

## MEDICAID WAIVER ASSESSMENT

### SECTION I – MEMBER DEMOGRAPHICS

Name <i>(last, first, middle)</i> Doe, Sally Jo	Date of birth <i>(mo., day, yr.)</i> 4 /18 /1956	Medicaid number 000000000
Street address 112 Hawthorne Drive	County code 000	Sex <i>(check one)</i> <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
City, state and zip code Sun City, Kentucky 40504	Emergency contact <i>(name)</i> Robert Doe	Marital status <i>(check one)</i> <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Member phone number ( 859 ) 260 -1212	Is member able to read and write <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Emergency contact <i>(phone #)</i> ( 259 ) 260 -1212
		Member's height 4'7" Member's weight 200 lbs

### SECTION II – MEMBER WAIVER ELIGIBILITY

Type of program applied for <i>(check one)</i> <input checked="" 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 checked="" type="checkbox"/> Consumer Directed Option <input type="checkbox"/> Blended	Adjudicated <input type="checkbox"/> /Nonadjudicated <input checked="" type="checkbox"/> Type of application <i>(check one)</i> <input checked="" type="checkbox"/> Certification <input type="checkbox"/> Re-certification <input type="checkbox"/> Re-application	
Member admitted from <i>(check one)</i> <input checked="" type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing facility <input type="checkbox"/> ICF/MR/DD <input type="checkbox"/> Other _____	Certification period <i>(enter dates below)</i> Begin date 12 /09 /2008 End date 12 /08 /2009 Certification number: 000000000 _____	
Has member's freedom of choice been explained and verified by a signature on the MAP 350 Form <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Has member been informed of the process to make a complaint <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>(see instructions)</i>	
Physician's name Dr. Good	Physician's license number (enter 5 digit #) 00000	Physician's phone number ( 000 ) 000 -0000
Enter member's primary diagnosis: HCB (ICD-9 code); SCL (DSM code); ABI (ICD-9 and/or DSM) Quadriplegia 344.00, IDDM 250.00, MR 299.0		
Enter all diagnoses including DSM or ICD-9 codes: AXIS I: (mental illness) AXIS II: (MR/DD)MR 299.0 AXIS III: (Medical)	Is the member diagnosed with one of the following? <input checked="" type="checkbox"/> Mental Retardation/ IQ= (Date-of-onset 04 /18 /1956 ) <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: Area Agency on Aging	Provider number 00000	Provider phone number ( 000 ) 000 -0000
Street address 1445 Lake Street	City, state and zip code Any town, USA	
Provider contact person Support Broker		

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**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)

<b>Name (last, first)</b> Doe, Sally Jo	<b>Medicaid Number</b> 000000000
<b>SECTION V – ACTIVITIES OF DAILY LIVING</b>	
<p><b>1) Is member independent with <u>  </u> <b>  </b> dressing/undressing</b></p> <p><input type="checkbox"/> Yes <input checked="" 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>	<p><b>Comments:</b></p> <p>Client requires total assistance with upper and lower body. Requires assistance with buttons, zippers, ties and any closures related to contractures.</p>
<p><b>2) Is member independent with <u>  </u> <b>  </b> grooming</b></p> <p><input type="checkbox"/> Yes <input checked="" 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>	<p><b>Comments:</b></p> <p>Client can brush her hair is brush placed in her right hand but requires assistance with styling. Client requires assistance with all over grooming needs due to lack of arm and hand movements.</p>
<p><b>3) Is member independent with <u>  </u> <b>  </b> bed mobility</b></p> <p><input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Always requires hands-on assistance</p> <p><input type="checkbox"/> Bed-bound</p> <p><input type="checkbox"/> Required bedrails</p>	<p><b>Comments:</b></p> <p>Requires total assist for bed mobility related to member being unable to use her fingers to grip. Requires assist of one for bed mobility.</p>
<p><b>4) Is member independent with <u>  </u> <b>  </b> bathing</b></p> <p><input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Requires total assistance</p>	<p><b>Comments:</b> Requires total assist with upper and lower body related to her dx. Member is unable to participate. Requires total assist with peri –care. Requires total bath preparation and receives a bed-bath.</p>
<p><b>5) Is member independent with <u>  </u> <b>  </b> toileting</b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If no, check below all that apply and comment)</p> <p><input checked="" type="checkbox"/> Bladder incontinence</p> <p><input checked="" 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 checked="" type="checkbox"/> Requires total assistance</p> <p><input type="checkbox"/> Bowel and bladder regimen</p>	<p><b>Comments:</b> Member requires In-Out catherization 2X day. Member has a colostomy bag. Member requires total assist to manage the in-out cath and colostomy on a daily basis.</p>
<p><b>6) Is member independent with <u>  </u> <b>  </b> eating</b> <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Requires assistance cutting meat or arranging food</p> <p><input checked="" 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>	<p><b>Comments:</b> Member requires arranging and cutting of food. Can feed herself but may require occasional help if weak and then requires to be fed.</p>

