Name: Member Assessment, Section II Personal Assistance/Homemaker (PA/HM) RN (Policy Reference: 501.7)
Purpose: A face-to-face interview in the member's home in order to identify the member's abilities, needs, preferences, and supports; determine needed services or resources; and provide a sound basis for developing the Service Plan and Plan of Care. A Secondary purpose is to provide the member a good understanding of the program, services," and expectations. There are 2 components to the Member Assessment ***whenever possible*** both of these assessments should be scheduled to be conducted at the same time.

Note: Complete all areas must be completed leaving no blanks:

Section II Personal Assistance/Homemaker RN

- Document member's name and date at the top of each page.
- Select the type of Assessment:
  - Initial
  - 6-month
  - Annual
  - Post-Hospital
  - Change in Needs

Demographics document members

- Last and First Name.
- Date of the Assessment
- Current PAS Date

1. **Review of Systems**
   - Neuromuscular; answer each area listed by circling or checking the findings of each item assessed. *All area's MUST be address*.

   - Cardio-Pulmonary; answer each area listed by circling or checking the findings of each item assessed. *All area's MUST be address*.

- GI/GU; answer each area listed by circling or checking the findings of each item assessed. *All area's MUST be address*.

- Integumentary; answer each area listed by circling or checking the findings of each item assessed. *All area's MUST be address*. Use the person diagram to show location(s) of any of skin problems documented.

- Describe any treatments and/or health care provided for the member not currently addressed elsewhere in the assessment.

- Medical Equipment in the home: Check all equipment the member has in the home and document any needed Medical Equipment.

2. **Member Activities:** Enter the level of Assist needed for each area in the box listed for "Level of Assist" using an "**I"** for Independent, "**S"** for Supervision, "**P"** for Partial or a "**T"** for Total assist. Make any needed comments in the Comment section.

3. If you have made a referral to the member's physician's office, sent the member to the emergency room, clinic or any other service referrals mark this area "yes" and document where, when, why, or how in the area below the question.

4. Document any changes in needs since the last Pre-Admission Screening (PAS) was completed and include any hospitalizations since the last assessment. Note any comments in the Comment section.

5. Document the PA/RN arrival time, departure time and total time it took to complete the assessment.

Once the assessment is ***completed*** it must be ***signed and dated*** by the following:

- Member/legal representative
- PA/HM RN completing the assessment.

The PA/HM RN **must** also provide a copy of this assessment to the member/legal representative and the Case Manager Agency as soon as possible and document the date the copies were provided.

6. Attachment A, Medication Profile
    - Enter Member name, DOB, Diagnosis, Allergies, Pharmacy, PCP and other specialist;
    - Enter the date the medication was reviewed by the RN.
    - Note the medication as new, changed (chg) or discontinued (D/C) (***If this is your first assessment for this member, skip this column and continue to enter the Medication/Dose).***
    - Document the name of the medication and dose, the frequency, reason the member is taking the medication, and the name of ordering physician in columns provided.
    - The RN must always sign to document any medication addition or change.
    - When the PA/HM RN is assessing a member for the first time, either as a newly enrolled member or a transfer, she/he may sign the first medication and then draw a line down to the last medication entered and initial the last box.

(Example) New enrolled member; Initial Assessment:

Review Date	New Chg D/C	Medication/Dose	Frequency	Reason	Physician	RN Signature
12/20/12		Tylenol/ 500mg	1tab PRN daily	Pain	Dr. Jones	*P. Pushkin*
12/20/12		Ducolax/5mg	1 tab at BT	constipation	Dr. Jones	|
12/20/12		Hyzaar / 50mg	1 tab qd	BP	Dr. Jones	|
12/20/12		Diabinese 250mg	1 tab q morning	Diabetes	Dr. Jones	|
12/20/12		Cymbalta/30mg	1 cap qd	Depression	Dr. Jones	*PP*

(Example)

- **Two months later you find out the doctor discontinued the Tylenol. You would note in the Box.**
- **Upon you 6 month Assessment you discover the doctor ordered a new medication for pain.**
- **At a later date member calls and tells you the doctor had to increase the Cymbalta dose to 60 mg.**
- **And so on:**

Review Date	New Chg D/C	Medication/Dose	Frequency	Reason	Physician	RN Signature
12/20/12	D/C 2/20/13	Tylenol/ 500mg	1tab PRN daily	Pain	Dr. Jones	P. Pushkin
12/20/12		Ducolax/5mg	1 tab at BT	constipation	Dr. Jones	|
12/20/12		Hyzaar / 50mg	1 tab qd	BP	Dr. Jones	|
12/20/12		Diabinese 250mg	1 tab q morning	Diabetes	Dr. Jones	|
12/20/12	D/C 8/1/13	Cymbalta/30mg	1 cap qd	Depression	Dr. Jones	PP
6/15/13	New	Advil	3 tabs q 8hrs	Pain	Dr. Jones	P. Pushkin
8/1/13	Chg	Cymbalta/60mg	1 cap q day	Depression	Dr. Jones	P. Pushkin
9/21/13	Chg	Hyzaar/ 100mg	1 tab qd	BP	Dr. Jones	P. Pushkin

As the example shows once you list the current medications on the Medication Profile which is an attachment to the assessment you can add new and changed medications without it being a part of the assessment requiring the members signature. This means once the page is full you would add a new page and so on. This will enable you to keep an ongoing updated medication profile at all times.

Please note the ONLY time it is acceptable to draw a line down and initial as shown on this example is for the first assessment you conduct for the member.