For CMPFE/HCBS Elderly Waiver

Client Name: ____________________

Client Telephone #: ____________________

Home- and Community-Based Services (HCBS) My right to choose a home- and community-based program has been explained to me. I have been advised that I may choose: (1) Home- and Community-Based Services or (2) Medical Institutional Services. I choose: ❑ HCBS ❑ Medical Institutional Services	
Signature of Consumer or Guardian or Durable Power of Attorney for Health Care:	Date:

VERIFICATION OF HCBS CONSUMER CHOICE

Ask the Client: What problems a
are you receiving? **(If no answer**

Source of Information (Complet

____
(Name)

Legal Guardian?

Conservator of Property and Finar

Durable Power of Attorney for hea

Financial Power of Attorney?

Representative Payee or Bill Paye

Name ____________

12/27/2004

Emergency Contact/Next of Kin

Name	Address	Relationship to Client	Phone

Income Sources (client) (or attach agency financial sheet if it contains the following information)

		(Check, If yes)	(Amount)
a.	Earnings from employment (wages, salaries, or income from your business)	______	$__________
b.	Social Security (includes Social Security disability payments but not SSI)	______	$__________
c.	VA benefits such as G.I. Bill and disability payments	______	$__________
d.	Disability payments not covered by Social Security, SSI or VA	______	$__________
e.	Retirement pension from job	______	$__________
f.	Money from children on a regular basis	______	$__________
g.	Interest or dividend income	______	$__________
h.	SSI payments (yellow government checks)	______	$__________
i.	Welfare payments/ADFC/Food Stamps (Circle those received)	______	$__________
j.	**Total Income**		$__________
k.	Assets (excluding home and automobile)		$__________

Estimate Spouses Income: $________________ Estimate Spouses Assets (Exclude home and auto) $__________

Are you or your spouse a Veteran? _____ Veteran _____ Spouse _____ Neither

HEALTH INSURANCES:	YES	NO	
Medicare – Part A	______	______	Medicare #: ____________________
Medicare – Part B	______	______	
Medicaid	______	______	Medicaid #: ____________________
Veteran's Administration	______	______	
HMO/Other (Specify)	______	______	

HEALTH PROBLEMS

Do you have any health problems, and how do they affect you? **(Ask):** For instance, has a doctor told you that you have any of the following health problems or symptoms of health problems? **(Read Health Conditions to Client)**

Health Conditions	Present	Interferes With Living	Condition Not Under Treatment	Notes:
Allergies (Type) (Drug/skin/etc): ________________	____	____	____	
*Amputation (Site):________________	____	____	____	
*Anemia (Type): ________________	____	____	____	
Arthritis (Type): ________________	____	____	____	
Asthma (Type): ________________	____	____	____	
*Bed Sore(s) (Decubitus Stage) :________________	____	____	____	
Bladder/Kidney Problems (UTI, etc.)	____	____	____	
Broken Bones (Type; Site): ________________	____	____	____	

*Cancer Type):_______________	____	____	____
*Dehydration	____	____	____
Dementia (Type); (Alz, OBS, etc):_______________	____	____	____
*Dialysis (Type): _______________	____	____	____
*Diabetes (Type): _______________	____	____	____
Dizziness	____	____	____
*Emphysema (COPD, etc.)	____	____	____
Falls (Past Year)	____	____	____
Gallbladder Problems (Gallstones, etc.)	____	____	____
Hearing Problems	____	____	____
Heart Problems (CHF, MI, etc.)	____	____	____
*High Blood Pressure (Type) _______________	____	____	____
*HIV/ARC/AIDS	____	____	____
*Liver Problems (Cirrhosis, Hepatitis, etc.)	____	____	____
*Osteoporosis	____	____	____
Paralysis (Site): _______________	____	____	____
Parkinson's Disease	____	____	____
Pneumonia	____	____	____
*Potassium/Sodium Imbalance (Electrolytes)	____	____	____
Seizure Disorders (epilepsy, etc.)	____	____	____
Shingles (Herpes Zoster)	____	____	____
Sleep Problems	____	____	____
Stroke (CVA, etc.)	____	____	____
Thyroid Problems (Graves, Myxedema, etc.)	____	____	____
Tuberculosis	____	____	____
*Ulcers (Type, Site): _______________	____	____	____
*Ulcerative Colitis/Crohn's	____	____	____
Vision Problems (Cataracts, Glaucoma, etc.)	____	____	____
Other (Specify) _______________	____	____	____

*Asterisked items refer to question on page 5 (nutrition section)

CLIENT SUPPORT: Complete for Services/Help received and needed.

a. SERVICES/HELP			b. NAME OF HELPER Person or agency name	c. HELPER CODE 1 = Spouse 2 = Children 3 = Friend 4 = Other relative 5 = Agency 5 = Agency 6 = Church	d. FREQUENCY Hours, visits, meals in a typical week.	e. ADDITIONAL HELP NEEDED
Do you receive help with…	Yes	No				
Personal Care Assistance (bathing, dressing, getting out of bed, toileting and eating)			1.			
			2.			
			3.			
			4.			
Housekeeping (laundry, cleaning, meals, etc.)			1.			
			2.			
			3.			
Transportation			1			
			2.			
Shopping/Errands			1.			
			2.			
Personal Finance (money management)			1.			
			2.			
Services from a health professional (such as a RN or therapist)			1.			
			2.			
Adult Day Care			1.			
			2.			
Home Delivered Meals (formal only)			1.			
			2.			
Congregate Meals (specify the site)			1.			
			2.			
Emergency Response Syst.			1.			
In Home Health Care Provider Program - DHS			1.			
Any other kind of help? (specify)			1.			
			2.			
Social Contacts: Phone calls from others						
Visits (from those not living with you)						
What activities/interests do you enjoy?						
Attend religious services as often as you like? (specify denomination)						

