PreAdmission Screening Tool

Elderly/Physically Disabled

Case Information			
AHCCCS ID		Medicare Part D	☐ Yes ☐ No
Person/App ID:			
Type of PAS	☐ Initial ☐ Reassessment ☐ Posthumous		
PSE Name			
PSE Phone			

I. Intake Information

Customer Information			
PAS Date		PAS Time	
Customer Name:			
Age			
Birthdate			
Gender	☐ Male ☐ Female		
Location at time of Assessment			
Telephone Number			

DD Status:	☐ Not DD ☐ Potential DD ☐ DD in NF ☐ DD

Prior Quarter:	Month 1:		Month 2:		Month 3:	

Authorized Representative	
Name	
Telephone Number	

Physical Measurements	
Height	Feet Inches
Weight	lbs.
Birth Weight (DD 0-5)	lbs.
Gestational Age (DD 0-5)	

Additional Information			
1.	Is customer currently hospitalized or in an intensive rehabilitation facility?	☐ YES	☐ NO
2.	If in an acute care facility, is discharge imminent (within 5 calendar days)?	☐ YES	☐ NO

Customer Name Person ID

	Projected discharge date:		
3.	Ventilator Dependent?	☐ YES	☐ NO
	Name and Model of Ventilator		
	Number of hours per day customer is on ventilator		
	Settings: Rate		
	Settings: Tidal Volume		
	Settings: Oxygen Concentration		
	Number of continuous days that customer has been on a ventilator at least 6 hours per day (or more):		
4.	**Number of Emergency Room visits in last 6 months**		
	Date for each:	Reason:	
5.	**Number of Hospitalizations in last 6 months**		
	Dates for each: Admission Discharge	Reasons:	
	Admission Discharge		
	Admission Discharge		
6.	**Number of Falls in last 90 days**		
	Describe approximate date, cause, and location of each:	Describe any injuries (how many, location, and what treatment was provided):	

Personal Contacts					
Contact #1					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #2					

Customer Name

Person ID

Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #3					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #4					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					

Customer Name

Person ID

II. FUNCTIONAL ASSESSMENT

A. ACTIVITIES OF DAILY LIVING (ADLs)

Select the box next to the appropriate number. Consider the last 30 days.

'Supervision' - observing the customer and being readily available to provide assistance, including verbal cues or reminders and set-up activities.

'Limited/Occasional' – A portion of an entire task or assistance required less than daily.

'Physical Participation' – The customer's active participation, not just being passive or cooperative. The ability to complete a small portion of the task.

MOBILITY

The extent of the individual's purposeful movement within residence. Score based on functionality achieved with assistive device(s), if used. Report specific assistance required.

☐ 0	INDEPENDENT – Customer is independent in completing activity safely
☐ 1	SUPERVISION/LIMITED OR OCCASIONAL HANDS-ON – Customer is mobile within the residence, but may need cueing, set-up or standby assistance OR limited/occasional hands-on assistance
☐ 2	HANDS-ON – Customer is mobile only with hands-on assistance for safety
☐ 3	TOTAL DEPENDENCE – Customer is dependent on others for all mobility

Comments:	

TRANSFERRING

Degree of human assistance necessary on a consistent basis for transfer, such as: assistance getting into wheelchair and into/out of bed – excluding transfer to toilet, bath or shower. Score based on functionality achieved with assistive device(s), if used. Report specific assistance required.

☐ 0	INDEPENDENT – Customer is independent in completing activity safely, but may require the use of assistive devices
☐ 1	SUPERVISION/LIMITED OR OCCASIONAL HANDS-ON – Customer transfers with supervision, physical guidance or set-up, OR with limited/occasional hands-on assistance
☐ 2	HANDS-ON – Customer needs to be physically lifted or moved, but can participate physically
☐ 3	TOTAL DEPENDENCE – Customer must be totally transferred by one or more persons, OR is bedfast

Comments:	

Customer Name

Person ID

BATHING

The ability to transfer to shower or bath, and to bathe or take sponge baths for the purpose of maintaining adequate hygiene and skin integrity. Score based on functionality achieved with assistive device(s), if used. Report specific assistance required.

