DIVISION OF HEALTH CARE FINANCING AND POLICY
Comprehensive Social Health Assessment

Assessment Type: ☐ Initial Assessment ☐ Reassessment ☐ Annual ☐ Other _____

Name of the Case Manager conducting this assessment: _____

Date of the assessment: / /

Where did the assessment take place?

☐ Adult day care
☐ Home
☐ Nursing Facility
☐ Rehab Facility
☐ Assisted Living or Group Care Facility
☐ Hospital
☐ Other's residence
☐ Other

_____

If Assessment took place in another location; where did the assessment take place?

_____

Primary source for communication for contact if other than recipient

☐ Family
☐ Provider
☐ Nurse/Social Worker
☐ Other
☐ N/A

1. RECIPIENT DEMOGRAPHICS and IDENTIFYING INFORMATION

Name: _____ Medicaid Number: _____

Physical Address: _____

Mailing Address: _____

Date of Birth: _____Social Security Number: _____

Phone Number (1): _____Phone Number (2): _____

Alternate Contact Method: _____

Emergency Contact: _____Relationship: _____

Phone Number: _____ Cell Number: _____

Address: _____

Emergency Contact: _____Relationship: _____

Phone Number: _____ Cell Number: _____

Address: _____

☐ Male ☐ Female Social Security Card: ☐ Yes ☐ No ☐ N/A Birth Certificate: ☐ Yes ☐ No ☐ N/A

Race/ Ethnicity: _____

ID: ☐ Yes ☐ No ☐ N/A Type: _____ Photo ID: ☐ Yes ☐ No ☐ N/A

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single ☐ Widowed

Language Spoken: _____ Needs Interpreter: ☐ Yes ☐ No

Speech: ☐ Good ☐ Limited ☐ Poor ☐ Unable to Communicate

☐ Communicates by: _____

Most current acute Admit Day: / /

NF Admit Date: / / Anticipated Discharge Date: / /

Does recipient have Medicare? ☐ Yes ☐ No ☐ A ☐ B ☐ D

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Does recipient have Advance Directives in place? ☐ Yes ☐ No ☐ N/A

Code Status: ☐ DNR ☐ Full Code ☐ Other: _____

Recipient received information about Advanced Directives? ☐ Yes ☐ Not applicable

Does recipient have a Legal Guardian? ☐ Yes ☐ No

Name: _____ Relationship: _____

Phone Number: _____ Cell Number: _____

Does recipient have a Durable Power of Attorney for Health Care? ☐ Yes ☐ No

Name: _____ Relationship: _____

Phone Number: _____ Cell Number: _____

Does recipient have an authorized representative? ☐ Yes ☐ No

Name: _____ Relationship: _____

Phone Number: _____ Cell Number: _____

2. CASE MANAGER ASSESSMENT

Does the recipient have a support system?

☐ Available ☐ Needs Assistance ☐ None

Support system by whom?

☐ Family ☐ Friend ☐ Paid Caregiver
☐ Spouse ☐ Other ☐ None

What are some of the factors that might limit the primary caregiver?

☐ Job ☐ Finances ☐ Family responsibilities
☐ Physical burden ☐ Emotional burden ☐ Caregiver's mental health
☐ Alcohol/drug abuse ☐ Health ☐ Unreliable
☐ Other ☐ N/A

Comment on anything that may make it difficult for a primary caregiver to provide care.

_____

3. MEDICAL INFORMATION

Primary Physician: _____ Phone Number: _____

Address: _____

Has the recipient fallen in the past three months?

☐ Yes ☐ No ☐ Unknown

In the past year, how many times have the recipient stayed overnight in a hospital?

☐ 2 or 3 times ☐ More than 3 times ☐ Unknown
☐ Not at all ☐ Once

Compliance with medical regimen

☐ Good ☐ Fair ☐ Poor

Medical Diagnosis:

_____

_____

A brief summary of medical status and recent/future medical appointments.

