ADW Participant's Name: _____ Date of Assessment: _____

CASE MANAGEMENT PERSON-CENTERED ASSESSMENT

Initial		6-Month		Annual/Anchor Date		Other	

1. DEMOGRAPHICS

Last Name:		**First Name:**
DOB:	**Current Anchor Date:**	**Financial Eligibility Effective Date:**
Current PAS Date:		**Medical Reevaluation *Request Due By:*** *(Up to 90 days before and no later than 45 days prior to the anchor date):*
Physical Address: **City:** **State** **Zip Code** **County**		
Mailing Address: **City:** **State** **Zip Code** **County**		
Home Phone:	**Cell Phone:**	**Other Phone:**
Detailed Directions to Home:		

2. HEALTHCARE AND INSURANCE INFORMATION

Medicaid #:	**Medicare #** *Document if participant has Part A, B, C, D; provider name (Highmark, Humana, etc.; phone*	**Other Health Insurance:**

Type	Name	Phone
A		
B		
C		
D		

Name	Phone

When present, place an X in the column below marked "yes". A copy verifying relationship, decision or decision making authority must be included in the participant's ADW file. Please indicate if the ADW participant would not provide a copy of _____.

Yes	Type	Yes	Type	Yes	Type
	Legal Guardian		Durable POA		POST Form
	Medical POA		Conservator		Document in Chart
	Legal POA		DNR		Deemed Incompetent
	Healthcare Surrogate		Living Will		Deemed Incapacitated
Person(s) with Legal Representation (Example: MPOA):					**Phone(s):**

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MEDICAL EQUIPMENT: *(What does the person currently have in place? Check all that apply)*

☐	**Ramp**	☐	**Wheelchair (manual or power)**	☐	**Lift Chair**
☐	**Hoyer Lift**	☐	**Bedside Commode**	☐	**Hand Held Shower**
☐	**Walker**	☐	**Elevated Commode Seat**	☐	**Shower Chair**
☐	**Crutches**	☐	**Scooter Chair**	☐	**Glucometer**
☐	**Hospital Bed**	☐	**Oxygen**	☐	**Other:**

Needed Medical Equipment *(What does the person not have now or what needs replaced?)*

Who is responsible for cleaning equipment?

3. **GOALS AND CURRENT RESOURCES:** *Tell me what you would prefer and need.*

GOAL(S): *What kinds of services and help are you expecting from this program (document in the ADW person's words.)?* ***EMPLOYMENT:*** *Are you interested in seeking employment? Yes ☐ No ☐* *If yes, do you need any assistance?*	**FINANCE:** *Do you have the option to manage your own finances (bill payment, banking, purchases, etc.)? Yes ☐ No ☐* *Do you need assistance with these activities?*
INFORMAL SUPPORT: *Do you currently have someone who assists you with bathing, dressing, etc. when the agency worker is not in the home? Yes ☐ No ☐* *If so, who?* *Phone:*	***FORMAL SUPPORT:*** *Do you have an agency or service helping you with activities such as bathing, dressing or meals? Yes ☐ No ☐* *If so, what agency or company?* *Phone:*

4. **ENVIRONMENTAL:** *Tell me about your home and neighborhood.*

Home Location	Type of Home						Own or Rent
☐ Rural ☐ Urban	☐ Apartment	☐ House	☐ Single Story				☐ Own Your Home
	☐ Mobile Home	☐ Multi Family	☐ 2 or More Floors				☐ Live with Home Owner
							☐ Rent/Lease
							☐ HUD Subsidy

- If you reside with an unrelated homeowner/renter, are they also your paid personal attendant?Yes ☐ No ☐ (If yes, provider controlled survey must be completed)
- If you reside with the homeowner/renter, are they also your informal support? Yes ☐ No ☐
- If you are a renter, is your name on the lease? Yes ☐ No ☐ If no, whose name is on the lease? _____ (Name on lease)

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Who Lives in the Home?	Phone	Relationship
I live alone		
Name:		
Name:		
Name:		

5. RISKS *Answer yes or no, note if no plan needed and reason. Note additional information.*

Home/Neighborhood Risks	**Yes**	**No**	**No Plan Needed**	**Comments** *Describe why plan is not needed or comment on the issue. Example: Years in neighborhood. Does not want to move.*
Is the home isolated from other homes in the area (no visible neighbors)?				
Unsafe feelings in the home				
Unsafe feelings in neighborhood				
Trouble with neighbors/others in the household/landlord				
In-Home Risks	**Yes**	**No**	**No Plan Needed**	*Describe why plan is not needed or comment on the issue. Example: Daughter carries in water for no running water.*
Running Water				
Adequate Heat/Air				
Working Cook Stove				
Working Refrigerator				
Pets (animals which may be a potential danger to a worker)				
Alarms (Smoke or Carbon Monoxide)				
Firearms not locked up				
Structural or Upkeep Problems				
Barriers to Access Inside or Outside (like steps, narrow doorways, etc.)				
Plumbing Issues				
Electrical Hazards/Unsafe/Poor Lighting				
Scattered Floor Rugs				
Uneven Flooring				
Grab Bar in Bathroom, if needed				
Other Safety/Sanitation Hazards (insects, rodents, no trash pickup, soiled living area, etc.)				
Medical Risks				*Example: Educated regarding smoking. Not interested.*
Oxygen				
Smoking				

