DEPARTMENT OF HEALTH OFFICE OF HEALTH SYSTEMS MANAGEMENT

THIS FORM MUST BE COMPLETED FOR ALL LONG TERM HOME HEALTH CARE PROGRAM PATIENTS AND ALL MEDICAID PATIENTS HOME ASSESSMENT ABSTRACT RECEIVING HOME HEALTH AIDE OR PERSONAL CARE SERVICES. PORTIONS AS INDICATED MUST BE COMPLETED BY RESPECTIVE 1. REASON FOR PREPARATION PERSONNEL FOR THE ABOVE MENTIONED PURPOSES. FOR MORE INFORMATION, SEE DETAILED INSTRUCTIONS. ☐ ADMISSION TO LTHHCP ABBREVIATIONS: ☐ INITIAL EVALUATION FOR HOME HEALTH AIDE CHHA - CERTFIED HOME HEALTH AGENCY ☐ INITIAL EVALUATION FOR PERSONAL CARE LTHHCP – LONG TERM HOME HEALTH CARE PROGRAM ☐ REASSESSMENT FROM ___ RN - REGISTERED NURSE SSW - SOCIAL SERVICE WORKER ☐ PERSONAL CARE ☐ LTHHCP ☐ CHHA **INSTRUCTION PAGE 1:** TO BE COMPLETED BY RN - PARTS 1, 2, 3 ☐ OTHER, SPECIFY TO BE COMPLETED BY SSW - PARTS 1, 2, 3, 4, 5, 6 2. PATIENT NAME **CURRENT LOCATION/DIAGNOSIS OF PATIENT** ☐ HOSP. ☐ HRF ☐ HOME \square SNF ☐ DCF ☐ OTHER (SPECIFY) RESIDENT ADDRESS NAME OF FACILITY/ORGANIZATION APT. NO. CITY STATE ZIP TEL. NO. STREET ADDRESS WHERE PRESENTLY RESIDING TEL. NO. CITY STATE 7IP TEL NO. DIRECTIONS TO CURRENT ADDRESS DATE ADMITTED PROJECTED DISCHARGE DATE SOCIAL SERVICES DISTRICT FIELD OFFICE DIAGNOSIS 4. NEXT OF KIN/GUARDIAN STREET 5. NOTIFY IN EMERGENCY NAME STATE CITY STATE 7IP CITY 7IP RELATION TEL NO. RELATION TEL NO. **PATIENT INFORMATION** _____AGE _____ SOCIAL SECURITY NO. _____ 6. DATE OF BIRTH LANGUAGE(S) SPOKEN/UNDERSTANDS ___ MEDICARE NO. PART A ____ PART B ☐ MALE ☐ FEMALE SEX: ☐ PENDING MEDICAID NO. MARITAL STATUS: ☐ MARRIED ☐ SEPARATED BLUE CROSS NO. SINGLE DIVORCED WORKMENS COMP. ☐ WIDOWED VETERANS CLAIM NO. ___ LIVING ARRANGEMENTS: ☐ YES ☐ NO VETERANS SPOUSE ☐ ONE FAMILY HOUSE ☐ HOTEL OTHER (SPECIFY) ☐ MULTI-FAMILY HOUSE ☐ APT. SOURCE OF INCOME/OTHER BENEFITS ☐ SOCIAL SECURITY ☐ FURNISHED ROOM ☐ BOARDING HOUSE ☐ VETERANS BENEFITS ☐ PUBLIC ASSIST. ☐ SENIOR CIT. HOUSING ☐ IF WALK-UP ☐ PENSION ☐ FOOD STAMPS (# FLIGHTS ____) ☐ OTHER, SPECIFY ___ ☐ S.S.I. OTHER (SPECIFY) LIVES WITH: ☐ SPOUSE ☐ ALONE ☐ OTHER

GENERAL INSTRUCTIONS:

UTILITIES, ETC.

AMOUNT OF AVAILABLE FUNDS AFTER PAYMENT OF RENT, TAXES

7. To be completed by S S W

tient.

OTHERS IN HOME/HOUSEHOLD:	Indicate days/hours	that these persons v	vill provide care to pa
If none will assist explain in narrative) .		

	NAME	Age	Relationship	Days/Hours at Home	Days/Hours will Assist
1.					
2.					
3.					
4.					

8.	To be completed by S S W	
	CLONIELO ANT OTLIEDO OLITOIDE OF LIONAE	The Proof of the Community and the community of the Commu

Name	Address	Age	Relationship	Days/Hours Assisting	

9.	To b	ое со	omple	eted I	bv S	S W

COMMUNITY SUPPORT: Indicate organization/persons serving patient at present or has provided a service in the past six (6) months.

Organization	Type of Service	Presently Receiving	Contact Person	Tel No.
1.				
2.				
3.				
1.				