Name: _____ Date: _____

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Can recipient safely self-administer medications?
☐ Yes ☐ No

If no, list barriers: _____

Drug Allergies: _____

Name of Medication	Dosage/Frequency/Route	Administered by

4. HEALTH ASSESSMENT

Recipient's general appearance
☐ Clean ☐ Hair clean ☐ Neat
☐ Odor-free ☐ Unclean ☐ Unkempt
☐ Unshaven

Is the recipient's attire environment appropriate?
☐ Yes ☐ No

Mental Status
☐ Alert ☐ Anxious ☐ Cheerful
☐ Communicative ☐ Confused ☐ Cooperative
☐ Depressed ☐ Disoriented ☐ Forgetful
☐ Irritable ☐ Oriented ☐ Sad
☐ Other

Have there been any mental status changes?
☐ Yes ☐ No ☐ N/A

5. COGNITIVE/BEHAVIOR COMMENTS

What is the Recipient's Sensory Status – Language? ☐ **N/A SECTION**
☐ Express complex ideas & needs. No observable impairment

Name: _____ Date: _____

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☐ Min difficulty expressing ideas & needs. May need extra time/prompting.
☐ Express simple ideas or need with moderate difficulty.
☐ Severe difficulty expressing ideas or needs. Requires max assist/guessing.
☐ Unable to express basic needs with max prompting. Not Unresponsive.
☐ Unresponsive, unable to speak
☐ Age appropriate

What is the Recipient's Sensory Status – Hearing and Auditory Comprehension of Language?
☐ No impairment with or without corrective aide
☐ Minimal difficulty. Able to hear and understand most multi-step instructions
☐ Has moderate difficulty hearing simple instructions needs frequent prompting
☐ Severe difficulty hearing/understanding simple comments. Req. Mult. Reps
☐ Unable to hear and understand familiar words consistently
☐ Not determined

What is the Recipient's Vision with Corrective Lenses as Applicable?
☐ Normal sees adequately including med labels
☐ Partially impaired, Cannot see news print or med labels; Can see obstacles
☐ Severely impaired; can't see obstacles; Req. feeling/cane/hearing/touching
☐ Completely blind; Compensates adequately
☐ Completely blind; As yet unable to compensate

Has recipient experienced any of the following qualified serious occurrence? If yes, check all that apply.
☐ Unplanned hospital visit/ ER
☐ Injury or fall requiring medical intervention
☐ Alleged exploitation
☐ Alleged physical, verbal, sexual abuse or harassment
☐ Alleged theft
☐ Death
☐ Loss of contact
☐ Medication error

Was the SOR completed?
☐ Yes ☐ No

If yes, by whom?
☐ ADSD ☐ DHCFP ☐ Provider

6.CRITICAL BEHAVIOR – NEED FOR SUPERVISION (AUGMENTED PERSONAL CARE ONLY) ☐ N/A SECTION

Wandering
☐ 0 - Seldom to never a problem
☐ 1 – Occurs a couple of times a week
☐ 2 – Frequently occurs (daily or between 3 and 7 times a week)
☐ 3 – Occurs multiple times within a day

Resists Care
☐ 0 - Seldom to never a problem
☐ 1 – Occurs a couple of times a week
☐ 2 – Frequently occurs (daily or between 3 and 7 times a week)
☐ 3 – Occurs multiple times within a day

Self Abusive Behavior
☐ 0 - Seldom to never a problem
☐ 1 – Occurs a couple of times a week
☐ 2 – Frequently occurs (daily or between 3 and 7 times a week)
☐ 3 – Occurs multiple times within a day

Abusive to Others
☐ 0 - Seldom to never a problem
☐ 1 – Occurs a couple of times a week
☐ 2 – Frequently occurs (daily or between 3 and 7 times a week)
☐ 3 – Occurs multiple times within a day

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Select the choice that most accurately describes the recipient's memory and use of information.

☐ 1- Mild ☐ 2 –Moderately Severe ☐ 3 - Severe

What is the Augmented Personal Care Service Level?

☐ Service Level 1: Supervision to Min assist w/an ADL and score a 3 on the LOC score line
☐ Service Level 2: Moderate assistance with both critical ADLs
☐ Service Level 2: Moderate assistance with any 4 ADLs
☐ Service Level 2: Dependent with 1 to 2 ADLs
☐ Service Level 2: Score of 2 in at least 1 Critical Behavior
☐ Service Level 3: Maximum to Dependent with both critical ADLs
☐ Service Level 3: Maximum assist with any 4 ADLs
☐ Service Level 3: Dependent for 3 or more ADLs
☐ Service Level 3: Score of 3 in at least one critical behavior area

7. AUGMENTED PERSONAL CARE

Does recipient have a facility preference?

☐ Yes ☐ No ☐ **N/A SECTION**

Name of the Assisted Living/Group Care facility of choice, recipient preference.

What are the considerations for the facility preference?