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Alcohol or Substance Abuse				
Morbid Obesity as R/T Mobility and Transport				
Other				
Fall Risks				*Example: Home cluttered. Does not want to de-clutter.*
Outside/Inside Stairs				
Ambulation Equipment				
Inability to evacuate the home				
Cluttered living environment and/or numerous throw rugs				
History of falls				
Vertigo, dizziness, numbness, tingling				
Unsteady gait				
Behavioral Risks				*If yes in this area, must address risk.*
Wandering				
Resistance to care				
Changes in behavior (describe)				
Emotional Risks	**Yes**	**No**	**No Plan Needed**	*If yes in this area, must address risk.*
Have you experienced a major loss that has had a big impact on you?				
Within the last year, are you experiencing feelings of depression, overwhelmed, crying or trouble sleeping which was not there before?				
Do you feel that you are not thinking as clearly or you feel confused?				
Do you feel depressed and think about hurting yourself?				
Do you have trouble taking medication as prescribed or eating when you are supposed to do so?				
Please describe any cognitive impairment (change in memory, concentration or attention span).				
Do you get frustrated, angry and lose control of your				

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actions? (verbal or physical threats)				
Other:				

6. MEDICAL: *(If needed, add another sheet with physician/specialist information)*

Primary Care Physician		**Other:** ***Specialists, Physical, Speech or Occupational Therapist, Counselors/Psychiatrist, etc.***	
Name:		Name:	
Frequency: Last Visit:	Phone:	Specialty:	Phone:
Name:		Name:	
Specialty:	Phone:	Specialty:	Phone:
Name:		Name:	
Specialty:	Phone:	Specialty:	Phone:
Name:		Name:	
Specialty:	Phone:	Specialty:	Phone:
Name:		Name:	
Specialty:	Phone:	Specialty:	Phone:
Name:		Name:	
Specialty:	Phone:	Specialty:	Phone:
Name:		Name:	
Specialty:	Phone:	Specialty:	Phone:

COORDINATION OF HEALTH CARE: *Complete this area in full.* ***It is a part of provider monitoring.***

- Do you have a Primary Care Physician who coordinates your healthcare? ☐ Yes ☐ No
- Do you think you need referrals to physicians, specialists or medical testing? ☐ Yes ☐ No
- Do you need assistance with making medical appointments? ☐ Yes ☐ No

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7. SOCIAL: *Tell me about yourself. Who you are and what you do is important to your services.*

Do you feel you have control over your daily activities, including eating, sleeping, socializing?	
Are you able to leave your home? How often?	
Do you have the chance to interact with others outside the home?	
What community activities do you enjoy?	
What type of work, education or training did you have in the past?	

8. IDENTIFIED SERVICE/RESOURCE NEEDS: *Check box or List Provider Name and Phone Number Below.*

	Housing		**Food Stamps**		**Utility Assistance**
	Hearing Aids		**Medical Appointments**		**Weatherization**
	Home Modifications		**Debt Counseling**		**Legal Services**

Advanced Directives Provider and Phone #	
Personal Emergency Response System and Phone #	
Home Delivered Meals Provider and Phone #	
Eyeglasses Provider and Phone #	
Dentures Provider and Phone #	
Incontinent Supply Provider and Phone #	
Durable Medical Equipment Provider and Phone #	
Assistive Technology Provider and Phone #	
Therapy Provider and Phone #	
Nursing (ADW Skilled Nursing or Home Health Skilled Nursing)	
Hospice	

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Transportation (ADW Transportation or Nonemergency Medical Transportation, NEMT, Community Transportation Resources)	
Personal Attendant Services (ADW or DRS)	
Dual Services (Personal Care Services)	
Other	
Other	

List of Those Present During Assessment	Relationship to ADW Member

Comments:

By signing, I certify that the reported information is complete and accurate. I understand that payment for the services certified on this form will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under Medicaid Fraud.

_____ _____

ADW Member/Legal Representative Signature **Date**

_____ _____

Case Manager Signature **Date**

Copy of the assessment was provided to the ADW member and Personal Attendant Agency on: _____

Note: Assessment is required to be uploaded to member's record in CareConnection.