

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
MEDICAID WAIVER ASSESSMENT

Name (<i>last, first</i>)	Medicaid Number
SECTION IV SELF ASSESSMENT	
*For SCL, MP 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)	

Name (last, first)	Medicaid Number
SECTION V – ACTIVITIES OF DAILY LIVING	
<p>1) Is member independent with 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 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 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 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 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 eating <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(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 (<i>last, first</i>)	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
MEDICAID WAIVER ASSESSMENT

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>	<p>Comments:</p>
<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>	<p>Comments:</p>
<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>	<p>Comments:</p>
<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>	<p>Comments:</p>
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
MEDICAID WAIVER ASSESSMENT

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>) <input type="checkbox"/> Forgetful <input type="checkbox"/> Confused <input type="checkbox"/> Unresponsive <input type="checkbox"/> Impaired Judgment</p>	<p>Comments:</p>
<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>	<p>Description:</p>
<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>	<p>Description:</p>
<p>5) Is the member experiencing any of the following <i>(For each checked, explain the frequency and details in the comments section)</i> <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>	<p>Comments:</p>

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 	<p>Comments:</p>

Name (last, first)	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>	<p>Comments:</p>
<p>14) Is this member receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Comments:</p>
SECTION VIII-CLINICAL INFORMATION	
<p>1) Is member's vision adequate (with or without glasses)</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>	<p>Comments:</p>
<p>2) Is member's hearing adequate (with or without hearing aid)</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>	<p>Comments:</p>
<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>	<p>Comments:</p>
<p>4) Does member maintain an adequate diet</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, check all that apply and comment)</i></p> <p><input type="checkbox"/> Uses dietary supplements</p> <p><input type="checkbox"/> Requires special diet (low salt, low fat, etc.)</p> <p><input type="checkbox"/> Refuses to eat</p> <p><input type="checkbox"/> Forgets to eat</p> <p><input type="checkbox"/> Tube feeding required <i>(Explain the brand, amount, and frequency in the comments section)</i></p> <p><input type="checkbox"/> Other dietary considerations <i>(PICA, Prader-Willie, etc.)</i></p>	<p>Comments:</p>

Name (<i>last, first</i>)	Medicaid Number
<p>5) Does member require respiratory care and/or equipment</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, check all that apply and comment</i>)</p> <p><input type="checkbox"/> Oxygen therapy (Liters per minute and delivery device)</p> <p><input type="checkbox"/> Nebulizer (Breathing treatments)</p> <p><input type="checkbox"/> Management of respiratory infection</p> <p><input type="checkbox"/> Nasopharyngeal airway</p> <p><input type="checkbox"/> Tracheostomy care</p> <p><input type="checkbox"/> Aspiration precautions</p> <p><input type="checkbox"/> Suctioning</p> <p><input type="checkbox"/> Pulse oximetry</p> <p><input type="checkbox"/> Ventilator (list settings)</p>	<p>Comments:</p>
<p>6) Does member have history of a stroke(s)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, check all that apply and comment</i>)</p> <p><input type="checkbox"/> Residual physical injury(ies)</p> <p><input type="checkbox"/> Swallowing impairments</p> <p><input type="checkbox"/> Functional limitations (Number of limbs affected)</p>	<p>Comments:</p>
<p>7) Does member's skin require additional, specialized care <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(<i>If yes, check all that apply and comment</i>)</p> <p><input type="checkbox"/> Requires additional ointments/lotions</p> <p><input type="checkbox"/> Requires simple dressing changes (i.e. band-aids, occlusive dressings)</p> <p><input type="checkbox"/> Requires complex dressing changes (i.e. sterile dressing)</p> <p><input type="checkbox"/> Wounds requiring "packing" and/or measurements</p> <p><input type="checkbox"/> Contagious skin infections</p> <p><input type="checkbox"/> Ostomy care</p>	<p>Comments:</p>
<p>8) Does member require routine lab work</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, what type and how often</i>)</p>	<p>Comments:</p>
<p>9) Does member require specialized genital and/or urinary care <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(<i>If yes, check all that apply and comment</i>)</p> <p><input type="checkbox"/> Management of reoccurring urinary tract infection</p> <p><input type="checkbox"/> In-dwelling catheter</p> <p><input type="checkbox"/> Bladder irrigation</p> <p><input type="checkbox"/> In and out catheterization</p>	<p>Comments:</p>
<p>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>)</p>	<p>Comments:</p>
<p>11) Does member have total or partial paralysis</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If yes, list limbs affected and comment</i>)</p>	<p>Comments:</p>

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
MEDICAID WAIVER ASSESSMENT

Name (last, first)	Medicaid Number
<p>18) Is any of the following adaptive equipment required (If needs, explain in the comments)</p> <p>Dentures <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Hearing aid <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Glasses/lenses <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Hospital bed <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Bedpan <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Elevated toilet seat <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Bedside commode <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Prosthesis <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Ambulation aid <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Tub seat <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Lift chair <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Wheelchair <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Brace <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p> <p>Hoyer lift <input type="checkbox"/> Has <input type="checkbox"/> Needs <input type="checkbox"/> N/A</p>	<p>Comments:</p>
<p>19) Please describe in detail any information regarding health, safety and welfare/crisis issues:</p>	

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
MEDICAID WAIVER ASSESSMENT

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/ID/DD admissions in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> 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
MEDICAID WAIVER ASSESSMENT

Name (last, first)		Medicaid Number	
2) Does the member receive services from other agencies (Example: Both Waiver and Non-waiver Services.) <input 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>			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give reason:			
Has the member chosen Consumer Direction Option? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	