☐ 0	INDEPENDENT – Customer is independent in completing activity safely
☐ 1	SUPERVISION/LIMITED OR OCCASIONAL HANDS-ON – Customer requires setup help or reminding – can bathe safely without continuous assistance or supervision OR requires limited/occasional hands-on assistance (e.g., washing back or a paralyzed limb)
☐ 2	HANDS-ON – Customer may need assistance transferring and may not be able to get into and out of the tub alone OR requires moderate hands-on help OR requires stand-by assistance throughout bathing activities in order to maintain safety
☐ 3	TOTAL DEPENDENCE – Customer is dependent on others to provide a complete bath

Comments:	

DRESSING

The ability to dress and undress as necessary – includes ability to put on prostheses, braces, anti-embolism hose or other assistive devices and includes fine motor coordination for buttons and zippers, choice of appropriate clothing for the weather (Note – difficulties with a zipper or buttons at the back of a dress or blouse does not constitute a functional deficit; score based on functionality achieved with assistive device(s), if used). Report specific assistance required.

☐ 0	INDEPENDENT– Customer is independent in completing activity safely in less than 30 minutes
☐ 1	SUPERVISION/LIMITED OR OCCASIONAL HANDS-ON – Customer can dress and undress, with or without assistive devices, but needs to be reminded, supervised or given setup assistance, OR needs limited or occasional hands-on assistance (e.g., putting on socks only or tying shoes) OR needs more than 30 minutes to complete independently due to medical/functional limitation(s)
☐ 2	HANDS-ON – Customer needs physical assistance or significant verbal assistance to complete dressing or undressing
☐ 3	TOTAL DEPENDENCE – Customer is totally dependent on others for dressing and undressing

Comments:	

GROOMING

How well does the customer manage with grooming activities, including: combing hair, shaving, oral care (excluding nail care)? Score based on functionality achieved with assistive device(s), if used. Report specific assistance required.

☐ 0	INDEPENDENT– Customer can groom without assistance from another person [may use mechanical aids independently]

Customer Name | Person ID

☐ 1	SUPERVISION/LIMITED OR OCCASIONAL HANDS-ON – Customer needs supervision or reminding (e.g., setting up grooming implements, giving advice or being available) or needs limited/occasional hands on assistance (e.g., shaving or brushing hair only; assistance with all tasks less than daily)
☐ 2	HANDS-ON – Customer needs hands-on physical assistance, but can participate physically
☐ 3	TOTAL DEPENDENCE – Customer must be totally groomed by another person

Comments:	.

EATING

Ability to eat and drink, with or without adaptive utensils; also includes ability to cut, chew and swallow foods [Note – if a person is fed via tube feedings or intravenously, check "0" if the person administers the feeding independently, or "1", "2", or "3" if another person is required to assist] Score based on functionality achieved with assistive device(s), if used. Report specific assistance required.

☐ 0	INDEPENDENT– Customer is independent in completing activity safely
☐ 1	SUPERVISION – Customer can feed self, chew and swallow foods, but may need reminding to maintain adequate intake; may need set-up including alteration of food (e.g. cutting, pureeing).
☐ 2	HANDS-ON – Customer can feed self, but needs stand-by assistance for frequent gagging, choking, swallowing difficulty, or aspiration OR must be fed some food by mouth by another person
☐ 3	TOTAL DEPENDENCE – Customer must be totally fed by another person; must be fed by another person by stomach tube or venous access

Comments:	

TOILETING

Ability to use the toilet, commode, bedpan or urinal; includes: transferring on/off toilet, flushing, cleansing of self, changing of protective garment, managing an ostomy or catheter and adjusting clothing. Score based on functionality achieved with assistive device(s), if used.

