

## Nevada Medicaid: Functional Assessment Service Plan

### Recipient Signature Page

| 1. Recipient information      |                                 |                             |           |                 |      |  |  |  |  |
|-------------------------------|---------------------------------|-----------------------------|-----------|-----------------|------|--|--|--|--|
| Last name:                    |                                 | First name:                 |           | Middle initial: |      |  |  |  |  |
| Recipient ID:                 |                                 |                             |           | Date of birth:  | / /  |  |  |  |  |
| Translator required:          | <input type="checkbox"/> Yes    | <input type="checkbox"/> No | Language: |                 |      |  |  |  |  |
| Address:                      |                                 |                             |           |                 |      |  |  |  |  |
| City:                         |                                 | State:                      |           | Zip code:       | - -  |  |  |  |  |
| <input type="checkbox"/> Male | <input type="checkbox"/> Female | HT:                         | Feet      | Inches          | WT:  |  |  |  |  |
|                               |                                 |                             |           |                 | Age: |  |  |  |  |

1. I have received a copy of the following documents:
  - Provider Responsibilities
  - Recipient Rights and Responsibilities
  - Program Criteria
  
2. I, my guardian, or personal care representative participated in the assessment process, providing accurate information to the best of my/their ability.
  
3. The physical/occupational therapist arrived (enter date of the assessment, along with the start and end times of the assessment):
  - Date:                    / /
  - Begin time:        :     a.m./  p.m.
  - End time:            :     a.m./  p.m.

By signing below, I acknowledge the above information is correct. My signature does not indicate that I agree or disagree with the final outcome of the assessment.

|            |           |      |
|------------|-----------|------|
|            |           | / /  |
| Print Name | Signature | Date |

Identify relationship of person signing this form:

- Self
- Legally Responsible Individual (Guardian)
- Personal Care Representative (PCR)
- Other (please specify): \_\_\_\_\_

Recipient Name: \_\_\_\_\_ ,

Recipient ID: \_\_\_\_\_

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At Risk Recipient:  YES  NO

Date of Assessment:    /    /

### 2. Legally responsible individual (LRI) information (if applicable)

|           |  |                            |  |
|-----------|--|----------------------------|--|
| LRI name: |  | Relationship to recipient: |  |
|-----------|--|----------------------------|--|

|   |  |
|---|--|
| Does LRI reside in the home with recipient? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

|                           |  |
|---------------------------|--|
| If no, enter LRI address: |  |
|---------------------------|--|

|       |  |        |  |           |   |        |     |
|-------|--|--------|--|-----------|---|--------|-----|
| City: |  | State: |  | Zip code: | - | Phone: | - - |
|-------|--|--------|--|-----------|---|--------|-----|

Identify the living arrangements of the LRI:

Resides in the Home     Disabled     Works (specify hours/days): \_\_\_\_\_

### 3. Emergency contact information

Complete this section if recipient has no guardian (such as: POA, family member, personal care representative, etc.).

|  |  |                            |  |
|--|--|----------------------------|--|
| Contact Name:<br><i>(other than recipient)</i> |  | Relationship to Recipient: |  |
|--|--|----------------------------|--|

|                  |  |
|------------------|--|
| Contact Address: |  |
|------------------|--|

|       |  |        |  |           |   |        |     |
|-------|--|--------|--|-----------|---|--------|-----|
| City: |  | State: |  | Zip Code: | - | Phone: | - - |
|-------|--|--------|--|-----------|---|--------|-----|

### 4. Daily routine (describe recipient's usual daily routine)

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**5. Assessment information**

|   |   |   |
|---|---|---|
| Purpose of request:<br><input type="checkbox"/> Initial<br><input type="checkbox"/> Annual Reassessment<br><input type="checkbox"/> Significant Change in Condition | Location:<br><input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Telephonic<br><input type="checkbox"/> Mobile Home <input type="checkbox"/> Facility<br><input type="checkbox"/> SLA (Supportive Living arrangement)<br><input type="checkbox"/> Other: | Information obtained from:<br><input type="checkbox"/> Recipient<br><input type="checkbox"/> Other: |
|---|---|---|

|  |  |
|--|--|
| Name of personal care services (PCS) agency: |  |
|--|--|

|                                   |  |
|-----------------------------------|--|
| Name of personal care aide (PCA): |  |
|-----------------------------------|--|

|  |  |
|--|--|
| Others in household (If children, include ages of children): |  |
|--|--|

|   |  |
|---|--|
| Allergies (medications, foods, seasonal): |  |
|---|--|

**6. Diagnosis affecting functional ability to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs). For example: affected limbs, affected gait, strength, endurance, sensory deficits, etc.**

| Diagnosis | Diagnosis | Diagnosis |
|-----------|-----------|-----------|
|           |           |           |
|           |           |           |
|           |           |           |
|           |           |           |