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<b>7) Is member independent with <b>ambulation</b></b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>(If no, check below all that apply and comment)</i> <input checked="" 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)	Comments: Member is dependent on a motorized w/c for mobility.
<b>8) Is member independent with <b>transferring</b></b> <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Hands-on assistance of two people <input checked="" type="checkbox"/> Requires mechanical device <input type="checkbox"/> Bedfast	Comments: Requires total lift of two people for all transfers. PCG (mother) uses a hooyer lift for transfers.
<b>SECTION VI - INSTRUMENTAL ACTIVITIES OF DAILY LIVING</b>	
<b>1) Is member able to prepare <b>meals</b></b> <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Requires total meal preparation	Comments: Member unable to prepare meals related to her dx. Requires total meal prep.
<b>2) Is member able to <b>shop</b> independently</b> <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Unable to participate in shopping	Comments: Requires PGC to shop. Can sometimes go along to get out of the house and to socialize. Can select items with assistance for getting off shelves and placing in cart.
<b>3) Is member able to perform light <b>housekeeping</b></b> <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Unable to perform any light housekeeping	Comments: Light housekeeping is performed by PCG (mother).
<b>4) Is member able to perform heavy <b>housework</b></b> <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Unable to perform any heavy housework	Comments: Member is unable to perform heavy housework due to dx. Mother performs this task.

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<p><b>5) Is member able to perform <b>laundry</b> tasks</b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i></p> <p><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 checked="" type="checkbox"/> Unable to perform any laundry tasks</p>	<p>Comments: Member is unable to perform any laundry task.</p>
<p><b>6) Is member able to plan/arrange for pick-up, delivery, or some means of gaining possession of <b>medication(s)</b> and take them independently</b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i></p> <p><input type="checkbox"/> Arranges for medication to be obtained and taken correctly  <input type="checkbox"/> Requires supervision or verbal cues  <input checked="" type="checkbox"/> Requires assistance with obtaining and taking medication correctly  <input type="checkbox"/> Unable to obtain medication and take correctly</p>	<p>Comments: PCG picks up medications and places in a medication planner. PCG assist with giving medications to the member.</p>
<p><b>7) Is member able to handle <b>finances</b> independently</b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i></p> <p><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 checked="" type="checkbox"/> Unable to handle finances</p>	<p>Comments: PCG handles all finances.</p>
<p><b>8) Is member able to use the <b>telephone</b> independently</b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>(If no, check below all that apply and explain in the comments)</i></p> <p><input type="checkbox"/> Requires adaptive device to use telephone  <input type="checkbox"/> Requires supervision or verbal cues  <input checked="" type="checkbox"/> Requires assistance when using telephone  <input type="checkbox"/> Unable to use telephone</p>	<p>Comments: Can talk on the phone if someone holds the phone to her ear. Unable to dial for out going calls.</p>
<b>SECTION VII-NEURO/EMOTIONAL/BEHAVIORAL</b>	
<p><b>1) Does member exhibit <b>behavior</b> problems</b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>(If yes, check below all that apply and explain the frequency in comments)</i></p> <p><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:</p> <p>Date of functional analysis:    /    /    and/or</p> <p>Date of behavior support plan:    /    /</p>