☐ Activities ☐ Category 1 ☐ Category 2
☐ Endorsement ☐ Level of Care ☐ Location
☐ Pets ☐ Private Room ☐ Size of Facility
☐ Smoking area ☐ Transportation ☐ Trust Account
☐ Other

Does the Recipient have a trust account?

☐ Yes ☐ No ☐ N/A

Trust account reviewed?

☐ Yes ☐ No ☐ N/A

Are they receiving their personal needs allowance?

☐ Yes ☐ No

Is the personal needs allowance being managed and documented appropriately?

☐ Yes ☐ No ☐ N/A

Was the facility daily record reviewed? (ADLs/IADLs)

☐ Yes ☐ No ☐ N/A

Does the daily record match the plan of care?

☐ Yes ☐ No ☐ N/A

Comment on the daily record not matching the plan of care.

Was provider education given regarding daily log? ☐ N/A

☐ Yes ☐ No

What is the facility's temperature setting? ☐ N/A

Is the current HC/QC grades posted in a conspicuous location?

☐ Yes ☐ No ☐ N/A

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Is a current menu posted?
☐ Yes ☐ No ☐ N/A

8. LEVEL OF CARE ASSESSMENT

Can recipient safely self-administer medications? (If no, count "1" functional deficit point)
☐ Yes ☐ No

Does the recipient need assistance with any Treatments/Special Needs? (If yes, count "1" functional deficit point)
☐ Yes ☐ No

Treatment/Special Needs (check all that pertain and explain below)
☐ Tracheostomy Suctioning ☐ Suctioning ☐ O2 ☐ Ventilator Dependent
☐ IV ☐ Central Line ☐ PICC ☐ Saline-Lock ☐ Feeding tube (G-tube, J-tube, NG-tube)
☐ Wound or Skin Care ☐ Glucose monitoring ☐ Dialysis
☐ Insulin Coverage (sliding scale with variable coverage)
☐ Secured (Alzheimer) Unit ☐ Specialty Bed
☐ Other Specialized DME** _____
☐ Other _____

****ADDITIONAL DME – SEE SECTION 12**

The recipient requires assistance with the following ADLs. (Each ADL=1 Functional Deficit Point)

ADL Bed Mobility
☐ Independent ☐ Total Dependence
☐ Supervision Min ☐ Supervision Mod ☐ Supervision Max
☐ Assist Min ☐ Assist Mod ☐ Assist Max

ADL Transfer
☐ Independent ☐ Total Dependence
☐ Supervision Min ☐ Supervision Mod ☐ Supervision Max
☐ Assist Min ☐ Assist Mod ☐ Assist Max

ADL Locomotion
☐ Independent ☐ Total Dependence
☐ Supervision Min ☐ Supervision Mod ☐ Supervision Max
☐ Assist Min ☐ Assist Mod ☐ Assist Max

What assistive devices does the recipient use for aid in Locomotion?
☐ No Devices ☐ Power Wheelchair ☐ Walker ☐ Braces
☐ Cane ☐ Manual Wheelchair ☐ Prosthesis ☐ Other

ADL Dressing
☐ Independent ☐ Total Dependence
☐ Supervision Min ☐ Supervision Mod ☐ Supervision Max
☐ Assist Min ☐ Assist Mod ☐ Assist Max

ADL Eating/Feeding
☐ Independent ☐ Total Dependence
☐ Supervision Min ☐ Supervision Mod ☐ Supervision Max
☐ Assist Min ☐ Assist Mod ☐ Assist Max

ADL Hygiene
☐ Independent ☐ Total Dependence
☐ Supervision Min ☐ Supervision Mod ☐ Supervision Max
☐ Assist Min ☐ Assist Mod ☐ Assist Max

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ADL Bathing

☐ Independent ☐ Total Dependence
☐ Supervision Min ☐ Supervision Mod ☐ Supervision Max
☐ Assist Min ☐ Assist Mod ☐ Assist Max

What is the recipient's bladder continence?

☐ Catheter ☐ Continent ☐ Incontinent

ADL Bladder

☐ Independent ☐ Total Dependence
☐ Supervision Min ☐ Supervision Mod ☐ Supervision Max
☐ Assist Min ☐ Assist Mod ☐ Assist Max

What is the recipient's bowel continence?