☐ 0	INDEPENDENT– Customer is independent in completing activity safely [includes with assistive device]
☐ 1	SUPERVISION/LIMITED OR OCCASIONAL HANDS-ON – Customer may need supervision, cueing or limited/occasional hands-on assistance with parts of the task, such as: clothing adjustment, changing protective garment, washing hands, limited/occasional wiping and cleansing; emptying bedpan/urinal
☐ 2	HANDS-ON – Customer needs hands-on physical assistance or stand-by [for safety] with toileting OR is unable to keep self clean
☐ 3	TOTAL DEPENDENCE – Customer is totally dependent on others for the entire toileting process [may include total care of catheter or ostomy]; customer may or may not be aware of the situation

Customer Name

Person ID

Comments:	

Customer Name

Person ID

B. CONTINENCE – Select the box next to the appropriate number.

BOWEL CONTINENCE

The ability to voluntarily control the discharge of body waste from the bowel.
Consider last 30 days.

☐	0	Continent. Complete voluntary control
☐	1	Incontinent episodes less than weekly
☐	2	Incontinent episodes once a week
☐	3	Incontinent episodes 2 or more times a week and/or no voluntary control

Comments:	

BLADDER CONTINENCE

The ability to voluntarily control the discharge of body waste from the bladder.
Consider last 30 days.

☐	0	Continent. Complete voluntary control or minimal stress incontinence/dribbling
☐	1	Usually Continent. Incontinent episodes less than weekly
☐	2	Occasionally Incontinent. Incontinent episodes one or more times per week, but not daily
☐	3	Frequently or Totally Incontinent. Incontinent daily and/or no voluntary control

Comments:	

Customer Name

Person ID

C. DETERIORATION IN OVERALL FUNCTION
(ADLs & Continence) (Consider last 90 days). Enter comment to explain change.

☐ 0	No deterioration
☐ 1	Deteriorated
☐ 2	Unable to determine

Comments:	

Customer Name

Person ID

D. COMMUNICATION/SENSORY
Select the box next to the appropriate number. (Consider last 30 days).

HEARING

The ability to perceive sounds. (With hearing aid, if used.)

☐	0	Hears adequately (e.g., conversations, TV, phone) / Unable to assess
☐	1	Minimal difficulty when not in quiet setting (understands conversations when in one-on-one situations)
☐	2	Hears in special situations only (e.g., speaker has to increase volume, adjust tonal quality and speak distinctly or when speaker's face is clearly visible); able to follow only loud conversation
☐	3	Highly impaired/absence of useful hearing (e.g., will hear only very loud voice; totally deaf)

Comments:	

EXPRESSIVE COMMUNICATION

The ability to express information and make self understood using any means.

☐	0	Understood/Unable to assess
☐	1	Usually Understood (e.g., difficulty finding words, finishing thoughts, or enunciating)
☐	2	Sometimes Understood - ability is limited to making concrete requests
☐	3	Rarely/Never Understood

Comments:	

VISION

The ability to perceive visual stimuli. (With corrective devices, if used.)

☐	0	Sees adequately (e.g., newsprint, TV, medication labels) /Unable to assess
☐	1	Impaired. Difficulty with focus at close (reading) range. Sees large print and obstacles, but not details or has monocular vision
☐	2	Highly impaired. Very poor focus at close range (e.g., unable to see large print); field of vision is severely limited (e.g., tunnel vision or central vision loss)
☐	3	Severe impairment. No vision or appears to see only light, colors or shapes

Comments:	

E. UNDERLYING CAUSES

Select all items that contribute to limitations in functional ability.