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<p><b>2) Is member oriented to person, place, time</b>  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>(If no, check below all that apply and comment)</i>  <input type="checkbox"/> Forgetful  <input type="checkbox"/> Confused  <input type="checkbox"/> Unresponsive  <input checked="" type="checkbox"/> Impaired Judgment</p>	<p>Comments: Member oriented to person and place not to time. Knows family and familiar places.</p>
<p><b>3) Has member experienced a major change or crisis within the past twelve months</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  <i>(If yes, describe)</i></p>	<p>Description:</p>
<p><b>4) Is the member actively participating in social and/or community activities</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  <i>(If yes, describe)</i></p>	<p>Description: Member unable to participate in social or community activities related to lack of transportation.</p>
<p><b>5) Is the member experiencing any of the following</b>  <i>(For each checked, explain the frequency and details in the comments section)</i>  <input type="checkbox"/> Difficulty recognizing others  <input checked="" 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>	<p>Comments: Mother (PCG) reports that the member appears lonely because she cannot participate in any community activities. Friends and relatives visit infrequently.</p>

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<p><b>6) Cognitive functioning (Participant’s current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.</li> <li><input checked="" type="checkbox"/> Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.</li> <li><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.</li> <li><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.</li> <li><input type="checkbox"/> Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.</li> </ul>	<p>Comments: Requires prompting for participation in conversations/activities. PCG must prompt member to greet people in the home.</p>
<p><b>7) When Confused (Reported or Observed):</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Never</li> <li><input type="checkbox"/> In new or complex situations only</li> <li><input checked="" type="checkbox"/> On awakening or at night only</li> <li><input type="checkbox"/> During the day and evening, but not constantly</li> <li><input type="checkbox"/> Constantly</li> <li><input type="checkbox"/> NA (non-responsive)</li> </ul>	<p>Comments: PCG reports that the member is sometimes confused and scared when she awakens at night.</p>
<p><b>8) When Anxious (Reported or Observed):</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> None of the time</li> <li><input type="checkbox"/> Less often than daily</li> <li><input type="checkbox"/> Daily, but not constantly</li> <li><input type="checkbox"/> All of the time</li> <li><input type="checkbox"/> NA (non-responsive)</li> </ul>	<p>Comments:</p>
<p><b>9) Depressive Feelings (Reported or Observed):</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Depressed mood (e.g., feeling sad, tearful)</li> <li><input type="checkbox"/> Sense of failure or self-reproach</li> <li><input type="checkbox"/> Hopelessness</li> <li><input type="checkbox"/> Recurrent thoughts of death</li> <li><input type="checkbox"/> Thoughts of suicide</li> <li><input type="checkbox"/> None of the above feelings reported or observed</li> </ul>	<p>Comments: Mother (PCG) reports that she thinks member is depressed (lack of interaction with others).</p>

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<p><b>10) Member Behaviors (Reported or Observed):</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Indecisiveness, lack of concentration</li> <li><input type="checkbox"/> Diminished interest in most activities</li> <li><input type="checkbox"/> Sleep disturbances</li> <li><input type="checkbox"/> Recent changes in appetite or weight</li> <li><input type="checkbox"/> Agitation</li> <li><input type="checkbox"/> Suicide attempt</li> <li><input checked="" type="checkbox"/> None of the above behaviors observed or reported</li> </ul>	Comments:
<p><b>11) Behaviors Demonstrated at Least Once a Week:</b></p> <ul style="list-style-type: none"> <li><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.</li> <li><input type="checkbox"/> Impaired decision-making: failure to perform usual ADL's, inability to inappropriately stop activities, jeopardizes safety through actions.</li> <li><input type="checkbox"/> Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.</li> <li><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).</li> <li><input type="checkbox"/> Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions).</li> <li><input type="checkbox"/> Delusional, hallucinatory, or paranoid behavior.</li> <li><input checked="" type="checkbox"/> None of the above behaviors demonstrated.</li> </ul>	Comments:
<p><b>12) Frequency of Behavior Problems (Reported or Observed) such as wandering episodes, self abuse, verbal disruption, physical aggression, etc.:</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Never</li> <li><input type="checkbox"/> Less than once a month</li> <li><input type="checkbox"/> Once a month</li> <li><input type="checkbox"/> Several times each month</li> <li><input type="checkbox"/> Several times a week</li> <li><input type="checkbox"/> At least daily</li> </ul>	