**7. Medications**

| Medication/dosage/frequency | Medication/dosage/frequency |
|-----------------------------|-----------------------------|
|                             |                             |
|                             |                             |
|                             |                             |
|                             |                             |
|                             |                             |
|                             |                             |

**8. Objective observations of functional ability including serious events over the past year**

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**9. Functional deficits (check all that apply)**

**Mobility**

Mobility/Range of motion:

|                |  |  |   |
|----------------|--|--|---|
| Gait:          | <input type="checkbox"/> Independent         | <input type="checkbox"/> Independent with Device | <input type="checkbox"/> Mildly impaired  |
|                | <input type="checkbox"/> Moderately impaired | <input type="checkbox"/> Severely impaired       | <input type="checkbox"/> Non-ambulatory   |
|                | <input type="checkbox"/> Bed bound           | <input type="checkbox"/> Other/Comment:          |   |
| Dominate Side: | <input type="checkbox"/> Right               | <input type="checkbox"/> Left                    | <input type="checkbox"/> N/A  |
| Right Arm:     | <input type="checkbox"/> Full Use            | <input type="checkbox"/> Mildly impaired         | <input type="checkbox"/> Moderately impaired <input type="checkbox"/> Severely impaired |
|                | <input type="checkbox"/> Other/Comment:      |  |   |
| Left Arm:      | <input type="checkbox"/> Full Use            | <input type="checkbox"/> Mildly impaired         | <input type="checkbox"/> Moderately impaired <input type="checkbox"/> Severely impaired |
|                | <input type="checkbox"/> Other/Comment:      |  |   |
| Right Leg:     | <input type="checkbox"/> Full Use            | <input type="checkbox"/> Mildly impaired         | <input type="checkbox"/> Moderately impaired <input type="checkbox"/> Severely impaired |
|                | <input type="checkbox"/> Other/Comment:      |  |   |
| Left Leg:      | <input type="checkbox"/> Full Use            | <input type="checkbox"/> Mildly impaired         | <input type="checkbox"/> Moderately impaired <input type="checkbox"/> Severely impaired |
|                | <input type="checkbox"/> Other/Comment:      |  |   |

**10. Sensory deficits (check all that apply) (continued to next page)**

Vision:

Within normal limits without glasses

Within normal limits with glasses

Glasses:  Reading Glassess

Vision Impaired:

|                                     |   |                                |   |
|-------------------------------------|---|--------------------------------|---|
| <input type="checkbox"/> Right Eye: | <input type="checkbox"/> Partially impaired | <input type="checkbox"/> Blind | <input type="checkbox"/> Other/Comment: |
| <input type="checkbox"/> Left Eye:  | <input type="checkbox"/> Partially impaired | <input type="checkbox"/> Blind | <input type="checkbox"/> Other/Comment: |
| <input type="checkbox"/> Both Eyes: | <input type="checkbox"/> Partially impaired | <input type="checkbox"/> Blind | <input type="checkbox"/> Other/Comment: |

Auditory:

Within normal limits with or without hearing aids

Decreased hearing:  Hearing aids  Deaf

Other/Comment:

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### 10. Sensory deficits (check all that apply) (continued from previous page)

Pain (affecting ability to do ADLs/IADLs):

Pain scale 0 to 10: \_\_\_\_\_

if > 0 indicate location/type of pain: \_\_\_\_\_

Other/Comment: \_\_\_\_\_

Touch/Sensation:

Within normal limits    Other/Comment: \_\_\_\_\_

### 11. Cognitive deficits (check all that apply)

Memory/Cognitive:

Within normal limits                       Not oriented

Oriented to:

Person     Place     Time     Other/comment: \_\_\_\_\_

Short term memory loss:     Mild     Moderate     Severe     Other/Comment: \_\_\_\_\_

Object Recognition:     Mild     Moderate     Severe     Other/Comme \_\_\_\_\_

Requires cueing:

Able to follow detailed directions                       Able to follow simple directions

Unable to follow simple directions

Other cognitive impairment/Comment: \_\_\_\_\_

Speech/Language:

Within normal limits (able to express and understand)     Slurred speech     Non verbal

Aphasia:

Expressive (difficulty expressing words/sentences)

Receptive (difficulty understanding words/sentences)

Global (difficulty expressing and understanding words/sentences)

Other/Comment: \_\_\_\_\_

### 12. Endurance deficits - the ability to withstand activities (check all that apply)

Within normal limits                       Shortness of breath                       Inability to stand > 10 minutes

Fatigues with activity of > 10 minutes                       Other(describe): \_\_\_\_\_

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| 13. Activities of daily living   |  |               |       |
|--|--|---------------|-------|
| Level of Assistance<br>(See instructions for detail)   |  | Days per week | Score |
| Bathing/Dressing/Grooming:<br>0 = Independent                      1 = Minimum assist<br>2 = Moderate assist                  3 = Maximum assist<br><br>Comments to justify score:   |  |               |       |
| Toileting:<br>0 = Independent                      1 = Minimum assist<br>2 = Moderate assist                  3 = Maximum assist<br><br>Comments to justify score:   |  |               |       |
| Transferring:<br>0 = Independent                      1 = Minimum assist<br>2 = Moderate assist                  3 = Maximum assist<br>NOTE: Does not include sitting to standing in ambulatory patients.<br>Comments to justify score:                  |  |               |       |
| Mobility/Ambulation:<br>0 = Independent                      1 = Minimum assist<br>2 = Moderate assist                  3 = Maximum assist<br>4 = Independent in wheelchair<br><br>Comments to justify score:  |  |               |       |
| Eating:<br>0 = Independent                      1 = Minimum assist<br>2 = Moderate assist                  3 = Maximum assist<br>0 = Non-covered services such as specialized feeding techniques and/or tube feedings.<br><br>Comments to justify score: |  |               |       |

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### 14. Instrumental activities of daily living

Recipient must have deficits that preclude them from actively shopping, doing their laundry, completing light housekeeping tasks, or preparing meals and there is not a willing and capable caregiver available. Indicate if the recipient is functionally independent with IADLs or meets criteria as described below.

To qualify for IADLs, the recipient must score a minimum of a Level 2 in two or more areas of ADLs.

Check boxes that apply:

- Recipient does not have a Level 2 in two or more ADL areas (from Section 13 above). = No IADLs
- Recipient is functionally independent in IADLs with or without modifications = No IADLs
- Legally responsible individual is capable/available to complete IADLs = No IADLs
- Recipient has other resources to complete IADLs. Identify: \_\_\_\_\_ = No IADLs

**NOTE:** If any one of the above four boxes are checked, **STOP** here. The assessment is complete. If none are checked, proceed.

- PCA to assist or complete IADLs as the recipient has an ADL need in two or more areas at a level 2 or higher and impairments in one of the following that directly impact their ability to perform IADLs:
  - Mobility deficits
  - Cognitive deficits
  - Endurance deficits
  - Sensory deficits

In the table below, check specific tasks that the recipient requires assistance with to complete and score as indicated.

| Level of Assistance<br>(See instructions for detail)   | Days per week | Score |
|--|---------------|-------|
| Light housekeeping:<br>0 = Criteria not met    1 = Level 1 criteria    2 = Level 2 criteria<br>3 = Level 3 criteria    4 = NA<br>Comments to justify score:  | Weekly        |       |
| Laundry:<br>0 = Criteria not met    1 = Level 1 criteria    2 = Level 2 criteria<br>3 = Level 3 criteria    4 = Level 4 criteria    5 = NA<br>Comments to justify score:                                       | Weekly        |       |
| Essential shopping:<br>0 = Criteria not met    1 = Level 1 criteria    2 = Level 2 criteria<br>3 = Level 3 criteria    4 = NA<br>Comments to justify score:  | Weekly        |       |
| Meal preparation:<br>0 = Criteria not met    1 = Level 1 criteria    2 = Level 2 criteria<br>3 = Level 3 criteria    4 = Level 4 criteria    5 = N/A<br>6 = Non-covered services<br>Comments to justify score: |               |       |

