

907 KAR 3:090
Material Incorporated by Reference

907 KAR 3:090 filed: 7-12-07

MAP-109, Plan of Care/Prior Authorization for Waiver Services, March 2007 edition.

MAP-24C, SCL or ABI Admission Discharge Department for Community Based Services (DCBS) Notification, April 2007 edition.

MAP-26, Acquired Brain Injury (ABI) Waiver Services Program Application, May 2003 edition.

MAP-95, Request for Equipment Form, June 2007 edition.

MAP-10, Waiver Services, January 2007 edition.

Incident Report, April 2007 edition.

MAP-2000, Initiation/Termination of Consumer Directed Option (CDO), March 2007 edition.

MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form, January 2000 edition.

Rancho Los Amigos Level of Cognitive Function Scale, November 1974 edition.

MAP-351, Medicaid Waiver Assessment, March 2007 edition.

Mayo-Portland Adaptability Inventory-4, March 2003 edition.

Person Centered Planning: Guiding Principles, March 2005.

Member Name: _____ MAID Number: _____

Identification of Needs/Outcomes/Services/Providers

NEED(S)	OUTCOMES/GOAL(S)	OBJECTIVES/INTERVENTION(S)	SERVICE CODE	PROVIDER NAME/#

Commonwealth of Kentucky
 Cabinet for Health and Family Services
 Department for Medicaid Services

Member Name: _____

MAID Number _____

Date Services Start: _____

Support Spending Plan

Traditional Waiver Services

Service Code A	Provider Name and Number B	Units per Week C	Units per Month D	Cost per Unit E	Cost per Week (Column CxE) F	Total Cost Monthly (4.6xColumn F) G
Total Cost per Month						\$ _____

Consumer Directed Services

Service Code A	Description of Service B	Employee Providing the Service C	Units per week D	Units per Month (Column Dx4.6) E	Hourly Wage F	Number of Hours per Month G	Sum of Wages Times Hours H	Administrative Costs I	Total Monthly Amount J
Total Cost Per Month									\$ _____

Member Name: _____ MAID Number: _____

Emergency Back-up Plan (CDO only)

I certify the information contained above is accurate and that I have made an informed choice when selecting the providers/employees to provide each service.

Member/Guardian Signature: _____ Date: _____

Case Manager/Support Broker Signature: _____ Date: _____

Representative Signature (CDO): _____ Date: _____

Plan of Care/Support Spending Plan **Approved** _____ **Denied** _____

QIO Signature/Title: _____ **Date:** _____

TO: (1) _____ County Office
Department for Community Based Services

(2) Quality Improvement Organization (QIO)

(3) Department for Mental Health/Mental Retardation for SCL or
Department for Medicaid Services/Brain Injury Services Branch for ABI

FROM: (4) _____
Case Management Agency/Support Broker

DATE: (5) _____

A. SCL or ABI WAIVER PROGRAM ADMISSION

(1) _____
(Last Name) (First Name) (MI) (Social Security Number)

_____ KY _____
(Address) (City) (Zip) (Phone number)

(2) Was admitted to the SCL or ABI Waiver Program on _____
(Circle SCL or ABI) (Date)

(3) Case Management Agency/Support Broker _____

(Phone Number) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)

(4) Primary Provider _____

(Phone) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)



B. SCL or ABI WAIVER PROGRAM DISCHARGE

(1) _____
(Last Name) (First Name) (MI) (Social Security Number)

_____ KY _____
(Address) (City) (Zip) (Phone number)

(2) Discharged from the SCL or ABI Program on _____
(Date)

(3) Case Management Agency/Support Broker _____

(Phone Number) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)

(4) Primary Provider _____

(Phone) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)

C. SCL or ABI WAIVER PROGRAM TRANSFER

(1) _____
(Last Name) (First Name) (MI) (Social Security Number)

_____ KY _____
(Address) (City) (Zip) (Phone number)

(2) Transferred on _____ from _____
(Date)

(3) Case Management Agency/Support Broker _____

(Phone Number) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)



(4) To Case Management Agency/Support Broker _____

(Phone Number) (Provider #) KY _____

(Address) (City) (Zip Code)

(5) From Primary Provider _____

(Phone) (Provider #) KY _____

(Address) (City) (Zip Code)

(6) To Primary Provider _____

(Phone) (Provider #) KY _____

(Address) (City) (Zip Code)

(7) To Hospital, Nursing Facility, or other facility _____
(Name of facility)

(Phone) (Provider #) _____

(Address) (City) (Zip Code)

PROCEDURAL INSTRUCTIONS FOR MAP-24C

Upon admittance/discharge/transfer of an individual in the Supports for Community Living Waiver or Acquired Brain Injury Waiver Program, the case manager/support broker shall forward a MAP-24C form to the local Department for Community Based Services Office in the county in which the member resides, the Quality Improvement Organization (QIO), the Department for Mental Health/Mental Retardation Services for the SCL waiver program or to the Department for Medicaid Services/Brain Injury Services Branch for the ABI waiver program. The case manager/support broker shall complete the form.

Use the following instructions to fill in the blanks on the MAP-24C:

INITIATION OF FORM

- Line One (1) Enter the name of the County of the Department for Community Based Services the form will be sent to.
- Line Two (2) Send the form to the Quality Improvement Organization.
- Line Three (3) Send the form to the Department for Mental Health/Mental Retardation for the SCL waiver program or to the Department for Medicaid Services/Brain Injury Services Branch for the ABI waiver program.
- Line Four (4) Enter the name of the Case Management Agency/Support Broker filling out the form.
- Line Five (5) Enter the date the form was completed.

A. FOR INITIAL ADMISSION TO THE SUPPORTS FOR COMMUNITY LIVING WAIVER PROGRAM OR THE ACQUIRED BRAIN INJURY WAIVER PROGRAM

- Line One (1) Enter the name, social security number, address and phone number of the member.
- Line Two (2) Enter the date the member entered the program.
- Line Three (3) Enter the name of the case management agency/support broker, phone number, and provider number.
- Line Four (4) Enter the name, phone number, and provider number of the primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider. If the member chooses the Consumer Directed Option, then the Department of Aging and Independent Living will be the primary provider.

**B. FOR DISCHARGE FROM THE SUPPORTS FOR COMMUNITY LIVING
WAIVER PROGRAM OR THE ACQUIRED BRAIN INJURY WAIVER
PROGRAM**

- Line (1) Enter the name, social security number, address and phone number of the member.
- Line (2) Enter the date the discharge.
- Line (3) Enter the case management agency/support broker, phone number, provider number and address.
- Line (4) Enter the name, phone number, provider number of the primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider. If the member chose the Consumer Directed Option, then the Department for Aging and Independent Living will be the primary provider.

**C. FOR TRANSFER WITHIN THE SUPPORTS FOR COMMUNITY
LIVING WAIVER PROGRAM OR THE ACQUIRED BRAIN INJURY
WAIVER PROGRAM**

- Line (1) Enter the name, social security number, address and phone number of the member.
- Line (2) Enter the date the transfer took place.
- Line (3) Enter the previous case management agency/support broker, phone number, provider number and address.
- Line (4) Enter the new case management agency/support broker, phone number, provider number and address.
- Line (5) Enter the name, phone number, provider number of the current primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider. If the member chooses the Consumer Directed Option, then the Department for Aging and Independent Living will be the primary provider.
- Line (6) Enter the name, phone number, provider number of the new primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider. If the member chooses the Consumer Directed Option, then the Department for Aging and Independent Living will be the primary provider.
- Line (7) Enter the name, phone number, provider number and address of the facility that the waiver member has been transferred to on a temporary basis.

