Medicaid Home and Community-Based Services Waiver Program
Participant Assessment (use only for people at home)

Participant Name: _____

GENERAL HEALTH
Temperature: _____ *Pulse*:_____ *Respiration*: _____ *Blood Pressure:* _____
Current Weight: _____ ☐gain ☐ loss *Target weight*: _____
Diet/Nutrition: ☐Regular ☐Low Salt ☐Puree/Chopped ☐Diabetic/No Concentrated Sweets ☐Other_____
Fluid: ☐Unlimited ☐ Restricted ☐ Amount: _____
Identify any changes over past month:
☐Diagnosis ☐Medications ☐Health Status ☐Hospitalization ☐Falls ☐ Incidents ☐ Other
Describe change:_____
_____

RESPIRATORY
☐ Within Normal Limits
☐ Cough ☐Wheezing ☐ Other: _____
When is the person noticeably short of breath?
☐Never short of breath
☐When walking > than 20 ft. or climbing stairs
☐With moderate exertion (e.g. dressing, using commode, walking <20ft.)
☐With minimal exertion (eating, talking)
☐At rest (during day/ night)
Respiratory treatments utilized at home:
☐ Oxygen (intermittent or continuous)
☐ Aerosol or nebulizer treatments
☐ Ventilator (intermittent or continuous)
☐ CPAP or BIPAP
☐ None

PAIN/DISCOMFORT
Pain frequency:
☐No pain or pain does not interfere with movement
☐Less often than daily
☐Daily, but not constant
☐All the time
Site(s): _____
Intensity ☐High ☐ Medium ☐Low
☐ Person is experiencing pain that is not easily relieved, occurs at least daily, and effects the ability to sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity
Cause (if known):_____
*Treatment:*_____

GENITOURINARY STATUS
☐Catheter ☐ Content _____
☐ Urine Frequency _____
☐Pain/Burning ☐ Discharge
☐ Distention/Retention
☐Hesitancy ☐ Hematuria
☐ Other: _____
☐Person has been treated for a Urinary Tract Infection over the past month
☐ Normal

CARDIOVASCULAR
☐ BP and Pulse within normal limits
Rhythm ☐ Regular ☐ Irregular
Edema:
RUE: ☐ Non-pitting ☐ Pitting
LUE: ☐ Non-pitting ☐ Pitting
RLE: ☐ Non-pitting ☐ Pitting
LLE: ☐ Non-pitting ☐ Pitting
*Other:*_____

GASTROINTESTINAL STATUS
Bowels: frequency _____
☐Diarrhea ☐Constipation ☐Nausea ☐ Vomiting
☐ Swallowing issues: _____
☐ Pain:_____ ☐abdominal ☐ epigastric
☐ Anorexia
☐ Other: _____
Bowel incontinence frequency:
☐ Very rarely or never incontinent of bowel
☐ Less than once per week
☐ One to three times per week
☐ Four to six times per week
☐ On a daily basis
☐ More than once daily
☐ Person has ostomy for bowel elimination

NEUROLOGICAL
Cognitive functioning
☐ Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently
☐ Requires prompting (cueing, repetition, reminders)only under stressful or unfamiliar situations
☐ Requires assistance, direction in specific situation, requires low stimulus environment due to distractibility
☐ Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall more than half the time.
☐ Totally dependent due to coma or delirium
Speech: ☐ Clear and understandable ☐ Slurred ☐ Garbled ☐Aphasic ☐ Unable to speak
Pupils: ☐ Equal ☐ Unequal
Movements: ☐Coordinated ☐ Uncoordinated
Extremities:
Right upper ☐ Strong ☐ Weak ☐Tremors ☐No movement
Left upper ☐ Strong ☐ Weak ☐Tremors ☐No movement
Right lower ☐ Strong ☐ Weak ☐Tremors ☐No movement
Left lower ☐ Strong ☐ Weak ☐Tremors ☐No movement

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SENSORY

Vision with corrective lenses if applicable

☐ Normal vision in most situations; can see medication labels, newsprint

☐ Partially impaired; can't see medication labels, but can see objects in path; can count fingers at arms length

☐ Severely impaired; cannot locate objects without hearing or touching or person non-responsive

Hearing with corrective device if applicable

☐ Normal hearing in most situations, can hear normal conversational tone

☐ Partially impaired; can't hear normal conversational tone

☐ Severely impaired; cannot hear even with an elevated tone

PSYCHOSOCIAL

Behaviors reported or observed

☐ Indecisiveness
☐ Diminished interest in most activities
☐ Sleep disturbances
☐ Recent change in appetite or weight
☐ Agitation
☐ A suicide attempt
☐ None of the above behaviors observed or reported

Is this person receiving psychological counseling?