Physical Impairments	Physical Impairments (cont.)	Supervision Need/Mental Health
☐ None	☐ Muscle Tone	☐ None
☐ Amputation	☐ Neurological Impairment	☐ Behavior Issues
☐ Balance Problems	☐ Obesity	☐ Cognitive Impairment
☐ Bladder Incontinence	☐ Oxygen Use	☐ History of Falls
☐ Bowel Incontinence	☐ Pain	☐ Lack of Awareness
☐ Decreased Endurance	☐ Paralysis	☐ Lack of Motivation/Apathy
☐ Fine or Gross Motor Impairment	☐ Sensory Impairment	☐ Memory Impairment
☐ Fractures	☐ Shortness of Breath	
☐ Limited Range of Motion	☐ Swallowing Problems	
	☐ Weakness	

Comments:	

Customer Name

Person ID

F. ASSISTIVE DEVICES

Select all assistive devices currently used. If customer requires but does not have device, list it in comments.

☐ None	☐ Geri Chair	☐ Shower Chair
☐ Commode – bedside	☐ Grab Bars/Side Rails	☐ Walker – not wheeled
☐ Commode – high rise seat	☐ Hospital Bed	☐ Walker – wheeled
☐ Cane -- standard	☐ Leg Brace	☐ Walker w/seat (trough)
☐ Cane – quad	☐ Motorized Scooter	☐ Wheelchair – standard
☐ Crutches	☐ Overhead Trapeze	☐ Wheelchair – motorized

Comments:	

Customer Name

Person ID

III. EMOTIONAL AND COGNITIVE FUNCTIONING

A. ORIENTATION

Consider last 90 days.

Orientation is defined as the applicant's awareness of his/her environment in relation to self, place and time.

☐ No Caregiver
Indicate No Caregiver if unable to locate or contact any caregiver, family member or person aware of the level of orientation for customer.

PERSON/CAREGIVER

Select appropriate boxes. If selecting 'Knows/Unable to assess', explain your choice in comments

Does customer know:	**Customer (at time of interview)**		**Caregiver Judgment**		
First Name	☐ Knows/ Unable to assess	☐ Does not know	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:					

Last Name	☐ Knows/ Unable to assess	☐ Does not know	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:					

Caregiver's Name	☐ Knows/ Unable to assess	☐ Does not know	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:					

PLACE

Select appropriate boxes. If selecting 'Knows/Unable to assess', explain your choice in comments.

Does customer know:	**Customer (at time of interview)**		**Caregiver Judgment**		
Immediate Environment	☐ Knows/ Unable to assess	☐ Does not know	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:					

Place of Residence	☐ Knows/ Unable to assess	☐ Does not know	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:					

Customer Name

Person ID

City	☐ Knows/ Unable to assess	☐ Does not know	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:					

State	☐ Knows/ Unable to assess	☐ Does not know	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:					

TIME

Select appropriate boxes. If selecting 'Knows/Unable to assess', explain your choice in comments.

Does customer know:	**Customer (at time of interview)**		**Caregiver Judgment**		
Day	☐ Knows/ Unable to assess	☐ Does not know	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:					

Month	☐ Knows/ Unable to assess	☐ Does not know	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:					

Year	☐ Knows/ Unable to assess	☐ Does not know	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:					

Time of Day	☐ Knows/ Unable to assess	☐ Does not know	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:					

Customer Name

Person ID

B. BEHAVIORS
Consider the last 90 days, except as indicated in self-injurious behavior and aggression. Select appropriate boxes.

WANDERING

Moving about with no rational purpose, tending to proceed beyond physical parameters of his/her environment in a manner that may jeopardize safety, as the result of an impaired ability to reorient or memory problems. (This is not leaving without permission).

Frequency of Behavior		**Intensity of Intervention (Most Common Method)**	
☐ 0.	Behavior has not been observed, or history of wandering behavior; not a current problem [includes if chemically controlled]	☐ 0.	Customer requires no intervention
☐ 1.	Occurrences may not pose a safety problem	☐ 1.	Customer is easy to verbally redirect
☐ 2.	Occurs predictably [in response to particular situations]; occurrences pose a threat to the safety of self or others	☐ 2.	Customer can be verbally redirected with difficulty
☐ 3.	Occurs at least daily, posing a threat to the safety of self or others	☐ 3.	Customer requires physical intervention or restraints [includes chemical restraints]
Comments:			

SELF INJURIOUS BEHAVIOR

Repeated behaviors that cause injury (e.g., biting, scratching for no apparent reason, picking behaviors; putting inappropriate objects into ear, mouth, or nose; head slapping or banging, etc.). Describe behavior and intervention in comment.

Frequency of Behavior		**Intensity of Intervention (Most Common Method)**	
☐ 0.	No problems in this area or history of injurious behavior; not a current problem [includes if chemically controlled]	☐ 0.	Customer requires no intervention
☐ 1.	Incidents occur less than weekly; OR do not pose a threat to health or safety	☐ 1.	Customer is easy to verbally redirect
☐ 2.	Incidents occur weekly to every other day and MAY pose a threat to health or safety	☐ 2.	Customer can be verbally redirected with difficulty
☐ 3.	Incidents occur at least once a day; OR has had episode(s) causing serious injury requiring medical attention in the last year	☐ 3.	Customer requires physical intervention or restraints [includes chemical restraints]
Comments:			

Customer Name

Person ID

AGGRESSION

Physically attacks others, including throwing objects, punching, biting, pushing, pinching, pulling hair, scratching, destroying property during attacks on others, threatening behavior. (Do NOT include self-injurious behaviors.) Describe behavior and intervention in comments.

Frequency of Behavior		**Intensity of Intervention (Most Common Method)**	
☐ 0.	No problems in this area or history of aggression; not a current problem [includes if chemically controlled – Describe in comments the controlled behavior(s)]	☐ 0.	Customer requires no intervention
☐ 1.	Incidents occur less than weekly; OR do not pose a threat to health or safety	☐ 1.	Customer is easy to verbally redirect
☐ 2.	Incidents occur weekly to every other day and MAY pose a threat to health or safety	☐ 2.	Customer can be verbally redirected with difficulty
☐ 3.	Incidents occur at least once a day; OR has had episode(s) causing serious injury requiring medical attention in the last year	☐ 3.	Customer requires physical intervention or restraints [includes chemical restraints]
Comments:			

RESISTIVENESS

Inappropriately stubborn and uncooperative, including passive or active obstinate behaviors. Refusing to participate in self care or to take necessary medications [Note – Do not include difficulties with auditory processing or reasonable expressions of self-advocacy. Also, do not include verbal threatening or acts of physical aggression to self or others.] Describe behavior and intervention in comments.

Frequency of Behavior		**Intensity of Intervention (Most Common Method)**	
☐ 0.	Problem does not occur or occurs at a level not requiring intervention [includes if chemically controlled – Describe in comments the controlled behavior(s)]	☐ 0.	Customer requires no intervention
☐ 1.	Behavior occurs less than weekly	☐ 1.	Customer is easy to verbally redirect
☐ 2.	Behavior occurs weekly to every other day	☐ 2.	Customer can be verbally redirected with difficulty
☐ 3.	Behavior occurs at least daily	☐ 3.	Customer requires physical intervention or restraints [includes chemical restraints]
Comments:			

Customer Name

Person ID

DISRUPTIVE BEHAVIOR

Interferes with activities of others or own activities through behaviors. [Including but not limited to: putting on or taking off clothing inappropriately; sexual behavior inappropriate to time, place or person; excessive whining or crying; screaming; persistent pestering or teasing; constantly demanding attention; and urinating in inappropriate places]. Describe behavior and intervention in comment.