Cabinet for Health Services
Department for Medicaid Services

For BISU Use Only:

Date received:	Time received:
Received by:	Date notice sent:

**PROGRAM APPLICATION
KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY (ABI) WAIVER SERVICES PROGRAM**

Please provide the following personal information for the individual seeking services through the Medicaid waiver.

Name: _____ Medical Assistance #: _____

Mailing Address: _____

Date of Birth: _____ Telephone #: _____

Name of guardian (if applicable): _____

Address of guardian: _____

Guardian Telephone #: _____

Name of individual's caregiver (if applicable): _____

Address of caregiver: _____

Caregiver Telephone #: _____

Please answer the following questions.

1. Has the individual identified a case management provider to assist in securing and coordinating services once you are admitted to the ABI waiver program? Yes No
2. If yes, what is the name of the organization that will provide case management?
3. Does the individual currently demonstrate behavior that places himself/herself or a caregiver at risk of significant harm? Yes No
4. If yes, please attach a statement from a physician or other qualified mental health professional describing the nature and extent of the risk of harm involved.

Cabinet for Health Services
Department for Medicaid Services

**PROGRAM APPLICATION
KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY (ABI) WAIVER SERVICES PROGRAM**

5. Has the individual been arrested? Yes No
6. If yes, please attach a statement from law enforcement or the court indicating when the type of offense(s) for which the individual has been arrested.

Signature of guardian

Signature of applicant

Name of person completing application

Relationship to applicant

Telephone # of person completing application

Questions about individual referrals or the Medicaid Acquired Brain Injury Waiver program may be directed to the brain Injury Services Unit by calling, toll free, (800) 374-9146. Thank you.

Cabinet for Health Services
Department for Medicaid Services

**PROGRAM APPLICATION
KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY (ABI) WAIVER SERVICES PROGRAM**

To be placed on the Acquired Brain Injury Medicaid Waiver waiting list, an individual must first submit this application and a signed physician certification form. A copy of the physician certification form is enclosed for your use. Please mail the completed application and the signed physician's certification form to:

Brain Injury Services Branch
100 Fair Oaks Lane, 4E-D
Frankfort, Kentucky 40621-0001

An individual will be placed in the waiting list in the order in which the application and the physician certification form are received in the office of the Brain Injury Services Unit. If the individual meets one of the following emergency criteria, he/she will be determined to have emergency status. Funding available will be allocated to individuals having emergency status prior to allocating funding to individuals having non-emergency status. The emergency status criteria are:

1. The individual is demonstrating behavior that places himself/herself, the caregiver, or others at risk of significant harm; OR
2. The recipient is demonstrating behavior which has resulted in arrest

If the individual is applying for emergency status, please provide detailed written information explaining his/her current circumstances. Additional sheets of paper may be used.

MAP 95
(Rev. 6/07)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

REQUEST FOR EQUIPMENT FORM

RECIPIENTS NAME: _____ DOB: _____

MAID or MEMBER #: _____ DX: _____

Estimated Time Needed: Months _____ Indefinitely _____ Permanently _____
One Time Only _____

Procedure Code: _____ Date: _____

ITEM	ESTIMATE 1	ESTIMATE 2	ESTIMATE 3	TOTAL COST (includes shipping)

AGENCY NAME: _____

PROVIDER NUMBER: _____

CASE MANAGER/SUPPORT BROKER: _____

TELEPHONE NUMBER: _____

AUTHORIZED DMS SIGNATURE: _____

DATE APPROVED: _____



Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

WAVIER SERVICES

TO: _____

AGENCY: _____

ADDRESS: _____

_____ KY _____ PHONE: () _____
(City) (Zip)

PHYSICIAN'S RECOMMENDATION

I recommend Wavier Services for:

MEMBER: _____

MAID NUMBER: _____

ADDRESS: _____

_____ KY _____ PHONE () _____
(City) (Zip)

DIAGNOSIS(ES): _____

Recommended Wavier Program: HCBW (ARNP, PA or Physician signature)
 ABI
 SCL (QMRP or Physician signature)

I certify that if Wavier Services were not available, institutional placement (nursing facility or Intermediate Care Facility for Individuals with Mental Retardation or Developmental Disability [ICF/MR/DD]) shall be appropriate for this member in the near future.

PHYSICIAN or QMRP NAME: _____ UPIN#: _____

ADDRESS: _____

_____ KY _____ PHONE () _____
(City) (Zip)

SIGNATURE

DATE



**LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM
CERTIFICATION FORM**

I. ESTATE RECOVERY

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/MR/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

Signature

Date

II. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, BRAIN INJURY WAIVER

A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement is requested _____; is not requested _____.

Signature

Date

B. This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD is requested _____; is not requested _____.

Signature

Date

C. MODEL WAIVER II - This is to certify that I/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement is requested _____; is not requested _____.

Signature

Date

D. BRAIN INJURY (BI) WAIVER - This is to certify that I/legal representative have been informed of the BI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested _____; is not requested _____.

Signature

Date

III. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

Signature

Date

IV. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

Signature

Date

V. RECIPIENT INFORMATION

Medicaid Recipient's Name: _____

Address of Recipient: _____

Phone: _____

Medicaid Number: _____

Responsible Party/Legal Representative: _____

Address: _____

Phone: _____

Signature and Title of Person Assisting with Completion of Form:

Agency/Facility: _____

Address: _____

SUPERVISOR/CASE MANAGER/SUPPORT BROKER FOLLOW-UP

(Add additional pages if necessary)

MAID/SS# _____ Name: _____ Date of Incident: _____

I. Why did the incident occur? What staff action was effective in diffusing the incident or redirecting problem behavior? What staff action may have contributed to or aggravated the incident? Was treatment obtained in a timely fashion? Was a Behavior Plan followed? Was a Crisis Plan followed? Were they effective?

II. How could this incident have been prevented? How will the agency ensure that the incident does not occur again? What specific changes will be made in the person's life (home, work, day, etc.)? What will staff do differently? Does the person's team need to meet? What systems changes need to occur? How will management's role change?

III. What staff training needs were identified? On what date will the training occur? Who will provide the training?

IV. Are any changes necessary that will be made to the Individual Plan of Care, Crisis Prevention Plan, and/or the Behavior Support Plan? How will these changes support the person to achieve his/her vision and cope effectively? What other positive changes can be made to enhance the person's life? (such as, more choice, pursuing the person's vision, variety, developing relationships, developing and enhancing communications)

V. What is the individual's current status? What kind of impact has the incident had on the individual's life?

Submitted by: _____ Title: _____ Date: _____

Additional Signatures:

_____ Title: Case Mgr./Support Broker Date: _____

_____ Title: _____ Date: _____

_____ Title: _____ Date: _____

INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

<input type="checkbox"/> SCL <input type="checkbox"/> HCB <input type="checkbox"/> ABI
--

Consumer's Name: _____ MAID #: _____

Case Manager/Support Broker: _____
Name Phone

Provider Number: _____

Addition of CDO Services Date: _____ Initials: _____

I understand that I have the freedom to choose the Consumer Directed Option for some or all of my waiver services. This has been explained to me and I choose consumer directed services. In making this decision, I understand the following terms of the program:

I understand that I may:

- Train or arrange training for employees necessary for providing care.
- Ask for a change in my POC/SSP if I feel my needs have changed.
- Select a representative to help me with decisions about the CDO.
- Bring whomever I want to all meetings pertaining to the CDO.
- Complain or ask for a hearing if I have problems with my health care.
- Voluntarily dis-enroll from the CDO Program at any time and receive my services through the traditional waiver program.