CAREGIVER ASSESSMENT - Address questions to caregiver

Name of Primary Caregiver: ______________________________

Consider the care you provide for ________________________, I would like to ask you if various aspects of your life have become b

	Better	Same	Worse	Don't
Relationship with the client	_____	_____	_____	_____
Relationship with other family members	_____	_____	_____	_____
Relationship with friends	_____	_____	_____	_____
Your health	_____	_____	_____	_____
Your work (if applicable)	_____	_____	_____	_____
Your emotional well-being	_____	_____	_____	_____

No Yes **If you were suddenly unable to provide care, would there be someone who could take your place?**
If yes, specify ______________________________

No Yes **Is there anything else we need to know that makes it difficult for you to manage care?**
If yes, please describe______________________________

No Yes **Do you need training or services?**

NUTRITION *(Circle the score of the items that apply.)*

		Yes
I have an illness or condition that made me change the kind and/or amount of food I eat. *[Assessor: Review diagnoses asterisked on page 2, If any are checked 'Interferes with Living', circle 4. If none are checked 'Interferes', but 1 or more are checked 'Present', circle 2.]*		2 4
I eat fewer than 2 meals per day.		3
I eat few fruits or vegetables or milk products.		2
I have 3 or more drinks of beer, liquor or wine almost every day.		2
I have problems that make it hard for me to eat...		
Tooth or mouth?	1	
Swallowing?	1	
Nausea/Vomiting/Diarrhea?	1	
Taste Problems?	1	
Problems eating certain foods?	1	
Food allergies?	1	
Heartburn?	1	
Poor Appetite?	1	
Enter 'Problem' Subtotal at Right		
I don't always have enough money to buy the food I need.		4
I eat alone most of the time.		1
I take 3 or more different prescribed or over-the-counter drugs a day. Height__________ Weight__________		1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.		2
I am not always physically able to shop, cook and/or feed myself.		2
Total		

Are you on any special diets for medical reasons? (Check those that apply)

_____ Low Sodium (salt)?
_____ Low fat/cholesterol?
_____ Low sugar?
_____ Calorie Supplement?
_____ Other special diet?
(Describe)______________________

If TOTAL nutritional score is:

0 - 3 **Low Risk.** No referral for dietician consultation is needed.

4 - 7 **Moderate Risk.** Assessor judgment required regarding client's overall status and ability to meet nutritional deficits with current resources to determine need for referral for dietician consultation.

8+ **High Risk.** Refer client to dietician for further nutritional assessment and consultation.

Do you drink any alcoholic beverages including beer and wine?

Yes How much/How often____

No

Do you smoke or use tobacco?

Yes How much/How often ________________________ Type_________________

No

Do you use other drugs not prescribed by your doctor? Yes No If yes, what are they?______________________

IFMC ROUTING - for AAA COORDINATOR USE ONLY

Area Agency on Aging Name: ______________________________

Date Assessment Completed: ______________ Date Entered CMPFE: ______________

Original Assessment Annual Update Reimbursement Requested
Suspected change in level of care Not admitted to CM
New application for HCBS-EW; most recent assessment more than 60 days old
OASIS electronically submitted Date ____________________

Person Completing Assessment: ______________________________

Assessor's Agency: ______________________________ Agency Type ______________

Assessor's Agency Medicare-certified? Yes No

Case Manager's Agency: ______________________________ Agency Type ______________

Agency Type:
1 Homemaker/Chore
2 Hospice
3 Alzheimer's Chapter
4 AAA/other aging services agency (e.g., CASI, ESA)
5 Public Health Agency
6 Private Home Health Agency
7 DHS
8 Mental Health
9 Adult Day Services Center
10 Other

Client's SS# ______________________________ County ______________

Client's Name ______________________________

Client's Address ______________________________

Physician's Name ______________________________ Phone ______________
FIRST/LAST

Physician's Address ______________________________
MAILING ADDRESS CITY ZIP

Client's Primary Language: English Spanish Other (SPECIFY) ______________
Can the client speak English? Yes No
Can the client understand English? Yes No
U.S. Citizen or Legal Resident? Yes No
Country of Origin? ______________________________
How many persons live in the household (including client)? ______________

Marital Status: Married Divorced/Separated Unknown
Widowed Single, Never Married

Does client need help with personal finances (money management)? Yes No

Health Status: Height____________ Weight___________

Lost or gained 10 pounds in the last 6 months? Yes No

Treatment of pressure ulcer, skin lesion/open wound: ____________
Self Assistance required

Care of urinary catheter (CHECK ALL THAT APPLY):
Self Assistance required Irrigations required

MEDICATION USE (Or attach Medication Sheet)

(Current medicines, refrigerated medicines, non-prescription drugs, e.g. aspirins, vitamins or laxatives.)

Name	Dosage	Method of Administration	Frequency	Person Administering	Physician

Pharmacy Name ____________ Phone ____________

Pharmacy Address

____
MAILING ADDRESS CITY ZIP

Length of time to complete the OASIS tool (if applicable) ____________
Length of time to complete 7 CMPFE pages ____________

IFMC Routing - For Internal Use Only

MDS/OASIS technician notified Date ____________
OASIS received from technician Date ____________
Data entry completed Date ____________
Notification sheet to file Date ____________