☐ Ostomy ☐ Continent ☐ Incontinent

ADL Bowel

☐ Independent ☐ Total Dependence
☐ Supervision Min ☐ Supervision Mod ☐ Supervision Max
☐ Assist Min ☐ Assist Mod ☐ Assist Max

NEED FOR SUPERVISION

What is the reason the recipient needs supervision? (NOTES REQUIRED)

☐ Wandering ☐ Resist Care ☐ Behavioral Problems
☐ Safety Risk ☐ Socially Inappropriate ☐ Verbally Abusive
☐ Physically Abusive

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

The recipient requires assistance with the following IADLs.

☐ Meal Preparation ☐ Finances ☐ Homemaking
☐ Laundry ☐ Medication Management ☐ Shopping
☐ Transportation

Does recipient require assistance with meal preparation?

☐ Yes ☐ No

Does the recipient require assistance with Homemaking?

☐ Yes ☐ No

Needed tasks for Homemaking services:

☐ Essential Shopping ☐ General Cleaning
☐ Laundry ☐ Meal Preparation

How are these tasks being accomplished now?

☐ Independent ☐ Assist ☐ Dependant

What is the assessment score?

Nursing Facility recommended placement?

☐ Meets Nursing Facility Level of Care (LOC)
☐ Does not meet a Nursing Facility (NF) LOC – Referred to appropriate resources.

9. PRIORITIES

Is the recipient currently in a nursing facility and desiring discharge?

☐ Yes ☐ No ☐ N/A

Name: _____ Date:_____

Assessment Type: _____

DRAFT

Is the recipient currently in acute care or hospital setting and in need of assistance upon discharge?
☐ Yes ☐ No ☐ N/A

Does the recipient have an explicit terminal prognosis?
☐ Yes ☐ No ☐ N/A

Is the recipient transitioning from another Home and Community Based program?
☐ Yes ☐ No ☐ N/A

Is the recipient requiring services due to a crisis or emergency (i.e. substantiated/severe EPS issues, significant change in support system, etc.)?
☐ Yes ☐ No ☐ N/A

Does the recipient require minimal essential personal assistance (bathing, eating, toileting) as defined by NRS 426.723?
☐ Yes ☐ No ☐ N/A

10. NUTRITION PROFILE and ASSESSMENT

What is the recipient's height in inches?

What is the recipient's weight in pounds?

Recipient's BMI:

Loss or gain of 10 pounds (or more) in the past 6 months?
☐ No ☐ Yes

Special Diet
☐ Yes ☐ No

Food Allergies
☐ Yes ☐ No

Home Delivered Meals
☐ Yes ☐ No ☐ Needs

Food Stamps
☐ Yes ☐ No ☐ Needs

Commodity Foods
☐ Yes ☐ No ☐ Needs

Dentures
☐ Yes ☐ No
☐ Needs ☐ Needs realignment

Dental Hygiene
☐ Good ☐ Fair ☐ Poor

Has illness or condition made the recipient change the kind and/or amount of food eaten?
☐ Yes (2) ☐ No

Does the recipient eat fewer than 2 meals per day?
☐ Yes (3) ☐ No

Does the recipient eat few (less than 5) fruits or vegetables, or milk products daily?

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Assessment Type: _____

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☐ Yes (2) ☐ No

Does the recipient have 3 or more drinks of beer, liquor or wine almost every day?
☐ Yes (2) ☐ No

Does the recipient have tooth or mouth problems that make it hard to eat?
☐ Yes (2) ☐ No

Does the recipient sometimes not have enough money to buy food?
☐ NO (4) ☐ Yes

Does the recipient eat alone most of the time?
☐ Yes (1) ☐ No

Does the recipient take 3 or more different prescribed or over-the-counter drugs a day?
☐ Yes (1) ☐ No

Without wanting to, has the recipient lost or gained 10 pounds in the last 6 months?
☐ Yes (2) ☐ No

Is the recipient not always physically able to shop, cook and/or feed him/herself?
☐ Yes (2) ☐ No

Total Nutritional Risk Score (0-2 Good, 3-5 Moderate Risk, 6 or more – High Risk)

11. SUPPORTIVE DEVICES/DME

Does the recipient HAVE and/or USE any of the following devices or equipment/SUPPLIES?

☐ Bedside commode
☐ Eyeglasses
☐ Hearing Aid
☐ Lift chair
☐ Ramp
☐ Wheelchair
☐ None at this time
☐ Other:_____
☐ Cane
☐ Grab bars
☐ Hospital bed
☐ Oxygen
☐ Shower Bench/Shower Chair
☐ Dentures
☐ Hand Held Shower
☐ Hoyer Lift
☐ Raised toilet seat
☐ Walker

Does the recipient need any of the following devices or equipment?