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**Section 15:**

**NOTE:** After values have been made in the 'Days per week' and 'Score' fields in the preceding tables, double-click the embedded Excel spreadsheet below. Enter those values into the appropriate cells of this spreadsheet. Calculations will be automatic after entry. After all values have been entered, click outside of the spreadsheet to close it.

| Task                      | Score | Score = Minutes per day or week | Days per week | Total minutes per task | Hours per week |
|---------------------------|-------|---------------------------------|---------------|------------------------|----------------|
| Bathing/Dressing/Grooming | 0     | 0                               | 0             | 0                      |                |
| Toileting                 | 0     | 0                               | 0             | 0                      |                |
| Transferring              | 0     | 0                               | 0             | 0                      |                |
| Mobility/Ambulation       | 0     | 0                               | 0             | 0                      |                |
| Eating                    | 0     | 0                               | 0             | 0                      |                |
| Light housekeeping        | 0     | 0                               | 1             | 0                      |                |
| Laundry                   | 0     | 0                               | 1             | 0                      |                |
| Essential shopping        | 0     | 0                               | 1             | 0                      |                |
| Meal preparation          | 0     | 0                               | 0             | 0                      |                |
| <b>Total Points</b>       |       |                                 |               | 0                      | 0              |

Based on my clinical assessment utilizing the Nevada Medicaid Personal Care Services Policy 3500 and the Nevada Medicaid Functional Assessment Service Plan Tool, I find the recipient met the criteria for the above hours as indicated on this tool, and that no additional hours are medically necessary.  YES  NO

If yes, populate chart 17. If no, use chart 16 to indicate the additional time that is medically necessary. Do not exceed the maximum in any individual category. Additional time cannot be an exception to Medicaid policy. Justify the additional time you have determined based on your objective clinical observations;

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| 16.. Task                 | Time from Above | Additional Time to be allowed | New Total Hours | Days per week | Total minutes per task | Hours per week |
|---------------------------|-----------------|-------------------------------|-----------------|---------------|------------------------|----------------|
| Bathing/Dressing/Grooming | 45              | 15                            | 60              | 7             | 420                    |                |
| Toileting                 | 15              | 15                            | 30              | 7             | 210                    |                |
| Transferring              | 15              | 15                            | 30              | 7             | 210                    |                |
| Mobility/Ambulation       | 5               | 10                            | 15              | 7             | 105                    |                |
| Eating                    | 15              | 30                            | 45              | 7             | 315                    |                |
| Light housekeeping        | 30              | 30                            | 60              | 1             | 60                     |                |
| Laundry                   | 15              | 15                            | 30              | 1             | 30                     |                |
| Essential shopping        | 15              | 15                            | 30              | 1             | 30                     |                |
| Meal preparation          | 15              | 30                            | 45              | 7             | 315                    |                |
| <b>Total Points</b>       |                 |                               |                 |               | 1695                   | 28.25          |

Recipient Name: \_\_\_\_\_ ,

Recipient ID: \_\_\_\_\_

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Grid 17

| FINAL AUTHORIZATION         |  |
|-----------------------------|--|
| <b>Total Hours Per Week</b> |  |
| <b>Total Days Per Week</b>  |  |
| <b>Visits per Day</b>       | <input type="checkbox"/> 1 or more <input type="checkbox"/> 2 or more <input type="checkbox"/> 3 or more |

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\_\_\_\_\_  
Signature PT/OT