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<b>Name (last, first) Doe, Sally</b>	<b>Medicaid Number</b> 0000000000
<b>13) Mental Status:</b> <input checked="" type="checkbox"/> Oriented <input type="checkbox"/> Forgetful <input type="checkbox"/> Depressed <input type="checkbox"/> Disoriented <input type="checkbox"/> Lethargic <input type="checkbox"/> Agitated <input type="checkbox"/> Other  <hr style="width: 50%; margin-left: 0;"/> <hr style="width: 50%; margin-left: 0;"/>	Comments: x2 to family and familiar places. Not to time.
<b>14) Is this member receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Comments:
<b>SECTION VIII-CLINICAL INFORMATION</b>	
<b>1) Is member's vision adequate (with or without glasses)</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <i>(If no, check below all that apply and comment)</i> <input type="checkbox"/> Difficulty seeing print <input type="checkbox"/> Difficulty seeing objects <input type="checkbox"/> No useful vision	Comments: Wears glasses that mother places on member each day.
<b>2) Is member's hearing adequate (with or without hearing aid)</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <i>(If no, check below all that apply, and comment)</i> <input type="checkbox"/> Difficulty with conversation level <input type="checkbox"/> Only hears loud sounds <input type="checkbox"/> No useful hearing	Comments:
<b>3) Is member able to communicate needs</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check below all that apply and comment)</i> <input checked="" type="checkbox"/> Speaks with difficulty but can be understood <input type="checkbox"/> Uses sign language and/or gestures/communication device <input type="checkbox"/> Inappropriate context <input type="checkbox"/> Unable to communicate	Comments: Member has a speech impediment but can be understood.

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<p><b>4) Does member maintain an adequate diet</b>  <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>	<p>Comments:</p>
<p><b>5) Does member require respiratory care and/or equipment</b>  <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If yes, check all that apply and comment)  <input checked="" type="checkbox"/> Oxygen therapy (Liters per minute and delivery device)  <input checked="" 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>	<p>Comments: Member uses O2 at 2/L per nasal cannula at night. Uses breathing treatments as needed for shortness of breath.</p>
<p><b>6) Does member have history of a stroke(s)</b>  <input type="checkbox"/> Yes <input checked="" 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>	<p>Comments:</p>
<p><b>7) Does member's skin require additional, specialized care</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No          (If yes, check all that apply and comment)  <input checked="" 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>	<p>Comments: Requires additional lotions and creams to prevent skin breakdown.</p>
<p><b>8) Does member require routine lab work</b>  <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If yes, what type and how often)</p>	<p>Comments: 1X month to check blood sugar levels and CBC every 3 months. PCG checks blood sugar 2X day with a finger stick.</p>
<p><b>9) Does member require specialized genital and/or urinary care</b> <input checked="" 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 checked="" type="checkbox"/> In and out catheterization</p>	<p>Comments: In-out catheterization 2X day performed by PCG.</p>

