Division of Health Care Financing and Policy
Universal Needs Assessment Tool for 1915(i) Services

Purpose: To determine whether a recipient is eligible for 1915(i) services through Nevada Medicaid. This assessment must be performed face-to-face by the recipient's physician who is an independent third party.

RECIPIENT INFORMATION	
Recipient Name:	Date of Birth:
Medicaid #:	Phone #:
ASSESSOR/PHYSICIAN INFORMATION	
Name (print):	NPI #:
Phone #:	Fax #:

CLINICAL INFORMATION *(Check all applicable boxes to indicate substantial impairments, risk factors and need).*

1. Activities of Daily Living:
☐ Bathing/Dressing/Grooming ☐ Toileting ☐ Transfers/Positioning ☐ Mobility/Ambulation
☐ Eating

2. Cognitive/Behavior:
☐ Speech/Language/Communication ☐ Self-Direction ☐ Social Development ☐ Learning
☐ Vocational Development ☐ Maladaptive Behavior ☐ Psychosis/Hallucinations
☐ Mild Memory Loss ☐ Moderate Memory Loss

3. Medical Needs:
☐ Trach ☐ Suctioning ☐ O2 ☐ Ventilator ☐ IV Central Line ☐ PICC
☐ Saline-LOC ☐ Feeding Tube ☐ Wound Care ☐ Glucose Monitoring ☐ Insulin Dependent
☐ Specialty Bed ☐ Pediatric Specialty Care ☐ Rehab Nursing ☐ Medication Management
☐ Loss of Sensation/Pain ☐ Vital Signs/Blood Pressure Monitoring ☐ Special Diet
☐ Nebulizer Treatment ☐ Folly Catheter

4. Supervision:
☐ Wandering ☐ Resist Care ☐ Inability for Independent Living ☐ Falls
☐ Risk of Harm ☐ Secured Unit

5. Substance Abuse:
☐ This recipient has been diagnosed with a substance abuse problem that will be addressed at the ADHC facility and that primarily contributes to his/her need for ADHC services.

6. Multiple Social Service System Involvement:
☐ This recipient is involved in multiple social service systems (e.g., criminal justice system or welfare systems) OR multiple case managers from various public and/or community organization and multi-system agencies related to the recipient's unmet needs.

VERIFICATION AND SIGNATURE

By signing below, I verify that I am an independent third party and am not related to the recipient or associated with the service provider.

Assessor's Signature: _____Assessment Date: _____

This Assessment Tool is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.

Universal Needs Assessment Tool for 1915(i) Services

Purpose:

The purpose of this form is to determine whether an individual is eligible for 1915(i) State Plan Home and Community-Based Services (HCBS). Check the boxes that directly indicate the individual's need for HCBS.

Assessor/Physician Information:

The assessor completing this form must be an independent third party from the provider of the above services and the individual. The assessor cannot be:

- related by blood or marriage to the individual, or any paid caregiver of the individual;
- financially responsible for the individual;
- empowered to make financial or health-related decisions on behalf of the individual; or
- service providers, or individuals or corporations with financial relationships with any service provider.

Clinical Information:

- Activities of Daily Living (ADLs) – Must have two ADLs for this box to be counted. Check the boxes the individual has substantial impairments in ADLs.
    1. Bathing/Dressing/Grooming: Includes bathing (washing oneself in a bathtub or shower, or by sponge bath. It also includes the individual's ability to get into and out of a shower or tub), dressing, undressing, grooming and personal hygiene.
    2. Mobility: Includes walking and getting around with the use of assistive devices or with assistance.
    3. Toileting: Includes getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
    4. Eating: Putting food into the body from a cup, plate, feeding tube or intravenously. Does not include the preparation of food which is an Instrumental Activity of Daily Living (IADLs).
    5. Transferring: Includes moving in to or out of a chair, bed or wheelchair.
- Cognitive Behavior – Must have one box checked for this box to be counted. Check the impairment/s that has a substantial impact on the individual's life.
- Medical Needs – Must have one box for this box to be counted. Check the box if the individual has a risk factor that requires nursing services.
- Supervision – Must have one box for this box to be checked. Check the box if the individual has a risk factor that requires supervision.
- Substance Abuse – Check the box if the individual has been diagnosed with a substance abuse problem that will be addressed with this service and primarily contributes to the individual's need for this service.
- Multiple Social Service Involvement – Check the box if the individual is involved in multiple social service systems, (e.g. the criminal justice or welfare systems) or multiple case managers from various public and/or community organizations and these multi-system agencies relate to the individual's unmet needs.