Frequency of Behavior		**Intensity of Intervention (Most Common Method)**	
☐ 0.	Problem does not occur or occurs at a low level not requiring intervention, or no history of disruptive behavior; not a current problem [includes if chemically controlled – Describe in comments the controlled behavior(s)]	☐ 0.	Customer requires no intervention
☐ 1.	Behavior occurs less than weekly	☐ 1.	Customer is easy to verbally redirect
☐ 2.	Behavior occurs weekly to every other day	☐ 2.	Customer can be verbally redirected with difficulty
☐ 3.	Behavior occurs at least daily	☐ 3.	Customer requires physical intervention or restraints [includes chemical restraints]
Comments:			

Customer Name

Person ID

IV. MEDICAL ASSESSMENT

A. MEDICAL CONDITIONS

Select only those diagnoses that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, skilled nursing care or risk of death.

Note: Do not indicate inactive diagnoses.

A1) Hematologic/Oncologic:	A2) Cardiovascular:	A3) Musculoskeletal:
☐ Anemia	☐ Angina (chest pain)	☐ Amputation
☐ Solid Cancers	☐ Atherosclerotic Heart Disease	☐ Arthritis
☐ Leukemia/Lymphoma	☐ Congestive Heart Failure	☐ Degenerative Joint Disease
☐ HIV Positive/AIDS *(Include Viral Load and T cell count in comments)*	☐ Myocardial Infarction	☐ Fracture
	☐ Hypertension	☐ Joint Replacement
	☐ Peripheral Vascular Disease	☐ Muscular Dystrophy
	☐ Cardiac Arrhythmia	☐ Osteoporosis
		☐ Contracture
		☐ Lower Back Pain
		☐ PARALYSIS

A4) Respiratory:	A5) Metabolic:	A6) Neurological:
☐ Asthma	☐ Diabetes *(Include HgA1C in comments)*	☐ Neurocognitive Disorder
☐ Emphysema/COPD/ Chronic Bronchitis	☐ Hypothyroidism	☐ Polio
☐ Pneumonia	☐ Hyperthyroidism	☐ Seizure Disorder
☐ Tuberculosis	☐ Electrolyte Imbalance	☐ Cerebral Palsy
☐ Respiratory Failure	☐ Hyperlipidemia	☐ Autism
		☐ Intellectual Cognitive Disability
		☐ Encephalopathy
		☐ CVA/Stroke
		☐ TIA - Transient Ischemic Attack
		☐ Parkinson's Disease
		☐ Multiple Sclerosis

Customer Name

Person ID

		☐ ALS - Amyotrophic Lateral Sclerosis
		☐ Head Trauma

Comments:	

A7) Genitourinary:	**A8) Gastrointestinal:**	**A9) Ophthalmologic/EENT:**
☐ Urinary Tract Infection	☐ Ulcers	☐ Blindness
☐ Chronic Renal Failure/ Insufficiency	☐ Hernia	☐ Cataract
☐ Benign Prostatic Hypertrophy	☐ Colitis	☐ Glaucoma
☐ Neurogenic Bladder	☐ Irritable Bowel Syndrome	☐ Hearing Deficit
☐ Urinary Incontinence	☐ Cirrhosis	☐ Macular Degeneration
	☐ Constipation	☐ Diabetic Retinopathy
	☐ Intestinal Obstruction	

A10) Psychiatric:	**A11a) Current Skin Condition(s):**	**A11b) History of a Skin Ulcer Resolved in the last year?**
☐ Major Depression	☐ Cellulitis	☐ Yes
☐ Other Depression (311)	☐ Pressure Ulcers	☐ No
☐ Bipolar Disorder	☐ Stasis Ulcers/Other	☐ Unable to Determine
☐ Schizophrenia		
☐ Alcohol Abuse		
☐ Drug Abuse		
☐ Behavior Disorder (Includes ADHD/ADD)		

A11c) If customer has ulcer(s), indicate pressure ulcer(s) using the following definitions: (select all that apply)
☐ Any area of persistent skin redness (without a break in the skin) that does not disappear when pressure is relieved
☐ Partial loss of skin layers that presents as an abrasion, blister or shallow crater
☐ A full thickness of skin is lost, exposing the underlying tissue (presents as a deep crater) or the underlying tissue is lost (exposing muscle or bone)
☐ Scab (eschar) over ulcer Number of current pressure ulcers