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<b>10)</b> Does member require specific, physician-ordered vital signs evaluation necessary in the management of a condition(s) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain in the comments section)		Comments: Vital signs checked 1X month by HH nurse	
<b>11)</b> Does member have total or partial paralysis <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If yes, list limbs affected and comment)		Comments: Upper and lower limbs.	
<b>12)</b> Does member require assistance with changes in body position <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If yes, check all that apply and comment) <input checked="" type="checkbox"/> To maintain proper body alignment <input type="checkbox"/> To manage pain <input checked="" type="checkbox"/> To prevent further deterioration of muscle/joints/skin		Comments: Member is unable to change positions without assistance.	
<b>13)</b> Does member require 24 hour caregiver <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
<b>14)</b> Does member require respite services <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If yes, how often) <b>Mother</b> requesting 4 to 5 hours a week.			
<b>15)</b> Does the member require intravenous fluids, intravenous medications or intravenous alimentation <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If yes, check below all that apply and list solution, location, amount, rate, frequency and prescribing physician)			
<input type="checkbox"/> <b>Peripheral IV Solution:</b>	Location	Amount/dosage	Rate
Frequency		Prescribing physician	
<input type="checkbox"/> <b>Central line Solution:</b>	Location	Amount/dosage	Rate
Frequency		Prescribing physician	
<b>16)</b> Drug allergies (list) opiates		<b>17)</b> Other allergies (list) N/A	
<b>17)</b> Does the member use any medications <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, list below) *add additional pages if needed			
<b>Name of medication</b> Calcium	600 mg, 2Xday		<b>Administered by</b> PCG
Insulin 70/30	Sliding scale dosage		PCG
Ducolax suppositories	1 every other day		PCG



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<b>Name of medication</b>	<b>Dosage/Frequency/Route</b>	<b>Administered by</b>

<p><b>18) Is any of the following adaptive equipment required (If needs, explain in the comments)</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Dentures</td> <td style="width: 10%;"><input type="checkbox"/> Has</td> <td style="width: 10%;"><input type="checkbox"/> Needs</td> <td style="width: 10%;"><input checked="" type="checkbox"/> N/A</td> </tr> <tr> <td>Hearing aid</td> <td><input type="checkbox"/> Has</td> <td><input type="checkbox"/> Needs</td> <td><input checked="" type="checkbox"/> N/A</td> </tr> <tr> <td>Glasses/lenses</td> <td><input checked="" type="checkbox"/> Has</td> <td><input type="checkbox"/> Needs</td> <td><input type="checkbox"/> N/A</td> </tr> <tr> <td>Hospital bed</td> <td><input checked="" type="checkbox"/> Has</td> <td><input type="checkbox"/> Needs</td> <td><input type="checkbox"/> N/A</td> </tr> <tr> <td>Bedpan</td> <td><input type="checkbox"/> Has</td> <td><input type="checkbox"/> Needs</td> <td><input checked="" type="checkbox"/> N/A</td> </tr> <tr> <td>Elevated toilet seat</td> <td><input type="checkbox"/> Has</td> <td><input type="checkbox"/> Needs</td> <td><input checked="" type="checkbox"/> N/A</td> </tr> <tr> <td>Bedside commode</td> <td><input type="checkbox"/> Has</td> <td><input type="checkbox"/> Needs</td> <td><input checked="" type="checkbox"/> N/A</td> </tr> <tr> <td>Prosthesis</td> <td><input type="checkbox"/> Has</td> <td><input type="checkbox"/> Needs</td> <td><input checked="" type="checkbox"/> N/A</td> </tr> <tr> <td>Ambulation aid</td> <td><input type="checkbox"/> Has</td> <td><input type="checkbox"/> Needs</td> <td><input checked="" type="checkbox"/> N/A</td> </tr> <tr> <td>Tub seat</td> <td><input type="checkbox"/> Has</td> <td><input type="checkbox"/> Needs</td> <td><input checked="" type="checkbox"/> N/A</td> </tr> <tr> <td>Lift chair</td> <td><input type="checkbox"/> Has</td> <td><input type="checkbox"/> Needs</td> <td><input checked="" type="checkbox"/> N/A</td> </tr> <tr> <td>Wheelchair</td> <td><input checked="" type="checkbox"/> Has</td> <td><input type="checkbox"/> Needs</td> <td><input type="checkbox"/> N/A</td> </tr> <tr> <td>Brace</td> <td><input type="checkbox"/> Has</td> <td><input type="checkbox"/> Needs</td> <td><input checked="" type="checkbox"/> N/A</td> </tr> <tr> <td>Hoyer lift</td> <td><input checked="" type="checkbox"/> Has</td> <td><input type="checkbox"/> Needs</td> <td><input type="checkbox"/> N/A</td> </tr> </table>	Dentures	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	<input checked="" type="checkbox"/> N/A	Hearing aid	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	<input checked="" type="checkbox"/> N/A	Glasses/lenses	<input checked="" type="checkbox"/> Has	<input type="checkbox"/> Needs	<input type="checkbox"/> N/A	Hospital bed	<input checked="" type="checkbox"/> Has	<input type="checkbox"/> Needs	<input type="checkbox"/> N/A	Bedpan	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	<input checked="" type="checkbox"/> N/A	Elevated toilet seat	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	<input checked="" type="checkbox"/> N/A	Bedside commode	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	<input checked="" type="checkbox"/> N/A	Prosthesis	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	<input checked="" type="checkbox"/> N/A	Ambulation aid	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	<input checked="" type="checkbox"/> N/A	Tub seat	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	<input checked="" type="checkbox"/> N/A	Lift chair	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	<input checked="" type="checkbox"/> N/A	Wheelchair	<input checked="" type="checkbox"/> Has	<input type="checkbox"/> Needs	<input type="checkbox"/> N/A	Brace	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	<input checked="" type="checkbox"/> N/A	Hoyer lift	<input checked="" type="checkbox"/> Has	<input type="checkbox"/> Needs	<input type="checkbox"/> N/A	<p><b>Comments:</b></p>
Dentures	<input type="checkbox"/> Has	<input type="checkbox"/> Needs	<input checked="" type="checkbox"/> N/A																																																						
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Hoyer lift	<input checked="" type="checkbox"/> Has	<input type="checkbox"/> Needs	<input type="checkbox"/> N/A																																																						