☐ Bedside commode
☐ Eyeglasses
☐ Hearing Aid
☐ Lift chair
☐ Ramp
☐ Wheelchair
☐ None at this time
☐ Other:_____
☐ Cane
☐ Grab bars
☐ Hospital bed
☐ Oxygen
☐ Shower Bench/Shower Chair
☐ Slide board
☐ Urinal
☐ Dentures
☐ Hand Held Shower
☐ Hoyer Lift
☐ Raised toilet seat
☐ Walker
☐ Prostheses

Does the recipient need any of the following supplies?

☐ Bed Pads and/or Chuxs
☐ Wound Care Supplies
☐ Breathing Supplies (O2 or Nebulizer)
☐ Other
☐ Briefs
☐ Catheter Supplies
☐ Nutrition Supplement
☐ Diabetic Supplies
☐ Feeding Tube Supplies
☐ Ostomy Supplies

12. INCOME

Specify the recipient's monthly social security income:

Specify the recipient's monthly SSI income:

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Specify the recipient's monthly retirement/pension income:

Specify the recipient's monthly VA benefits income:

Specify the recipient's other monthly income:

Does the recipient have any of the following? Check all that apply.

☐ Trust account ☐ Burial policy ☐ Life Insurance policy

Specify the total income of the recipient's other family members (PAS only):

Total Income:

How much money does the recipient spend each month, out of his/her own pocket, on medical expenses?

13. HOUSING

Does the recipient own or rent his/her residence?

☐ Assisted Living ☐ Own
☐ Rent ☐ Lives With Family

What is the recipient's monthly rent or mortgage payment?

What are the recipient's community living arrangements?

☐ Assisted living facility ☐ Friend/Roommate ☐ Hotel
☐ Lives Alone ☐ Lives with child/children ☐ Shelter
☐ Lives with spouse and child ☐ Lives with spouse only ☐ Mobile home
☐ Pets ☐ Private residence ☐ Rent
☐ Residential facility for group ☐ Lives with other family members
☐ Significant Other

Enter the names and relationships of other persons in the household:

What are conditions regarding cleanliness at the recipient's residence?

☐ Clean ☐ Cluttered ☐ Dirty
☐ Neat ☐ Odor Free ☐ Unsafe

Structural barriers in the recipient's environment that limit independent mobility.

☐ Availability of wheelchair ramp ☐ Multi-level
☐ Narrow or obstructed doorways ☐ Narrow or obstructed hallways
☐ Stairs ☐ None
☐ Other: _____

Is the recipient's residence in need of repairs?

☐ Yes ☐ No

What is the case manager's assessment of the consumer's home safety?

☐ Adequate ☐ Questionable
☐ Unsafe ☐ Other

Specify the Housing Related Benefits Needed by the recipient.

☐ Energy Assistance ☐ Rent Subsidy ☐ Property Tax Credit
☐ Reverse Mortgage ☐ Renter Tax Refund ☐ Telephone Lifeline

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☐ N/A
☐ Other:

Does the recipient have any existing warrants? ☐ Yes ☐ No

Does the recipient have any previous evictions? ☐ Yes ☐ No

14. ADDITIONAL DOCUMENTATION for PAS

Does recipient require Self-Directed Skilled services?
☐ Yes ☐ No ☐ **N/A SECTION**

Has recipient trained his/her current caregiver(s) on how to complete these tasks?
☐ Yes ☐ No

Has a medical professional determined your caregiver(s) has/have the knowledge, skill and ability to perform these skills competently?
☐ Yes ☐ No

Continued to pursue Medicaid eligibility?
☐ Yes ☐ No ☐ N/A
Describe Medicaid eligibility follow-up, when was application submitted?