☐ Yes
☐ No

MUSCULOSKELETAL

☐ Within Normal limits
☐ Unsteady Gait
☐ Poor endurance
☐ Altered Balance
☐ Weakness
☐ Other
☐ Deformity
☐ Contracture
☐ Impaired ROM
☐ Poor coordination

MENTAL HEALTH

☐ Angry ☐ Depressed ☐ Uncooperative ☐ Hostile
☐ Panic ☐ Flat affect ☐ Anxious ☐ Phobia
☐ Agitated ☐ Paranoid ☐ Obsessive/Compulsive
☐ Tics Spasms ☐ Mood swings
☐ Depressive feeling reported or observed
☐ None of above

SKIN

Color ☐ Normal ☐ Pale ☐ Red ☐ Irritation ☐ Rash

Skin Intact ☐ Yes ☐ No (if no, complete next section)

Pressure Ulcer Stages	Number of Pressure Ulcers				
Stage 1: Redness of intact skin; warmth, edema, hardness, or discolored skin may be indicators	0	1	2	3	4 or more
Stage 2: Partial thickness skin loss of epidermis and/or dermis. The ulcer is superficial and appears as an abrasion, blister, or shallow crater.					
Stage 3: Full thickness skin loss; damage or necrosis of subcutaneous tissue; deep crater					
Stage 4: Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures					
Location of ulcers:					

Surgical or other types of wounds (describe location, size and nature of wound) _____

_____

_____

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Mobility and Transfers:
☐ Dependent ☐Independent ☐ Assist ☐ Stand-by
☐One person ☐ Two person assist with transfer
Uses _____ to aid in ambulating.
Uses_____ to aid in transfer.

Bathing:
☐Dependent ☐Independent ☐ Assist ☐ Cue
☐Uses transfer bench or shower chair

Personal Hygiene: hair, nails, skin, oral care
☐Dependent ☐Independent ☐ Assist ☐ Cue

Toileting: bladder, bowel routine, ability to access toilet
☐Dependent ☐Independent ☐ Assist ☐ Cue
☐Incontinent bowel
☐Incontinent bladder

Dressing:
☐Dependent ☐Independent ☐ Assist ☐ Cue

Eating and Drinking:
☐Dependent ☐Independent ☐ Assist ☐ Cue

HEALTH MAINTENANCE NEEDS
☐Reinforce diet education
☐Supervision of blood sugar monitoring
☐Routine care of prosthetic/orthotic device
☐Education on medical equipment use or maintenance
☐Referral to physician
☐Other health education needed
☐Other_____
Notes:_____

GENERAL PHYSICAL CONDITION
☐improving ☐stable ☐deteriorating
☐ Other: _____

MEDICATION MANAGEMENT
Current Medications (attach additional pages if necessary)

Medication	Dose	Freq.	Physician	Purpose

☐Able to independently take the correct medications at the correct times
☐Able to take medications at the correct time if:
-individual doses are prepared in advance by another person
-given daily reminders
☐Unable to take medication unless administered by someone else
☐No medications prescribed
☐Other_____

NOTES:

Nurse Monitor visit: ☐**initial** ☐**monthly** ☐ **45 day** ☐ **3 month** ☐**4 month** ☐**annual assessment**

Activities of Visit: ☐Developed Caregiver Support Plan ☐ Provided Information and Training to Caregiver
☐ Reviewed Caregiver Support Plan ☐ Assessed/Monitored Caregiver
☐ Assessed/Monitored Participant

Caregiver Names (Please list all caregivers in this section)

By signing below, both the participant and nurse certify that services were delivered.

RN Name (Print):

RN Signature: Date:

Please send the white copy of the signed form to the case manager within 10 days of completing the participant's assessment.

Participant Signature: Date

Immediately report suspected abuse, neglect, and exploitation to Adult Protective Services at 1-800-917-7383.
Immediately contact the case manager to report health and safety concerns.

Medicaid Home and Community-Based Services Waiver Programs
Caregiver Assessment

Participant Name:_____ **Service Date:** _____

Nurse Monitor - Use the Caregiver Assessment (CA) to observe and evaluate the caregiver's ability to correctly perform Caregiver Service Plan (CSP) tasks. Complete a CA during each visit. If multiple caregivers are used, assess each caregiver according to program requirements. Write "yes" or "no" in the box next to each task observed during the visit. Give detailed information on concerns, findings, or training in the comment section. Attach additional pages as needed. Immediately contact the case manager to report health and safety concerns or recommend Caregiver Service Plan or Plan of Care/Service changes. Immediately report abuse, neglect or exploitation to Adult Protective Services 1-800-917-7383.

	Task	Observed (Yes/No)	Comment
Activities of Daily Living	Bathing		
	Personal Hygiene (i.e. hair, oral, nail, and skin care)		
	Toileting (i.e. bladder, bowel, bed pan routines, etc.)		
	Dressing & Changing Clothes		
	Mobility & Transfers		
	Eating & Drinking		
	Medications (**Review MAR** - Medication Admin. Report)		
	Task	**Observed (Yes/No)**	**Comment**
Instrumental Activities	Meal Preparation		
	Light Housekeeping		
	Grocery Shopping		
	Transportation/Traveling in the Community		
	Laundry		
	Handling Money		
	Using the Telephone		
	Reading of Specific Items		
	Wash Equipment		
	Other		

Nurse Name:	Signature:	Date:
Caregiver Name:	Signature:	Date: