Name: Personal Care Member Assessment (Policy Reference: 517.8.1 and 517.8.2) 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 Personal Care Plan of Care.

Note: All areas must be completed leaving no blanks:

- Document member's name and assessment date at the top of each page.
- Select the type of Assessment: Initial, 6 month, Annual

1. **Demographics:** Document the members;
   - Last and First Name
   - Date of Birth (DOB)
   - Date of the Assessment
   - Financial Eligibility Effective Date: Date of **confirmation** of Medicaid eligibility, i.e. personally viewed Medicaid card or called local DHHR office.
   - Current PAS Date
   - Anchor date: date next PAS is due.
   - Physical Address: city, county, zip code
   - Mailing Address: city, county, zip code
   - Home phone, Cell phone and any other phone.
   - Detailed directions to members home.

2. **Legal Representative**: Check any that apply. Request a copy of the document for the member's record or note no copy provided. Document the person's Name and phone number.

3. **Environmental Assessment**: Check all that apply. Document the name, phone number and relationship of anyone living with the member.

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

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

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

- 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.

5. 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.

6. 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.

7. Document the name and relationship of anyone present during the assessment.

8. Document the PC 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
- Personal Care RN completing the assessment.

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

9. 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 PC 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 member's 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.