood (expressive communication) | 🞏 Always understood *(0)* 🞏 Usually understood / understood with prompts or time *(0)*🞏 Sometimes understood *(1)* 🞏 Rarely or never understood *(2)* |
| 10c. Speech clarity  | 🞏 Clear speech: distinct, intelligible words *(0)* 🞏 Unclear speech: slurred or mumbled words *(1)*🞏 No speech: absence of spoken words, aphasia *(2)* |
| 10d. Ability to understand others (receptive communication) | 🞏 Understands / clear comprehension *(0)*🞏 Usually understands / misses some parts but comprehends most conversation *(0)*🞏 Sometimes understands / responds to direct communication only *(1)*🞏 Rarely or never understands *(2)* |

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| 10e. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

X. Cognitive and Behavioral Assessment, Continued

| Behavior and behavioral symptoms |
| --- |
| 10f. Does the individual have any of the following? | 🞏 Hallucinations🞏 Delusions🞏 None of these |
| Does the individual exhibit any of the following behaviors? | 10g. Physical behavioral symptoms directed toward others (hitting, kicking, pushing, grabbing, sexual abuse of others, etc.) | 🞏 Behavior not exhibited *(0)*🞏 Behavior exhibited 1 to 3 days per week *(1)*🞏 Behavior exhibited 4 to 6 days per week *(2)*🞏 Behavior exhibited daily *(3)* |
| 10h. Verbal behavioral symptoms directed toward others (threatening, screaming, cursing at others) | 🞏 Behavior not exhibited *(0)*🞏 Behavior exhibited 1 to 3 days per week *(0)*🞏 Behavior exhibited 4 to 6 days per week *(1)*🞏 Behavior exhibited daily *(2)* |
| 10i. Other physical behaviors not directed toward others (self-injury, pacing, public sexual acts, disrobing in public, throwing food or waste, etc.) | 🞏 Behavior not exhibited *(0)*🞏 Behavior exhibited 1 to 3 days per week *(1)*🞏 Behavior exhibited 4 to 6 days per week *(2)*🞏 Behavior exhibited daily *(2)* |
| 10j. If any of the above behaviors were exhibited, please indicate if the behaviors did any of the following:  | 🞏 Put the individual at significant risk of injury or illness *(3)*🞏 Interfere significantly with care *(2)*🞏 Interfere significantly with his/her activities or social interactions *(1)*🞏 Does not interfere significantly with activities or interactions *(0)* |
| 10k. If any of the above behaviors were exhibited, please indicate if the behaviors did any of the following:  | 🞏 Put others at significant risk of injury or illness *(3)*🞏 Interfere significantly with the privacy or activities of others *(1)*🞏 Disrupt the care or living environment for others *(1)*🞏 Does not disrupt the care or living environment for others *(0)* |

X. Cognitive and Behavioral Assessment, Continued

|  |  |
| --- | --- |
| 10l. Did the individual reject assessment or health care, except in cases where that decision is supported by individual’s or family goals or preferences? | 🞏 Behavior not exhibited *(0)*🞏 Behavior exhibited 1 to 3 days per week *(0)*🞏 Behavior exhibited 4 to 6 days per week *(1)*🞏 Behavior exhibited daily *(2)* |
| 10m. Does the person have a history of eloping or wandering?  | 🞏 Behavior not exhibited *(0)*🞏 Behavior exhibited 1 to 3 days per week *(1)*🞏 Behavior exhibited 4 to 6 days per week *(2)*🞏 Behavior exhibited daily *(3)* |
| 10n. Indicate if the individual’s wandering has done any of the following:  | 🞏 Put the individual at significant risk of entering a dangerous place *(3)*🞏 Intruded on the privacy of others *(1)*🞏 Wandering has not put individual or others at risk *(0)* |

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| 10o. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

1. Individual Activities, Routines, and Preferences

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| --- |
| Daily routines (to be answered by the individual being assessed) |
| 11a. When do you normally rise from bed? | 🞏 Before 6 a.m. 🞏 6 – 8 a.m. 🞏 8 – 10 a.m. 🞏 After 10 a.m.  |
| 11b. How many meals do you eat per day? | 🞏 One 🞏 Two 🞏 Three 🞏 More than three  |
| 11c. When do you usually eat for the first time each day? | 🞏 Before 6 a.m. 🞏 6 – 8 a.m. 🞏 8 – 10 a.m. 🞏 After 10 a.m.  |
| 11d. When do you typically eat again following your first meal? | 🞏 I typically only eat one full meal per day🞏 9 – 11 a.m. 🞏 11 a.m. – 1 p.m. 🞏 1 – 3 p.m. 🞏 After 3 p.m.  |
| 11e. When do you typically eat a third meal? | 🞏 I typically only eat one or two full meals per day🞏 Before 3 p.m. 🞏 3 – 5 p.m. 🞏 5 – 7 p.m. 🞏 After 7 p.m.  |
| 11f. When do you typically bathe? | 🞏 Before 8 a.m. 🞏 8 a.m. – 12 p.m. 🞏 12 - 4 p.m. 🞏 After 4 p.m.  |
| 11g. When do you typically get dressed or brush your teeth after rising for the day? | 🞏 Before 6 a.m. 🞏 6 – 8 a.m. 🞏 8 – 10 a.m. 🞏 After 10 a.m.  |
| 11h. When do you typically brush your teeth or change clothes before bed? | 🞏 Before 7 p.m. 🞏 7 – 9 p.m. 🞏 9 – 11 p.m. 🞏 After 11 p.m.  |
| 11i. When do you normally go to bed in the evening? | 🞏 Before 8 p.m. 🞏 8 – 10 p.m. 🞏 10 p.m. to 12 a.m. 🞏 After 12 a.m.  |
| 11j. Do you frequently leave your home or residence for employment or leisure activities? | 🞏 Yes, for both work and leisure 🞏 Yes, for leisure🞏 No, I leave my home only infrequently or only for medical care  |

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| 11k. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |

1. Informal Supports

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| --- |
| Informal supports provided by a family member or other individual |
| 12a. Does the individual have a family or other person providing informal care? | 🞏 No informal care provided🞏 Yes, a family member (provide details below) 🞏 Yes, another (unrelated) person (provide details below) |
| 12b. Where does the person described above reside? | 🞏 With the individual 🞏 Near the individual (e.g., a neighbor) 🞏 Not within walking distance |
| 12ca – 12cc. How often and for how long does this person provide care?*Please limit to hours spent providing care only.* | Daily: Hours per day x days per week Weekly: Hours per weekly visit |
| 12da – 12dd. With what types of tasks does this person assist? | 🞏 Activities of daily living (bathing, dressing, eating, transferring, mobility, etc.) 🞏 Instrumental activities (shopping, medication management, money management) 🞏 Other activities (household chores, etc.)🞏 Skilled care (injections, infusion therapy, etc.) |

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| 12o. Individuals providing information for assessment 🞏 Individual  🞏 Other respondent (select name from list provided in Section I)**Please ensure this information is completed for all sections of the assessment.** |