10. To be completed by S S W and R.N.

PATIENT TRAITS:				
	Yes	No	?N/A	If you check No. ?N/A, describe
Appears self directed and/or independent				
Seems to make appropriate decisions				
Can recall med routine/recent events				
Participates in planning/treatment program				
Seems to handle crises well				
Accepts diagnosis				
Motivated to remain at home				

11. To be completed by S S W and R.N. as appropriate

FAMILY TRAITS:		_	Т	7
	Yes	No	?	
a. Is motivated to keep patient home				If no, because
b. Is capable of providing care (physically & emotionally)				If no, because
c. Will keep patient home if not involved with care				Because
d. Will give care if support service given				How much
e. Requires instruction to provide care				In what – who will give
12. To be completed by R.N.				
Home/Place where care will be provided:	Yes	No	?	If problem, describe
Neighborhood secure/safe				
Housing adequate in terms of: Space				
Convenient toilet facilities				
Heating adequate and safe				
Cooking facilities & refrigerator				
Laundry facilities				
Tub/shower/hot water				
Elevator				
Telephone accessible & usable				
Is patient mobile in house				
Any discernible hazards (please circle)				Leaky gas, poor wiring, unsafe floors, steps, other (specify)
Construction adequate				
Excess use of alcohol/drugs by patient/ caretaker; smokes carelessly.				
Is patient's safety threatened if alone?				
Pets				
ADDITIONAL ASSESSMENT FACTORS:				
13. To be completed by R.N.				
RECOVERY POTENTIAL ANTICIPATED				COMMENTS
Full recovery				
Recovery with patient management residual		_		
Limited recovery managed by others		_ 🗆		
Deterioration		_		

14. To be completed by R.N. – S S W to complete "D" as appropriate FOR THE PATIENT TO REMAIN AT HOME – SERVICES REQUIRED

WHO WILL PROVIDE

SEI	RVICES REQUIRED	YES	NO	TYPE/FREQ/DUR	AGENCY/FAMILY	AGENCY FREQUENCY				
A.	Bathing									
	Dressing									
	Toileting									
	Admin. Med.									
	Grooming									
	Spoon feeding									
	Exercise/activity/walking									
	Shopping (food/supplies)									
	Meal preparation									
	Diet Counseling									
	Light housekeeping									
	Personal laundry/household linens									
	Personal/financial errands									
	Other									
В.	Nursing									
	Physical Therapy									
	Home Health Aide									
	Speech Pathology									
	Occupational Therapy									
	Personal Care									
	Homemaking									
	Housekeeping									
	Clinic/Physician									
	Other 1.									
	2.									
C.	Ramps outside/inside									
<u>U.</u>	Grab bars/hallways/bathroom									
	Commode/special bed/wheelchair									
	Cane/walker/crutches									
	Self-help device, specify									
	Dressings/cath. equipment, etc.									
	Bed protector/diapers									
_	Other									
D.	Additional Services (Lab, O ² , medication)									
	Telephone reassurance									
	Diversion/friendly visitor									
	Medical social service/counseling									
	Legal/protective services									
	Financial management/conservatorship									
	Transportation arrangements									
	Transportation attendant									
	Home delivered meals									
	Structural modification									
	Other									
4 5	To be completed by S.S.W. and D.N.									
15.	To be completed by S S W and R.N									
	DMS Predictor Score Override necessary									
	Can patient's health/safety needs be met through home care now?									
	If no, give specific reason why not									
	Institutional care required now? Yes		o If ye	es, give specific reason why	<u></u>					
	Level of institutional care determined by your p	rofessional	judgment:	☐ SNF	☐ HRF ☐ DCF					
	Can the patient be considered at a later time for	r home ca	re?	☐ Yes ☐ No	□ N/A					
				(4)						

16. To be completed by S S W
SUMMARY OF SERVICE REQUIREMENTS
Indicate services required, schedule and charges (allowable charge in area)

			Date	Est.	Unit			ment by	
Services	Provided by	Hrs./Days/Wk.	Effective	Dur.	Cost	MC	MA	Self	Other
Physician									
Nursing									
Home Health Aide									
Physical Therapy									
Speech Pathology									
Resp. Therapy									
Med. Soc. Work									
Nutritional									
Personal Care									
Homemaking									
Housekeeping									
Other (Specify)									
Medical Supplies/Medication 1.									
2.									
3.									
Medical Equipment 1.									
2.									
3.									
Home Delivered Meals									
Transportation									
Additional Services 1.									
2.									
		1	SUBTOTAL						
Structural Modification			SOLIGIAL						
Other (Specify)									
1.									
2.									

7. To be completed by S S W and R.N.							
	e in case of emergency						
Name	Address		Telephone	Relationship			
Narrative: Use this space to	describe aspects of the patients care not adec	quately covered above.					
Assessment completed by:							
	R.N.	Agency					
	Date Completed	Telephone No.					
	Local DSS Staff	District					
	Date Completed	Telephone No.					
	Date Completed	тетерноне по.					
	Supervisor DSS	District					
	Date	Telephone No.					
		•					
Authoritant							
Authorization to provide serv	Local DSS Commissioner or Designer	ne Date					