\_\_\_\_\_  
Date

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**17. Assistive devices and other services (check all that apply)**

| Equipment: H=Has U=Uses N=Needs |                            |                            |                      |                            |                            | Services: R=Receives N=Needs |               |                            |                            |  |                            |                                    |
|---------------------------------|----------------------------|----------------------------|----------------------|----------------------------|----------------------------|------------------------------|---------------|----------------------------|----------------------------|--|----------------------------|------------------------------------|
| <input type="checkbox"/> H      | <input type="checkbox"/> U | <input type="checkbox"/> N |                      | <input type="checkbox"/> H | <input type="checkbox"/> U | <input type="checkbox"/> N   |               | <input type="checkbox"/> R | <input type="checkbox"/> N |  | <input type="checkbox"/> R | <input type="checkbox"/> N         |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Lift/Hoyer           | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>     | Slide Board   | <input type="checkbox"/>   | <input type="checkbox"/>   | ADSD aging and disability services       |                            |                                    |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Commode              | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>     | Power Chair   | <input type="checkbox"/>   | <input type="checkbox"/>   | Disability waiver (WIN)                  |                            |                                    |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Bath/Shower Bench    |                            |                            |                              |               | <input type="checkbox"/>   | <input type="checkbox"/>   | Dental                                   | <input type="checkbox"/>   | <input type="checkbox"/> Medical   |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Manual Chair         |                            |                            |                              |               | <input type="checkbox"/>   | <input type="checkbox"/>   | Ocular                                   | <input type="checkbox"/>   | <input type="checkbox"/> Audiology |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Incontinent Supplies |                            |                            |                              |               | <input type="checkbox"/>   | <input type="checkbox"/>   | Physical Therapy                         |                            |                                    |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Raised Toilet Seat   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>     | Walker        | <input type="checkbox"/>   | <input type="checkbox"/>   | Occupational Therapy                     |                            |                                    |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Lifeline             | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>     | Cane Crutches | <input type="checkbox"/>   | <input type="checkbox"/>   | Home Health                              | <input type="checkbox"/>   | <input type="checkbox"/> Hospice   |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Hospital Bed         | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>     | Hoyer Lift    | <input type="checkbox"/>   | <input type="checkbox"/>   | MHDS                                     | <input type="checkbox"/>   | <input type="checkbox"/> ADHC      |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Oxygen               |                            |                            |                              |               | <input type="checkbox"/>   | <input type="checkbox"/>   | Companion                                | <input type="checkbox"/>   | <input type="checkbox"/> Respite   |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Diabetic Supplies    |                            |                            |                              |               | <input type="checkbox"/>   | <input type="checkbox"/>   | Homemaker                                |                            |                                    |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Glucometer           |                            |                            |                              |               | <input type="checkbox"/>   | <input type="checkbox"/>   | Transportation                           |                            |                                    |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Hand Held Shower     |                            |                            |                              |               | <input type="checkbox"/>   | <input type="checkbox"/>   | Home Delivered Meals                     | <input type="checkbox"/>   | <input type="checkbox"/> Chore     |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Nebulizer            |                            |                            |                              |               | <input type="checkbox"/>   | <input type="checkbox"/>   | Other                                    |                            |                                    |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Other:               |                            |                            |                              |               | <input type="checkbox"/>   | <input type="checkbox"/>   | Other                                    |                            |                                    |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Other:               |                            |                            |                              |               | <input type="checkbox"/>   | <input type="checkbox"/>   | ADHC                                     |                            |                                    |
| <input type="checkbox"/>        | <input type="checkbox"/>   | <input type="checkbox"/>   | Other                |                            |                            |                              |               |                            |                            | Attends__ days per week __ hours per day |                            |                                    |
|                                 |                            |                            |                      |                            |                            |                              |               | <input type="checkbox"/>   | <input type="checkbox"/>   | Work Program                             |                            |                                    |
|                                 |                            |                            |                      |                            |                            |                              |               |                            |                            | Attends__ days per week __ hours per day |                            |                                    |
|                                 |                            |                            |                      |                            |                            |                              |               | <input type="checkbox"/>   | <input type="checkbox"/>   | School                                   |                            |                                    |
|                                 |                            |                            |                      |                            |                            |                              |               |                            |                            | Attends__ days per week __ hours per day |                            |                                    |

Comments: \_\_\_\_\_

16. Sign and date here after the assessment has been completed:  
 Assessor's signature/title \_\_\_\_\_ Date / / \_\_\_\_\_

19. Quality Improvement Organization (QIO) like vendor use only:  
 Math Verified       Policy Verified      Total Authorized weekly Hour \_\_\_\_  
 QIO Signature: \_\_\_\_\_ Date / / \_\_\_\_\_