**19) Please describe in detail any information regarding health, safety and welfare/crisis issues:**  
 52 y/o w/f residing with elderly parents. Dwelling is sound and w/c assessable with an outside w/c ramp. Parents are beginning to have health issues and need assistance with care of the member. Home currently has adequate heating but no cooling system for summer. SB will contact Community Action Agency later in the year for assistance with home cooling needs. Doorways in home will accommodate the member's w/c but not the hospital bed. SB will discuss and assist in developing an emergency evacuation plan with the parents. Hot water heater is being replaced by family. No other health, safety and welfare issues at this time.



<b>Name</b> ( <i>last, first</i> ) Doe, Sally	<b>Medicaid Number</b> 00000000000000
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**SECTION IX-ENVIRONMENT INFORMATION**

<p><b>1) Answer the following items relating to the member's physical environment</b> (<i>Comment if necessary</i>)</p> <table style="width: 100%; border: none;"> <tr><td>Sound dwelling</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Adequate furnishings</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Indoor plumbing</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Running water</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Hot water</td><td><input type="checkbox"/> Yes</td><td><input checked="" type="checkbox"/> No</td></tr> <tr><td>Adequate heating/cooling</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Tub/shower</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Stove</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Refrigerator</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Microwave</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Telephone</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>TV/radio</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Washer/dryer</td><td><input type="checkbox"/> Yes</td><td><input checked="" type="checkbox"/> No</td></tr> <tr><td>Adequate lighting</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Adequate locks</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Adequate fire escape</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Smoke alarms</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Insect/rodent free</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Accessible</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Safe environment</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Trash management</td><td><input checked="" type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> </table>	Sound dwelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Adequate furnishings	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Indoor plumbing	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Running water	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Hot water	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Adequate heating/cooling	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Tub/shower	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Stove	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Refrigerator	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Microwave	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Telephone	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	TV/radio	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Washer/dryer	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Adequate lighting	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Adequate locks	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Adequate fire escape	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Smoke alarms	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Insect/rodent free	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Accessible	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Safe environment	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Trash management	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<p>Comments: Hot water heater is broken. Family and friends are in the process of purchasing a new one and installing. Adequate heating but no cooling system. Family and friends takes laundry to laundry mat 1 x week.</p>
Sound dwelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																														
Adequate furnishings	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																																														
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**2) Provide an inventory of home adaptations already present in the member's dwelling.** (*Such as wheelchair ramp, tub rails, etc.*) *Wheelchair ramp*