Customer Name

Person ID

(Describe size and location(s) in comments section)

Comments:	

A12) Other Conditions (ICD-10):	**Description**

A13) Major Diagnoses:	
Category	Diagnosis

Comments:	

Customer Name

Person ID

B. MEDICATIONS/TREATMENTS/ALLERGIES
(currently being received)

MEDICATIONS/TREATMENTS

B1) Medications/Treatments/Comments:
1 –
2 –
3 –
4 –
5 –
6 –
7 –
8 –
9 –
10 –
11 –
12 –
13 –
14 –
15 –
16 –
17 –
18 –
19 –
20 –

Comments:	

INSULIN

Select “Yes” to all that apply.

B2a) Does the customer take insulin? ☐ Yes ☐ No

Customer Name

Person ID

B2b) Does customer require any assistance drawing up insulin? ☐ Yes ☐ No	B2c) Does customer require any assistance self-injecting insulin? ☐ Yes ☐ No
B2d) Does customer require any assistance with finger sticks? ☐ Yes ☐ No	

Comments (including who assists and why):	

MEDICATION ASSISTANCE

B3) Assistance with taking medications?	☐ Yes ☐ No

Comments:	

THERAPEUTIC DIET

B4) Therapeutic diet?	☐ Yes ☐ No
Diet order:	

Comments:	

MEDICATION ALLERGIES

B5) Medication Allergies? (If yes, please list) NKMA	☐ Yes ☐ No

Comments:	

Customer Name Person ID

C. SERVICES & TREATMENTS
(currently being received – unmet need must be supported in comments)

C1) Injections/IV:	C2) Medications/Monitoring:	C3) Skin Care:
☐ Intravenous Infusion Therapy	☐ Drug Regulation	☐ Pressure/Other Ulcers
☐ Intramuscular/Subcutaneous Injections	☐ Drug Administration	☐ Non Bowel/Bladder Ostomy Care
		☐ Wound Care

C4) Feedings:	C5) Bladder/Bowel:	C6) Respiratory:
☐ Parenteral Feedings/TPN	☐ Catheter Care	☐ Suctioning
☐ Tube Feedings	☐ Ostomy Care	☐ OXYGEN
	☐ Bowel Dilitation	☐ Small Volume Nebulizer
		☐ Ventilator
		☐ Trach Care
		☐ Chest Physio-Therapy
		☐ CPAP

C7) Therapies:	C8) Rehabilitative Nursing:	C9) Other Services & Treatments:
☐ Physical	☐ Teaching/Training Program	☐ Peritoneal Dialysis
☐ Occupational	☐ Bowel/Bladder Training	☐ Hemodialysis
☐ Speech	☐ Turning & Positioning	☐ Chemotherapy/Radiation
☐ Respiratory	☐ Range of Motion	☐ Restraints
☐ Alcohol/Drug Treatment	☐ Other Rehab Nursing	☐ Fluid Intake/Output
☐ Vocational Rehabilitation		☐ Other:
☐ Individual/Group Therapy		

Comments:	

Informal Supports

1.	Does the customer have a primary caregiver?	☐ Yes ☐ No
2.	If yes, name & relationship to applicant	
	☐ Same as informant/personal contact	

Customer Name

Person ID

Personal Contacts/Source of Information

Name:	Relationship:	Phone:
Physician:		Phone:
Case Manager:		Phone:
Other:		Phone:

Customer Name

Person ID

D. SUMMARY EVALUATION

Include information on Medicare Part D, ER visits, Hospitalizations and falls.

ELIGIBILITY REVIEW REQUESTED?	☐ Yes ☐ No	DATE	

Signature	Title	Date
Signature and Title	Title	Date

Reassessment Requested?	☐ 6 months ☐ 1 year