I understand that I shall:

- Develop a Plan of Care (POC)/Support Spending Plan (SSP) to meet my needs within the Consumer Directed Options (CDO) according to program guidelines and my individual budget.
- Hire, supervise, and when necessary, fire my providers.
- Submit timesheets, paperwork required for my employees.
- Treat my providers and others that work for the CDO program the same way I want to be treated.
- Participate in the development of my POC/SSP and manage my individual budget.
- Complete all the paperwork necessary to participate in the CDO program, and follow all tax and labor laws.
- Be treated with respect and dignity and to have my privacy respected.
- Keep all my scheduled appointments.
- Pay my patient liability as determined by Department for Community Based Services (DCBS), failure to do so will result in termination from CDO.

*For addition of CDO services, attach revised MAP 109 Plan of Care.

Date traditional case management ends and Support Broker begins ____/____/____

Date traditional services end and CDO services begin: ____/____/____



INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

Member Name: _____ MAD# _____

Representative Designation Date: _____ Initials: _____

I appoint _____ as my representative for the Consumer Directed Option (CDO) Program.

Representative Address: _____ Phone: _____

Relationship to Consumer: _____

My representative and I understand the following requirements

A CDO representative must:

- Be at least 21 years of age
- Not be paid for this role or for providing any other service to me
- Be responsible for assisting me in managing my care and individual budget
- Participate in training as directed by me and/or my support broker
- Have a strong personal commitment to me and know my preferences
- Have knowledge of me and be willing to learn about resources available in my community
- Be chosen by me

*For voluntary or involuntary termination of CDO service, attach revised MAP 109-Plan of Care.

Voluntary Termination of CDO Services Date: _____ Initials: _____

I choose to terminate my services through the Consumer Directed Option and choose to receive my services through the traditional waiver program.

Involuntary Termination of CDO Services
(To be completed by the Support Broker)

Reason for termination of CDO:

- Health and Safety Concerns
- Exceeding Individual Budget
- Inappropriate Utilization of Funds
- Other (Describe)

Traditional Provider Agency _____
Traditional Provider Number _____

Consumer/Guardian Signature

Date

Representative Signature

Date

Case Manager/Support Broker Signature

Date



Assessment Scales

Rancho Los Amigos - Revised

Levels of Cognitive Functioning

Level I - No Response: Total Assistance

- Complete absence of observable change in behavior when presented visual, auditory, tactile, proprioceptive, vestibular or painful stimuli.

Level II - Generalized Response: Total Assistance

- Demonstrates generalized reflex response to painful stimuli.
- Responds to repeated auditory stimuli with increased or decreased activity.
- Responds to external stimuli with physiological changes generalized, gross body movement and/or not purposeful vocalization.
- Responses noted above may be same regardless of type and location of stimulation.
- Responses may be significantly delayed.

Level III - Localized Response: Total Assistance

- Demonstrates withdrawal or vocalization to painful stimuli.
- Turns toward or away from auditory stimuli.
- Blinks when strong light crosses visual field.
- Follows moving object passed within visual field.
- Responds to discomfort by pulling tubes or restraints.
- Responds inconsistently to simple commands.
- Responses directly related to type of stimulus.
- May respond to some persons (especially family and friends) but not to others.

Level IV - Confused/Agitated: Maximal Assistance

- Alert and in heightened state of activity.
- Purposeful attempts to remove restraints or tubes or crawl out of bed.
- May perform motor activities such as sitting, reaching and walking but without any apparent purpose or upon another's request.
- Very brief and usually non-purposeful moments of sustained alternatives and divided attention.
- Absent short-term memory.

- May cry out or scream out of proportion to stimulus even after its removal.
- May exhibit aggressive or flight behavior.
- Mood may swing from euphoric to hostile with no apparent relationship to environmental events.
- Unable to cooperate with treatment efforts.
- Verbalizations are frequently incoherent and/or inappropriate to activity or environment.

Level V - Confused, Inappropriate Non-Agitated: Maximal Assistance

- Alert, not agitated but may wander randomly or with a vague intention of going home.
- May become agitated in response to external stimulation, and/or lack of environmental structure.
- Not oriented to person, place or time.
- Frequent brief periods, non-purposeful sustained attention.
- Severely impaired recent memory, with confusion of past and present in reaction to ongoing activity.
- Absent goal directed, problem solving, self-monitoring behavior.
- Often demonstrates inappropriate use of objects without external direction.
- May be able to perform previously learned tasks when structured and cues provided.
- Unable to learn new information.
- Able to respond appropriately to simple commands fairly consistently with external structures and cues.
- Responses to simple commands without external structure are random and non-purposeful in relation to command.
- Able to converse on a social, automatic level for brief periods of time when provided external structure and cues.
- Verbalizations about present events become inappropriate and confabulatory when external structure and cues are not provided.

Level VI - Confused, Appropriate: Moderate Assistance

- Inconsistently oriented to person, time and place.
- Able to attend to highly familiar tasks in non-distracting environment for 30 minutes with moderate redirection.
- Remote memory has more depth and detail than recent memory.
- Vague recognition of some staff.

- Able to use assistive memory aide with maximum assistance.
- Emerging awareness of appropriate response to self, family and basic needs.
- Moderate assist to problem solve barriers to task completion.
- Supervised for old learning (e.g. self care).
- Shows carry over for relearned familiar tasks (e.g. self care).
- Maximum assistance for new learning with little or nor carry over.
- Unaware of impairments, disabilities and safety risks.
- Consistently follows simple directions.
- Verbal expressions are appropriate in highly familiar and structured situations.

Level VII - Automatic, Appropriate: Minimal Assistance for Daily Living Skills

- Consistently oriented to person and place, within highly familiar environments. Moderate assistance for orientation to time.
- Able to attend to highly familiar tasks in a non-distraction environment for at least 30 minutes with minimal assist to complete tasks.
- Minimal supervision for new learning.
- Demonstrates carry over of new learning.
- Initiates and carries out steps to complete familiar personal and household routine but has shallow recall of what he/she has been doing.
- Able to monitor accuracy and completeness of each step in routine personal and household ADLs and modify plan with minimal assistance.
- Superficial awareness of his/her condition but unaware of specific impairments and disabilities and the limits they place on his/her ability to safely, accurately and completely carry out his/her household, community, work and leisure ADLs.
- Minimal supervision for safety in routine home and community activities.
- Unrealistic planning for the future.
- Unable to think about consequences of a decision or action.
- Overestimates abilities.
- Unaware of others' needs and feelings.
- Oppositional/uncooperative.
- Unable to recognize inappropriate social interaction behavior.

Level VIII - Purposeful, Appropriate: Stand-By Assistance

- Consistently oriented to person, place and time.
- Independently attends to and completes familiar tasks for 1 hour in distracting environments.
- Able to recall and integrate past and recent events.
- Uses assistive memory devices to recall daily schedule, "to do" lists and record critical information for later use with stand-by assistance.
- Initiates and carries out steps to complete familiar personal, household, community, work and leisure routines with stand-by assistance and can modify the plan when needed with minimal assistance.
- Requires no assistance once new tasks/activities are learned.
- Aware of and acknowledges impairments and disabilities when they interfere with task completion but requires stand-by assistance to take appropriate corrective action.
- Thinks about consequences of a decision or action with minimal assistance.
- Overestimates or underestimates abilities.
- Acknowledges others' needs and feelings and responds appropriately with minimal assistance.
- Depressed.
- Irritable.
- Low frustration tolerance/easily angered.
- Argumentative.
- Self-centered.
- Uncharacteristically dependent/independent.
- Able to recognize and acknowledge inappropriate social interaction behavior while it is occurring and takes corrective action with minimal assistance.

Level IX - Purposeful, Appropriate: Stand-By Assistance on Request

- Independently shifts back and forth between tasks and completes them accurately for at least two consecutive hours.
- Uses assistive memory devices to recall daily schedule, "to do" lists and record critical information for later use with assistance when requested.
- Initiates and carries out steps to complete familiar personal, household, work and leisure tasks independently and unfamiliar personal, household, work and leisure tasks with assistance when requested.
- Aware of and acknowledges impairments and disabilities when they interfere with task completion and takes appropriate corrective action but requires stand-by assist to anticipate a problem before it occurs and take

action to avoid it.

- Able to think about consequences of decisions or actions with assistance when requested.
- Accurately estimates abilities but requires stand-by assistance to adjust to task demands.
- Acknowledges others' needs and feelings and responds appropriately with stand-by assistance.
- Depression may continue.
- May be easily irritable.
- May have low frustration tolerance.
- Able to self monitor appropriateness of social interaction with stand-by assistance.

Level X - Purposeful, Appropriate: Modified Independent

- Able to handle multiple tasks simultaneously in all environments but may require periodic breaks.
- Able to independently procure, create and maintain own assistive memory devices.
- Independently initiates and carries out steps to complete familiar and unfamiliar personal, household, community, work and leisure tasks but may require more than usual amount of time and/or compensatory strategies to complete them.
- Anticipates impact of impairments and disabilities on ability to complete daily living tasks and takes action to avoid problems before they occur but may require more than usual amount of time and/or compensatory strategies.
- Able to independently think about consequences of decisions or actions but may require more than usual amount of time and/or compensatory strategies to select the appropriate decision or action.
- Accurately estimates abilities and independently adjusts to task demands.
- Able to recognize the needs and feelings of others and automatically respond in appropriate manner.
- Periodic periods of depression may occur.
- Irritability and low frustration tolerance when sick, fatigued and/or under emotional stress.
- Social interaction behavior is consistently appropriate.

Original Scale co-authored by Chris Hagen, Ph.D., Danese Malkmus, M.A., Patricia Durham, M.A. Communication Disorders Service, Rancho Los Amigos Hospital, 1972. Revised 11/15/74 by Danese Malkmus, M.A., and Kathryn Stenderup, O.T.R.

Glasgow Coma Scale . Disability Rating Scale (DRS)

Mayo-Portland Adaptability Inventory-4

Muriel D. Lezak, PhD, ABPP & James F. Malec, PhD, ABPP

Name: _____ Clinic # _____ Date _____

Person reporting (circle one): Single Professional Professional Consensus Person with brain injury Significant other: _____

Below each item, circle the number that best describes the level at which the person being evaluated experiences problems. Mark the greatest level of problem that is appropriate. Problems that interfere rarely with daily or valued activities, that is, less than 5% of the time, should be considered not to interfere. Write comments about specific items at the end of the rating scale.

For Items 1-20, please use the rating scale below.

0 None	1 Mild problem but does <u>not</u> interfere with activities; may use assistive device or medication	2 Mild problem; interferes with activities 5-24% of the time	3 Moderate problem; interferes with activities 25-75% of the time	4 Severe problem; interferes with activities more than 75% of the time
---------------	---	---	--	---

Part A. Abilities

1. Mobility: Problems walking or moving; balance problems that interfere with moving about 0 1 2 3 4
2. Use of hands: Impaired strength or coordination in one or both hands 0 1 2 3 4
3. Vision: Problems seeing; double vision; eye, brain, or nerve injuries that interfere with seeing 0 1 2 3 4
4. *Audition: Problems hearing; ringing in the ears 0 1 2 3 4
5. Dizziness: Feeling unsteady, dizzy, light-headed 0 1 2 3 4
6. Motor speech: Abnormal clearness or rate of speech; stuttering 0 1 2 3 4
7A. Verbal communication: Problems expressing or understanding language 0 1 2 3 4
7B. Nonverbal communication: Restricted or unusual gestures or facial expressions; talking too much or not enough; missing nonverbal cues from others 0 1 2 3 4
8. Attention/Concentration: Problems ignoring distractions, shifting attention, keeping more than one thing in mind at a time 0 1 2 3 4
9. Memory: Problems learning and recalling new information 0 1 2 3 4
10. Fund of Information: Problems remembering information learned in school or on the job; difficulty remembering information about self and family from years ago 0 1 2 3 4
11. Novel problem-solving: Problems thinking up solutions or picking the best solution to new problems 0 1 2 3 4
12. Visuospatial abilities: Problems drawing, assembling things, route-finding, being visually aware on both the left and right sides 0 1 2 3 4

Part B. Adjustment

13. Anxiety: Tense, nervous, fearful, phobias, nightmares, flashbacks of stressful events 0 1 2 3 4
14. Depression: Sad, blue, hopeless, poor appetite, poor sleep, worry, self-criticism 0 1 2 3 4
15. Irritability, anger, aggression: Verbal or physical expressions of anger 0 1 2 3 4
16. *Pain and headache: Verbal and nonverbal expressions of pain; activities limited by pain 0 1 2 3 4
17. Fatigue: Feeling tired; lack of energy; tiring easily 0 1 2 3 4
18. Sensitivity to mild symptoms: Focusing on thinking, physical or emotional problems attributed to brain injury; rate only how concern or worry about these symptoms affects current functioning over and above the effects of the symptoms themselves 0 1 2 3 4
19. Inappropriate social interaction: Acting childish, silly, rude, behavior not fitting for time and place 0 1 2 3 4
20. Impaired self-awareness: Lack of recognition of personal limitations and disabilities and how they interfere with everyday activities and work or school 0 1 2 3 4

Use scale at the bottom of the page to rate item #21

21. Family/significant relationships: Interactions with close others; describe stress within the family or those closest to the person with brain injury; "family functioning" means cooperating to accomplish those tasks that need to be done to keep the household running

0 Normal stress within family or other close network of relationships	1 Mild stress that does <u>not</u> interfere with family functioning	2 Mild stress that interferes with family functioning 5-24% of the time	3 Moderate stress that interferes with family functioning 25-75% of the time	4 Severe stress that interferes with family functioning more than 75% of the time
--	---	--	---	--

Part C. Participation

22. Initiation: Problems getting started on activities without prompting

0 None	1 Mild problem but does <u>not</u> interfere with activities; may use assistive device or medication	2 Mild problem; interferes with activities 5-24% of the time	3 Moderate problem; interferes with activities 25-75% of the time	4 Severe problem; interferes with activities more than 75% of the time
--------	--	--	---	--

23. Social contact with friends, work associates, and other people who are not family, significant others, or professionals

0 Normal involvement with others	1 Mild difficulty in social situations but maintains normal involvement with others	2 Mildly limited involvement with others (75-95% of normal interaction for age)	3 Moderately limited involvement with others (25-74% of normal interaction for age)	4 No or rare involvement with others (less than 25% of normal interaction for age)
----------------------------------	---	---	---	--

24. Leisure and recreational activities

0 Normal participation in leisure activities for age	1 Mild difficulty in these activities but maintains normal participation	2 Mildly limited participation (75-95% of normal participation for age)	3 Moderately limited participation (25-74% of normal participation for age)	4 No or rare participation (less than 25% of normal participation for age)
--	--	---	---	--

25. Self-care: Eating, dressing, bathing, hygiene

0 Independent completion of self-care activities	1 Mild difficulty, occasional omissions or mildly slowed completion of self-care; may use assistive device or require occasional prompting	2 Requires a little assistance or supervision from others (5-24% of the time) including frequent prompting	3 Requires moderate assistance or supervision from others (25-75% of the time)	4 Requires extensive assistance or supervision from others (more than 75% of the time)
--	--	--	--	--

26. Residence: Responsibilities of independent living and homemaking (such as, meal preparation, home repairs and maintenance, personal health maintenance beyond basic hygiene including medication management) but not including managing money (see #29)

0 Independent; living without supervision or concern from others	1 Living without supervision but others have concerns about safety or managing responsibilities	2 Requires a little assistance or supervision from others (5-24% of the time)	3 Requires moderate assistance or supervision from others (25-75% of the time)	4 Requires extensive assistance or supervision from others (more than 75% of the time)
--	---	---	--	--

27. *Transportation

0 Independent in all modes of transportation including independent ability to operate a personal motor vehicle	1 Independent in all modes of transportation, but others have concerns about safety	2 Requires a little assistance or supervision from others (5-24% of the time); cannot drive	3 Requires moderate assistance or supervision from others (25-75% of the time); cannot drive	4 Requires extensive assistance or supervision from others (more than 75% of the time); cannot drive
--	---	---	--	--

28A. *Paid Employment: Rate either item 28A or 28B to reflect the primary desired social role. Do not rate both. Rate 28A if the primary social role is paid employment. If another social role is primary, rate only 28B. For both 28A and 28B, "support" means special help from another person with responsibilities (such as, a job coach or shadow, tutor, helper) or reduced responsibilities. Modifications to the physical environment that facilitate employment are not considered as support.

0 Full-time (more than 30 hrs/wk) without support	1 Part-time (3 to 30 hrs/wk) without support	2 Full-time or part-time with support	3 Sheltered work	4 Unemployed; employed less than 3 hours per week
---	--	---------------------------------------	------------------	---

28B. *Other employment: Involved in constructive, role-appropriate activity other than paid employment.

Check only one to indicate primary desired social role: Childrearing/care-giving Homemaker, no childrearing or care-giving Student Volunteer Retired (Check retired only if over age 60; if unemployed, retired as disabled and under age 60, indicate "Unemployed" for item 28A.

0 Full-time (more than 30 hrs/wk) without support; full-time course load for students	1 Part-time (3 to 30 hrs/wk) without support	2 Full-time or part-time with support	3 Activities in a supervised environment other than a sheltered workshop	4 Inactive; involved in role-appropriate activities less than 3 hours per week
---	--	---------------------------------------	--	--

29. Managing money and finances: Shopping, keeping a check book or other bank account, managing personal income and investments; if independent with small purchases but not able to manage larger personal finances or investments, rate 3 or 4.

0 Independent, manages small purchases and personal finances without supervision or concern from others	1 Manages money independently but others have concerns about larger financial decisions	2 Requires a little help or supervision (5-24% of the time) with large finances; independent with small purchases	3 Requires moderate help or supervision (25-75% of the time) with large finances; some help with small purchases	4 Requires extensive help or supervision (more than 75% of the time) with large finances; frequent help with small purchases
---	---	---	--	--

Part D: Pre-existing and associated conditions. The items below do not contribute to the total score but are used to identify special needs and circumstances. For each rate, pre-injury and post-injury status.

30. Alcohol use: Use of alcoholic beverages.

Pre-injury _____ Post-injury _____									
0	No or socially acceptable use	1	Occasionally exceeds socially acceptable use but does not interfere with everyday functioning; current problem under treatment or in remission	2	Frequent excessive use that occasionally interferes with everyday functioning; possible dependence	3	Use or dependence interferes with everyday functioning; additional treatment recommended	4	Inpatient or residential treatment required

31. Drug use: Use of illegal drugs or abuse of prescription drugs.

Pre-injury _____ Post-injury _____									
0	No or occasional use	1	Occasional use does not interfere with everyday functioning; current problem under treatment or in remission	2	Frequent use that occasionally interferes with everyday functioning; possible dependence	3	Use or dependence interferes with everyday functioning; additional treatment recommended	4	Inpatient or residential treatment required

32. Psychotic Symptoms: Hallucinations, delusions, other persistent severely distorted perceptions of reality.

Pre-injury _____ Post-injury _____									
0	None	1	Current problem under treatment or in remission; symptoms do not interfere with everyday functioning	2	Symptoms occasionally interfere with everyday functioning but no additional evaluation or treatment recommended	3	Symptoms interfere with everyday functioning; additional treatment recommended	4	Inpatient or residential treatment required

33. Law violations: History before and after injury.

Pre-injury _____ Post-injury _____									
0	None or minor traffic violations only	1	Conviction on one or two misdemeanors other than minor traffic violations	2	History of more than two misdemeanors other than minor traffic violations	3	Single felony conviction	4	Repeat felony convictions

34. Other condition causing physical impairment: Physical disability due to medical conditions other than brain injury, such as, spinal cord injury, amputation. Use scale below #35.

35. Other condition causing cognitive impairment: Cognitive disability due to nonpsychiatric medical conditions other than brain injury, such as, dementia, stroke, developmental disability.

Pre-injury _____ Post-injury _____									
0	None	1	Mild problem but does <u>not</u> interfere with activities; may use assistive device or medication	2	Mild problem; interferes with activities 5-24% of the time	3	Moderate problem; interferes with activities 25-75% of the time	4	Severe problem; interferes with activities more than 75% of the time

Comments:

Item #

Scoring Worksheet

Items with an asterisk (4, 16, 27, 28/28A) require rescoring as specified below before Raw Scores are summed and referred to Reference Tables to obtain Standard Scores. Because items 22-24 contribute to both the Adjustment Subscale and the Participation Subscale, the Total Score will be less than the sum of the three subscales.

Abilities Subscale

Rescore item 4. Original score = _____
 If original score = 0, new score = 0
 If original score = 1, 2, or 3, new score = 1
 If original score = 4, new score = 3
 A. New score for item 4 = _____
 B. Sum of scores for items 1-3 and 5-12 = _____
 (use highest score for 7A or 7B)
 Sum of A and B = Raw Score for Abilities subscale = _____ (place in Table below)

Adjustment Subscale

Rescore item 16. Original score = _____
 If original score = 0, new score = 0
 If original score = 1 or 2, new score = 1.
 If original score = 3 or 4, new score = 2
 C. New score for item 16 = _____
 D. Sum of scores for items 13-15 and 17-24 = _____
 Sum of C and D = Raw Score for Adjustment Subscale = _____ (place in Table below)

Participation Subscale

Rescore item 27. Original score = _____
 If original score = 0 or 1, new score = 0
 If original score = 2 or 3, new score = 1
 If original score = 4, new score = 3

 Rescore item 28A or 28B. Original score = _____
 If original score = 0, new score = 0
 If original score = 1 or 2, new score = 1
 If original score = 3 or 4, new score = 3
 E. New score for item 27 = _____
 F. New score for item 28A or 28B = _____
 G. Sum of scores for items 22-24 = _____ (place in Table below)
 H. Sum of scores for items 25, 26, 29 = _____
 Sum of E through H = Raw Score for Participation Subscale = _____ (place in Table below)

Use Reference Tables to Convert Raw Scores to Standard Scores

	Raw Scores (from worksheet above)	Standard (Obtain from appropriate reference Table)
I. Ability Subscale (Items 1-12)	_____	_____
II. Adjustment Subscale (Items 13-24)	_____	_____
III. Participation Subscale (Items 22-29)	_____	_____
IV. Subtotal of Subscale Raw Scores (I-III)	_____	_____
V. Sum of scores for items 22-24	_____	_____
VI. Subtract from V. from IV = Total Score	_____	_____

MEDICAID WAIVER ASSESSMENT

SECTION I – MEMBER DEMOGRAPHICS

Name (last, first, middle)	Date of birth (mo., day, yr.) / /	Medicaid number
Street address	County code	Sex (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female
		Marital status (check one) <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed
City, state and zip code	Emergency contact (name)	Emergency contact (phone #) () -
Member phone number () -	Is member able to read and write <input type="checkbox"/> Yes <input type="checkbox"/> No	Member's height Member's weight

SECTION II – MEMBER WAIVER ELIGIBILITY

Type of program applied for (check one) <input type="checkbox"/> Home and Community Based Waiver <input type="checkbox"/> Model Waiver II <input type="checkbox"/> Acquired Brain Injury Waiver <input type="checkbox"/> Supports for Community Living Waiver <input type="checkbox"/> Consumer Directed Option <input type="checkbox"/> Blended	Adjudicated <input type="checkbox"/> / Nonadjudicated <input type="checkbox"/> Type of application (check one) <input type="checkbox"/> Certification <input type="checkbox"/> Re-certification <input type="checkbox"/> Re-application	
Member admitted from (check one) <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing facility <input type="checkbox"/> ICF/MR/DD <input type="checkbox"/> Other _____	Certification period (enter dates below) Begin date / / End date / / Certification number: _____	
Has member's freedom of choice been explained and verified by a signature on the MAP 350 Form <input type="checkbox"/> Yes <input type="checkbox"/> No	Has member been informed of the process to make a complaint <input type="checkbox"/> Yes <input type="checkbox"/> No (see instructions)	
Physician's name	Physician's license number (enter 5 digit #)	Physician's phone number () -
Enter member's primary diagnosis: HCB (ICD-9 code); SCL (DSM code); ABI (ICD-9 and/or DSM)		
Enter all diagnoses including DSM or ICD-9 codes: AXIS I: (mental illness) AXIS II: (MR/DD) AXIS III: (Medical)	Is the member diagnosed with one of the following? <input type="checkbox"/> Mental Retardation/ IQ= (Date-of-onset / /) <input type="checkbox"/> Developmental Disability (Date-of-onset / /) <input type="checkbox"/> Mental Illness (Date-of-onset / /) <input type="checkbox"/> Brain Injury Cause of Brain Injury: Date of Brain Injury: / / Rancho Scale _____	

SECTION III – ASSESSMENT PROVIDER INFORMATION

Assessment/Reassessment provider name:	Provider number	Provider phone number () -
Street address	City, state and zip code	
Provider contact person		

Name (last, first)	Medicaid Number
---------------------------	------------------------

SECTION IV SELF ASSESSMENT

***For SCL and ABI waivers only**

***add additional pages as needed**

Community Inclusion (what do you like to do or where would you like to go in the community, where do you go for recreation, do you not get to go somewhere that you would like to)

Relationships (How do you stay in contact with your friends and family, do you need assistance in making or keeping friends, who are your friends)

Rights (do you understand your rights, are any of your rights restricted, do you know what is abuse or neglect)

Dignity and Respect (how are you treated by staff, do you have a place you can go to be with friends or to be alone or have privacy)

Health (who are your doctors, do you have any health concerns, what medicine do you take, how do they make you feel,)

Lifestyle (do you have a job, do you want to work, do you want to go to school, do you go to the bank, do you have spending money to carry)

Satisfaction with supports (are you satisfied with your services and supports, what do you like about them, what do you dislike about them, do you feel like you have choices about what you can do, are you happy with your life, what are you happy about, what are you unhappy about)

Name (last, first)	Medicaid Number
SECTION V – ACTIVITIES OF DAILY LIVING	
<p>1) Is member independent with <u> </u> dressing/undressing</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p><input type="checkbox"/> Requires hands-on assistance with upper body</p> <p><input type="checkbox"/> Requires hands-on assistance with lower body</p> <p><input type="checkbox"/> Requires total assistance</p>	Comments:
<p>2) Is member independent with <u> </u> grooming</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p>Requires hands-on assistance with</p> <p><input type="checkbox"/> oral care <input type="checkbox"/> shaving</p> <p><input type="checkbox"/> nail care <input type="checkbox"/> hair</p> <p><input type="checkbox"/> Requires total assistance</p>	Comments:
<p>3) Is member independent with <u> </u> bed mobility</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p><input type="checkbox"/> Occasionally requires hands-on assistance</p> <p><input type="checkbox"/> Always requires hands-on assistance</p> <p><input type="checkbox"/> Bed-bound</p> <p><input type="checkbox"/> Required bedrails</p>	Comments:
<p>4) Is member independent with <u> </u> bathing</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p><input type="checkbox"/> Requires hands-on assistance with upper body</p> <p><input type="checkbox"/> Requires hands-on assistance with lower body</p> <p><input type="checkbox"/> Requires Peri-Care</p> <p><input type="checkbox"/> Requires total assistance</p>	Comments:
<p>5) Is member independent with <u> </u> toileting</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Bladder incontinence</p> <p><input type="checkbox"/> Bowel incontinence</p> <p><input type="checkbox"/> Occasionally requires hands-on assistance</p> <p><input type="checkbox"/> Always requires hands-on assistance</p> <p><input type="checkbox"/> Requires total assistance</p> <p><input type="checkbox"/> Bowel and bladder regimen</p>	Comments:
<p>6) Is member independent with <u> </u> eating <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input type="checkbox"/> Requires supervision or verbal cues</p> <p><input type="checkbox"/> Requires assistance cutting meat or arranging food</p> <p><input type="checkbox"/> Partial/occasional help</p> <p><input type="checkbox"/> Totally fed (by mouth)</p> <p><input type="checkbox"/> Tube feeding (type and tube location)</p>	Comments:

Name (last, first)	Medicaid Number
<p>7) Is member independent with ambulation <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and comment)</i> <input type="checkbox"/> Dependent on device <input type="checkbox"/> Requires aid of one person <input type="checkbox"/> Requires aid of two people <input type="checkbox"/> History of falls (number of falls, and date of last fall)</p>	Comments:
<p>8) Is member independent with transferring <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and comment)</i> <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Hands-on assistance of one person <input type="checkbox"/> Hands-on assistance of two people <input type="checkbox"/> Requires mechanical device <input type="checkbox"/> Bedfast</p>	Comments:

SECTION VI - INSTRUMENTAL ACTIVITIES OF DAILY LIVING

<p>1) Is member able to prepare meals <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for meal preparation <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with meal preparation <input type="checkbox"/> Requires total meal preparation</p>	Comments:
<p>2) Is member able to shop independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for shopping to be done <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with shopping <input type="checkbox"/> Unable to participate in shopping</p>	Comments:
<p>3) Is member able to perform light housekeeping <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for light housekeeping duties to be performed <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with light housekeeping <input type="checkbox"/> Unable to perform any light housekeeping</p>	Comments:
<p>4) Is member able to perform heavy housework <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for heavy housework to be performed <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with heavy housework <input type="checkbox"/> Unable to perform any heavy housework</p>	Comments:

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Name (last, first)	Medicaid Number
<p>5) Is member able to perform laundry tasks. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for laundry to be done <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with laundry tasks <input type="checkbox"/> Unable to perform any laundry tasks</p>	Comments:
<p>6) Is member able to plan/arrange for pick-up, delivery, or some means of gaining possession of medication(s) and take them independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for medication to be obtained and taken correctly <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with obtaining and taking medication correctly <input type="checkbox"/> Unable to obtain medication and take correctly</p>	Comments:
<p>7) Is member able to handle finances independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Arranges for someone else to handle finances <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance with handling finances <input type="checkbox"/> Unable to handle finances</p>	Comments:
<p>8) Is member able to use the telephone independently <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i> <input type="checkbox"/> Requires adaptive device to use telephone <input type="checkbox"/> Requires supervision or verbal cues <input type="checkbox"/> Requires assistance when using telephone <input type="checkbox"/> Unable to use telephone</p>	Comments:
SECTION VII-NEURO/EMOTIONAL/BEHAVIORAL	
<p>1) Does member exhibit behavior problems <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check below all that apply and explain the frequency in comments)</i> <input type="checkbox"/> Disruptive behavior <input type="checkbox"/> Agitated behavior <input type="checkbox"/> Assaultive behavior <input type="checkbox"/> Self-injurious behavior <input type="checkbox"/> Self-neglecting behavior</p>	<p>Comments: Date of functional analysis: / / and/or Date of behavior support plan: / /</p>



Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Name (<i>last, first</i>)	Medicaid Number
<p>2) Is member oriented to person, place, time <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If no, check below all that apply and comment</i>)</p> <p><input type="checkbox"/> Forgetful <input type="checkbox"/> Confused <input type="checkbox"/> Unresponsive <input type="checkbox"/> Impaired Judgment</p>	Comments:
<p>3) Has member experienced a major change or crisis within the past twelve months <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, describe)</i></p>	Description:
<p>4) Is the member actively participating in social and/or community activities <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, describe)</i></p>	Description:
<p>5) Is the member experiencing any of the following <i>(For each checked, explain the frequency and details in the comments section)</i></p> <p><input type="checkbox"/> Difficulty recognizing others <input type="checkbox"/> Loneliness <input type="checkbox"/> Sleeping problems <input type="checkbox"/> Anxiousness <input type="checkbox"/> Irritability <input type="checkbox"/> Lack of interest <input type="checkbox"/> Short-term memory loss <input type="checkbox"/> Long-term memory loss <input type="checkbox"/> Hopelessness <input type="checkbox"/> Suicidal behavior <input type="checkbox"/> Medication abuse <input type="checkbox"/> Substance abuse <input type="checkbox"/> Alcohol Abuse</p>	Comments:

Name (<i>last, first</i>)	Medicaid Number
<p>6) Cognitive functioning (Participant's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands)</p> <p><input type="checkbox"/> Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.</p> <p><input type="checkbox"/> Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.</p> <p><input type="checkbox"/> Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.</p> <p><input type="checkbox"/> Required considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.</p> <p><input type="checkbox"/> Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.</p>	<p>Comments:</p>
<p>7) When Confused (Reported or Observed):</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> In new or complex situations only</p> <p><input type="checkbox"/> On awakening or at night only</p> <p><input type="checkbox"/> During the day and evening, but not constantly</p> <p><input type="checkbox"/> Constantly</p> <p><input type="checkbox"/> NA (non-responsive)</p>	<p>Comments:</p>
<p>8) When Anxious (Reported or Observed):</p> <p><input type="checkbox"/> None of the time</p> <p><input type="checkbox"/> Less often than daily</p> <p><input type="checkbox"/> Daily, but not constantly</p> <p><input type="checkbox"/> All of the time</p> <p><input type="checkbox"/> NA (non-responsive)</p>	<p>Comments:</p>
<p>9) Depressive Feelings (Reported or Observed):</p> <p><input type="checkbox"/> Depressed mood (e.g., feeling sad, tearful)</p> <p><input type="checkbox"/> Sense of failure or self-reproach</p> <p><input type="checkbox"/> Hopelessness</p> <p><input type="checkbox"/> Recurrent thoughts of death</p> <p><input type="checkbox"/> Thoughts of suicide</p> <p><input type="checkbox"/> None of the above feelings reported or observed</p>	<p>Comments:</p>

Name (<i>last, first</i>)	Medicaid Number
<p>10) Member Behaviors (Reported or Observed):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Indecisiveness, lack of concentration <input type="checkbox"/> Diminished interest in most activities <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Recent changes in appetite or weight <input type="checkbox"/> Agitation <input type="checkbox"/> Suicide attempt <input type="checkbox"/> None of the above behaviors observed or reported 	<p>Comments:</p>
<p>11) Behaviors Demonstrated at Least Once a Week:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24-hours, significant memory loss so that supervision is required. <input type="checkbox"/> Impaired decision-making: failure to perform usual ADL's, inability to inappropriately stop activities, jeopardizes safety through actions. <input type="checkbox"/> Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc. <input type="checkbox"/> Physical aggression: aggressive or combative to self and others (e.g. hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects). <input type="checkbox"/> Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions). <input type="checkbox"/> Delusional, hallucinatory, or paranoid behavior. <input type="checkbox"/> None of the above behaviors demonstrated. 	<p>Comments:</p>
<p>12) Frequency of Behavior Problems (Reported or Observed) such as wandering episodes, self abuse, verbal disruption, physical aggression, etc.:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> Once a month <input type="checkbox"/> Several times each month <input type="checkbox"/> Several times a week <input type="checkbox"/> At least daily 	

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Name (<i>last, first</i>)	Medicaid Number
<p>13) Mental Status:</p> <p><input type="checkbox"/> Oriented</p> <p><input type="checkbox"/> Forgetful</p> <p><input type="checkbox"/> Depressed</p> <p><input type="checkbox"/> Disoriented</p> <p><input type="checkbox"/> Lethargic</p> <p><input type="checkbox"/> Agitated</p> <p><input type="checkbox"/> Other</p> <hr/>	Comments:
<p>14) Is this member receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	Comments:
SECTION VIII-CLINICAL INFORMATION	
<p>1) Is member's vision adequate (<i>with or without glasses</i>)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined</p> <p><i>(If no, check below all that apply and comment)</i></p> <p><input type="checkbox"/> Difficulty seeing print</p> <p><input type="checkbox"/> Difficulty seeing objects</p> <p><input type="checkbox"/> No useful vision</p>	Comments:
<p>2) Is member's hearing adequate (<i>with or without hearing aid</i>)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined</p> <p><i>(If no, check below all that apply, and comment)</i></p> <p><input type="checkbox"/> Difficulty with conversation level</p> <p><input type="checkbox"/> Only hears loud sounds</p> <p><input type="checkbox"/> No useful hearing</p>	Comments:
<p>3) Is member able to communicate needs</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and comment)</i></p> <p><input type="checkbox"/> Speaks with difficulty but can be understood</p> <p><input type="checkbox"/> Uses sign language and/or gestures/communication device</p> <p><input type="checkbox"/> Inappropriate context</p> <p><input type="checkbox"/> Unable to communicate</p>	Comments:

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Name (last, first)	Medicaid Number
<p>4) Does member maintain an adequate diet <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check all that apply and comment) <input type="checkbox"/> Uses dietary supplements <input type="checkbox"/> Requires special diet (low salt, low fat, etc.) <input type="checkbox"/> Refuses to eat <input type="checkbox"/> Forgets to eat <input type="checkbox"/> Tube feeding required (Explain the brand, amount, and frequency in the comments section) <input type="checkbox"/> Other dietary considerations (PICA, Prader-Willie, etc.)</p>	Comments:
<p>5) Does member require respiratory care and/or equipment <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, check all that apply and comment) <input type="checkbox"/> Oxygen therapy (Liters per minute and delivery device) <input type="checkbox"/> Nebulizer (Breathing treatments) <input type="checkbox"/> Management of respiratory infection <input type="checkbox"/> Nasopharyngeal airway <input type="checkbox"/> Tracheostomy care <input type="checkbox"/> Aspiration precautions <input type="checkbox"/> Suctioning <input type="checkbox"/> Pulse oximetry <input type="checkbox"/> Ventilator (list settings)</p>	Comments:
<p>6) Does member have history of a stroke(s) <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, check all that apply and comment) <input type="checkbox"/> Residual physical injury(ies) <input type="checkbox"/> Swallowing impairments <input type="checkbox"/> Functional limitations (Number of limbs affected)</p>	Comments:
<p>7) Does member's skin require additional, specialized care <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, check all that apply and comment) <input type="checkbox"/> Requires additional ointments/lotions <input type="checkbox"/> Requires simple dressing changes (i.e. band-aids, occlusive dressings) <input type="checkbox"/> Requires complex dressing changes (i.e. sterile dressing) <input type="checkbox"/> Wounds requiring "packing" and/or measurements <input type="checkbox"/> Contagious skin infections <input type="checkbox"/> Ostomy care</p>	Comments:
<p>8) Does member require routine lab work <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, what type and how often)</p>	Comments:
<p>9) Does member require specialized genital and/or urinary care <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, check all that apply and comment) <input type="checkbox"/> Management of reoccurring urinary tract infection <input type="checkbox"/> In-dwelling catheter <input type="checkbox"/> Bladder irrigation <input type="checkbox"/> In and out catheterization</p>	Comments:



Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Name (last, first)	Medicaid Number		
10) Does member require specific, physician-ordered vital signs evaluation necessary in the management of a condition(s) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, explain in the comments section)</i>	Comments:		
11) Does member have total or partial paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, list limbs affected and comment)</i>	Comments:		
12) Does member require assistance with changes in body position <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check all that apply and comment)</i> <input type="checkbox"/> To maintain proper body alignment <input type="checkbox"/> To manage pain <input type="checkbox"/> To prevent further deterioration of muscle/joints/skin	Comments:		
13) Does member require 24 hour caregiver <input type="checkbox"/> Yes <input type="checkbox"/> No			
14) Does member require respite services <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, how often)</i>			
15) Does the member require intravenous fluids, intravenous medications or intravenous alimentation <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, check below all that apply and list solution, location, amount, rate, frequency and prescribing physician)</i>			
<input type="checkbox"/> Peripheral IV Solution:	Location	Amount/dosage	Rate
Frequency		Prescribing physician	
<input type="checkbox"/> Central line Solution:	Location	Amount/dosage	Rate
Frequency		Prescribing physician	
16) Drug allergies (list)	17) Other allergies (list)		
17) Does the member use any medications <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, list below) *add additional pages if needed</i>			
Name of medication	Dosage/Frequency/Route	Administered by	



Name (last, first)	Medicaid Number
---------------------------	------------------------

SECTION IX-ENVIRONMENT INFORMATION

<p>1) Answer the following items relating to the member's physical environment (Comment if necessary)</p> <p>Sound dwelling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate furnishings <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Indoor plumbing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Running water <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hot water <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate heating/cooling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tub/shower <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stove <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Refrigerator <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Microwave <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Telephone <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>TV/radio <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Washer/dryer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate lighting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate locks <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Adequate fire escape <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Smoke alarms <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insect/rodent free <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Accessible <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Safe environment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Trash management <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Comments:</p>
--	-------------------------

2) Provide an inventory of home adaptations already present in the member's dwelling. (Such as wheelchair ramp, tub rails, etc.)

SECTION X – HOUSEHOLD INFORMATION

<p>1) Does the member live alone <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, does the member receive any assistance from others <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain)</p>	<p>Comments:</p>
--	-------------------------



Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Name (last, first)	Medicaid Number
---------------------------	------------------------

2) Household Members (Fill in household member info below)

a) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
b) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
c) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		
d) Name	Relationship	Age	Are they functionally able to provide care <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in the comments section)
Comments:	Care provided/frequency		

SECTION XI-ADDITIONAL SERVICES

1) Has the member had any hospital, nursing facility or ICF/MR/DD admissions in the past 12 months?
 Yes No (If yes, please list below)

a-Facility name	Facility address	
Reason for admission	Admission date / /	Discharge date / /
b-Facility name	Facility address	
Reason for admission	Admission date / /	Discharge date / /

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Name (last, first)	Medicaid Number
---------------------------	------------------------

2) Does the member receive services from other agencies (Example: Both Waiver and Non-waiver Services.) Yes No
(If yes, list services already provided and to be provided in accordance with a plan of care by an agency/organization, include Adult Day Health Care and traditional Home health services covered by Medicare/Third party insurance)

a-Service(s) received	Agency/worker name	Phone number () -
Agency address	Frequency	Number of units
b-Service(s) received	Agency/worker name	Phone number () -
Agency address	Frequency	Number of units
c-Service(s) received	Agency/worker name	Phone number () -
Agency address	Frequency	Number of units

SECTION XII-CONSUMER DIRECTED OPTION

Has the member been provided information on Consumer Directed Option (CDO) and their right to choose CDO, traditional or blended services? Yes No **If no, give reason:**

Has the member chosen Consumer Direction Option? Yes No If yes, include form MAP 2000

SECTION XIII-SIGNATURES

Person(s) performing assessment or reassessment:

Signature:	Title:	Date / /
Signature:	Title:	Date / /

Verbal Level of Care Confirmation:

Date: / /	Time: am/pm
-----------	-------------

Assessment/Reassessment forwarded to Support Broker/Case Management provider:

Date Forwarded: / /	Time Forwarded: am/pm
Name of Person Forwarding:	Title of Person Forwarding:

Receipt of assessment/reassessment by Support Broker/case management provider:

Date Received: / /	Time Received: am/pm
Name of Person Logging Receipt:	Title of Person Logging Receipt:

QIO Signature:	Level of Care Date / /	Approval dates From: / / To: / /
-----------------------	---------------------------	-------------------------------------



Person Centered Planning: Guiding Principles

Supports for individuals with disabilities will:

- ✓ Ensure dignity and respect for each person as a valued individual.
- ✓ Be entitled to the rights, privileges, opportunities, and responsibilities of community membership.
- ✓ Be supported and encouraged to develop personal relationships, learning opportunities, work and income options, and worship opportunities as full participants in community life.
- ✓ Be based on individually determined goals, choices, and priorities.
- ✓ Be easily accessed and provided regardless of the intensity of individual need.
- ✓ Be afforded the opportunity to direct the planning, selection, implementation, and evaluation of their services and supports.
- ✓ Require that funding be flexible and cost effective and make use of natural, generic, and specialized resources.
- ✓ Be the primary decision makers in their own lives.
- ✓ Be evaluated based on outcomes for individuals.

The work we do and the way we work will:

- ✓ Ensure that all persons have dignity and value, and are worthy of respect.
- ✓ Provide safeguards to ensure personal security, safety, and protection of legal and human rights.
- ✓ Be coordinated on person-centered and family-centered principles, focusing on individual needs, strengths, and choices.
- ✓ Support that all people have strengths and abilities and are the primary decision-makers in their lives.
- ✓ Provide information and supports that promote informed decision-making
- ✓ Promote partnerships with all stakeholders critical to the success of our efforts.
- ✓ Be accessible and culturally responsible.
- ✓ Access informal and generic community resources whenever possible in the most integrated community setting appropriate to the person.
- ✓ Be based on best practice and utilize state-of-the-art skills and information.
- ✓ Be directed toward the achievement of interdependence, contribution, and meaningful participation in the community.
- ✓ Distribute resources in an equitable manner according to individual need and comply with requirements governing public funds administered by the system.