**SECTION X – HOUSEHOLD INFORMATION**

<p><b>1) Does the member live alone</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No        If yes, does the member receive any assistance from others <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (<i>Explain</i>)</p>	<p>Comments: Member lives with elderly parents. Member's siblings, living outside the home, assist on weekends and after work hours. Also has an extended family of aunts and uncles that will assist with care and to provide respite for the PCG.</p>
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<b>2) Household Members</b> ( <i>Fill in household member info below</i> )			
<b>a) Name</b> Sue Doe	<b>Relationship</b> mother	<b>Age</b> 76	<b>Are they functionally able to provide care</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ( <i>If no, explain in the comments section</i> )
Comments: Elderly and beginning to have health issues.	Care provided/frequency PCG. Provides care 24/7		
<b>b) Name</b> Joe Doe	<b>Relationship</b> Father	<b>Age</b> 77	<b>Are they functionally able to provide care</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No ( <i>If no, explain in the comments section</i> )
Comments: Elderly and disabled from a back injury.	Care provided/frequency Will assist with supervision but unable to provide any hands on care.		
<b>c) Name</b>	<b>Relationship</b>	<b>Age</b>	<b>Are they functionally able to provide care</b> <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>If no, explain in the comments section</i> )
Comments:	Care provided/frequency		
<b>d) Name</b>	<b>Relationship</b>	<b>Age</b>	<b>Are they functionally able to provide care</b> <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>If no, explain in the comments section</i> )
Comments:	Care provided/frequency		

**SECTION XI-ADDITIONAL SERVICES**

<b>1) Has the member had any hospital, nursing facility or ICF/MR/DD admissions in the past 12 months?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No ( <i>If yes, please list below</i> )		
<b>a-Facility name</b>	Facility address	
Reason for admission	Admission date / /	Discharge date / /
<b>b-Facility name</b>	Facility address	
Reason for admission	Admission date / /	Discharge date / /

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<b>Name (last, first)</b> Doe , Sally		<b>Medicaid Number</b> 0000000000000	
<b>2) Does the member receive services from other agencies (Example: Both Waiver and Non-waiver Services.)</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>(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)</i>			
<b>a-Service(s) received</b> Skilled nursing- nursing checks and blood draws		Agency/worker name Anytown Home Health	Phone number ( 000 ) 000 -0000
Agency address Anytown , USA		Frequency 1X month	Number of units 10
<b>b-Service(s) received</b>		Agency/worker name	Phone number ( ) -
Agency address		Frequency	Number of units
<b>c-Service(s) received</b>		Agency/worker name	Phone number ( ) -
Agency address		Frequency	Number of units
<b>SECTION XII-CONSUMER DIRECTED OPTION</b>			
Has the member been provided information on Consumer Directed Option (CDO) and their right to choose CDO, traditional or blended services? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>If no, give reason:</b>			
Has the member chosen Consumer Direction Option? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, include form MAP 2000			
<b>SECTION XIII-SIGNATURES</b>			
<b>Person(s) performing assessment or reassessment:</b>			
Signature: Support Broker Signature		Title: SB	Date 00 /00 /00
Signature:		Title:	Date / /
<b>Verbal Level of Care Confirmation:</b>			
Date: 0 /00 /00		Name of QIO personnel	
		Time: 0:00 am/pm	
<b>Assessment/Reassessment forwarded to Support Broker/Case Management provider:</b>			
Date Forwarded: / /		Time Forwarded: am/pm	
Name of Person Forwarding:		Title of Person Forwarding:	
<b>Receipt of assessment/reassessment by Support Broker/case management provider:</b>			
Date Received: / /		Time Received: am/pm	
Name of Person Logging Receipt:		Title of Person Logging Receipt:	
<b>QIO Signature:</b>			
		Level of Care Date / /	Approval dates From: / / To: / /