Is recipient on the wait list for WIN?
☐ Yes ☐ No ☐ N/A

15. RISK ASSESSMENT

Identified Risks (Identify on following page)
☐ Yes ☐ No

If yes, how are risks mitigated: See Narrative

Back-up plan, if applicable:

Identified risks?
☐ Requires minimal essential personal assistance as defined by NRS 426.723
☐ Terminal illness
☐ History of falls with injury or multiple falls within the last year
☐ Advanced dementia/Alz's requiring continuous supervision and/or assistance
☐ Three or more ER visits or hospitalizations within the last 6 months
☐ Incontinent and unable to maintain care and cleanliness
☐ Resides in rural area or community with limited resources
☐ Crisis or emergency situation such as a significant change in support system
☐ Does not have able or available caregiver to provide assistance with ADLs/IADLs
☐ Legally responsible individual is unable to provide assistance with ADLs/IADLs
☐ Difficulty performing essential shopping to obtain food or prescriptions
☐ Medication or treatment compliance ☐ Difficulty preparing or obtaining meals
☐ Environmental/Home maintenance ☐ Inconsistent supports available
☐ Seizures ☐ Substance abuse ☐ Tobacco Use
☐ Multiple prescriptions ☐ Lives alone ☐ Chronic health problems
☐ Victimization/exploitation ☐ Access to medical services ☐ Service refusal
☐ Loss of Medicaid ☐ Non-cooperation ☐ Wandering
☐ Resist Care ☐ Behavioral Problems ☐ Mental Illness
☐ Safety risk ☐ Socially inappropriate ☐ Verbally abusive
☐ Physically abusive ☐ Nutritional Risk ☐ None

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☐ Other: _____

Are additional services needed?
☐ Yes ☐ No

Does the recipient need assistance in obtaining transportation?
☐ Yes ☐ No

Type of transportation needed or used:
☐ Independent ☐ Assisted living ☐ Chair car
☐ Group home ☐ Logisticare transportation ☐ Medical Transportation
☐ Private vehicle ☐ Public transportation ☐ Support system
☐ Taxi ☐ VA ☐ Paratransit
☐ Other

Are individual goals being met?
☐ Yes ☐ No ☐ N/A

Evaluate goal status?
☐ Met ☐ Ongoing
☐ Partially Met ☐ Abandoned
☐ Revised ☐ N/A

Still eligible and appropriate for waiver services?
☐ Yes ☐ No

17. CARE PLAN DEVELPOMENT

What waiver/non waiver services were identified as being needed when developing the Care Plan?
☐ Adult Day Care (Waiver) ☐ Adult Day Health Care ☐ Attendant Care Services
☐ Case Management ☐ Chore ☐ DME/Supplies
☐ Energy Assistance ☐ Environmental Adaptations ☐ Food Stamps
☐ HCBW ☐ Home Companion ☐ Home Delivered Meals
☐ Home Health ☐ Homemaker ☐ Hospice
☐ Housing Assistance ☐ Legal Services ☐ Meals on Wheels
☐ Other ☐ PERS ☐ Personal Care Aid
☐ PT/OT/ST ☐ Respite ☐ Senior Rx
☐ Senior Tax ☐ Specialized Med Equip ☐ Transportation
☐ Weatherization ☐ Companion ☐ Counseling
☐ Assisted Living (Waiver) ☐ Alcohol and substance abuse treatment

18. SERVICES

Does the recipient have a PERS unit?
☐ Yes ☐ No

If yes, what type?
☐ Necklace ☐ Wristband ☐ Pendant

Was the PERS unit delivered as authorized?
☐ Yes ☐ No

Are you satisfied with your services? If not, comment
☐ Yes ☐ No

Was the service quality adequate?
☐ Yes ☐ No

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Is the PERS unit tested every month?
☐ Yes ☐ No ☐ N/A

Equipment needs repair
☐ Yes ☐ No

Equipment or supplies needed
☐ Yes ☐ No

If response other than yes, describe:

Was the recipient offered choice of providers? (If no, specify in Notes.)
☐ Yes ☐ No

Was the recipient offered choice between home and community based services or NF placement?
☐ Yes ☐ No

Education provided to recipient regarding the need to sign daily record for validation of services?
☐ Yes ☐ No

Education provided on who to notify in the event of a change of condition or service need?
☐ Yes ☐ No

Any unresolved issues or needs? (If yes, specify in Notes.)
☐ Yes ☐ No

Education provided that if there is a personal care representative for personal care services, they must be present during the provision of services?
☐ Yes ☐ No

Who participated in the assessment and development of the Care Plan?
☐ Recipient ☐ Spouse ☐ Family Member
☐ Caregiver ☐ Paid Caregiver ☐ Personal Care Representative (PCR)
☐ Guardian ☐ Friend

Does client desire to self direct their care? ☐ Yes ☐ No

What is the reason for the designated representative?

What is the designated representative's relationship to the recipient?

19. FOLLOW-UP

Describe items to follow up:

20. ASSESSMENT NARRATIVE

DRAFT

Name: _____ Date: _____

Assessment Type: _____