Traumatic Brain Injury (TBI) Waiver Program
Member Assessment

Member Name _____ Date: _____

Section I. CASE MANAGEMENT

☐ **Initial** ☐ **6 month** ☐ **Annual** ☐ **Change in Needs**

1. DEMOGRAPHICS

Last Name:	First Name:	Middle Initial:
Date of Assessment:	Financial Eligibility Effective Date:	
Current PAS Date:	Medical Re-evaluation Request due by:	
Current Rancho- LCF Date:		
Physical Address:		
City/State/ZIP:	Phone:	
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married		
Race: ☐ Asian ☐ Hispanic ☐ Black ☐ Native American ☐ Caucasian ☐ Other		
Military/Veteran Status: ☐ Active Duty ☐ Veteran ☐ Spouse of Veteran/AD ☐ None		
Detailed directions to member's home:		

2. INSURANCE AND HEALTH CARE INFORMATION

Medicaid #:	Medicare #:
Medicare Part A Effective Date:	Medicare Part B Effective Date:
Medicare Plan:	Drug Plan Name:

Check any that apply. A copy showing either the relationship or the document needs to be included in member's file.

☐ **Legal Guardian** ☐ **Conservator** ☐ **Committee**

☐ **Health Care Surrogate** ☐ **Medical POA** ☐ **Living Will**

☐ **Legal POA** ☐ **Durable POA** ☐ **Do Not Resuscitate**

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Legal Representative Name:	Phone:
Address:	
Primary Care Doctor Name:	Phone:
Pharmacy Name:	Phone:
Specialist Name:	Phone:

3. GOALS AND CURRENT RESOURCES (MEMBER'S ABILITIES AND SUPPORTS)

What kinds of services and help are you expecting from this program?

_____

_____

Do you manage your finances (pay bills, go to bank, make purchases, balance checkbook, make simple purchases, handle money matters, etc.)? ☐ YES ☐ NO

If No, do you need someone to assist you? ☐ YES ☐ NO

Do you need assistance to use the telephone? ☐ YES ☐ NO

Do you need assistance with housekeeping? ☐ YES ☐ NO

Do you need assistance with home maintenance? ☐ YES ☐ NO

Do you currently have someone who assists you with activities such as bathing, grooming, preparing meals, etc.? ☐ YES ☐ NO If yes, who helps and what do they help you with?

_____

_____

Activity	Name	Paid (formal) or friends/family (informal) support
Bathing		
Dressing		
Grooming		
Walking		
Wheeling		
Transferring/repositioning		
Toileting		
Medication prompting		

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Activity	Name	Paid (formal) or friends/family (informal) support
Meal preparation		
Laundry		
Essential errand (Describe)		
Community Activities		
Dishes		
Take out trash		

Once you are on this program will these individuals/agencies continue to provide you with these services? ☐ **YES** ☐ **NO**
Note any that will not continue supports:

_____

_____

4. ENVIRONMENTAL NEEDS ASSESSMENT

Location: ☐ Urban ☐ Suburban ☐ Rural

Type of home: ☐ Apartment ☐ Single Family Home ☐ Duplex
☐ Single Story ☐ Multiple Family Home ☐ Two or more floors

Do you own or rent your home? ☐ **Own** ☐ **Rent**

Is the home isolated (no visible neighbors) from other homes in the area? ☐ **YES** ☐ **NO**

Who Lives with You?

☐ I live alone

Name	Relationship

What changes to your home would make it easier for you to get in/out of the home or to do activities in your home? List Home Modifications:

_____

_____

_____

_____

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Does the home have:		Comments
Running water	☐ YES ☐ NO	
Adequate heat	☐ YES ☐ NO	
Air conditioning	☐ YES ☐ NO	
Working cook stove	☐ YES ☐ NO	
Working refrigerator	☐ YES ☐ NO	
Telephone access	☐ YES ☐ NO	
Smoke alarm/detector	☐ YES ☐ NO	
Carbon monoxide alarm/detector	☐ YES ☐ NO	
Plumbing issues	☐ YES ☐ NO	
Electrical hazards	☐ YES ☐ NO	
Poor lighting	☐ YES ☐ NO	
Structural/upkeep problems	☐ YES ☐ NO	
Uneven flooring	☐ YES ☐ NO	
Scattered floor rugs	☐ YES ☐ NO	
Grab bars in bathroom	☐ YES ☐ NO	
Barriers to access, inside or outside (such as stairs, narrow doorways, etc.)	☐ YES ☐ NO	
Room temperature appropriate to season	☐ YES ☐ NO	
Apparent natural gas leak	☐ YES ☐ NO	
Rodent or insect infestation	☐ YES ☐ NO	
Excessive number of pets	☐ YES ☐ NO	

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Do you have any pets? ☐ YES ☐ NO If yes, what type and how many:

_____

_____

Are any of these pets a potential danger to others? ☐ YES ☐ NO
If yes, which pets and how are they a danger:

_____

_____

Note any other safety and/or sanitation hazards found in the home such as insects, rodents present, no trash pickup, soiled living area, etc.

_____

_____

Do you ever feel unsafe in your home? ☐ YES ☐ NO If yes, with whom and when?

_____

_____

Do you ever feel unsafe in your neighborhood? ☐ YES ☐ NO If yes, with whom and when?

_____

_____

Are you satisfied with your living conditions? ☐ YES ☐ NO

_____

_____

5. MEDICAL NEEDS ASSESSMENT

Do you have a Primary Care Physician? ☐ YES ☐ NO

What is your Physician's number? _____

When is the last time you saw your Physician? _____

What do you think are your most serious medical conditions?

_____

_____

How do these medical conditions affect you?

_____

_____

Place a checkmark next to the type of services you need:

☐ Specialist	☐ Occupational Therapy	☐ Optometrist
☐ Physical Therapy	☐ Blood work	☐ Audiologist
☐ Speech Therapy	☐ Dentist	☐ Podiatrist

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☐ Other Medical services (please explain): _____

Do you need assistance in making an appointment for these services? ☐ YES ☐ NO
If so, who currently helps you? _____

MEDICATION NAME	REASON FOR MEDS	DOSE/METHOD	FREQUENCY	PRESCRIBING PHYSICIAN

Any recent medication changes? ☐ YES ☐ NO

If yes, what and why? _____

How much does your medication cost you per month? _____

Have you made any changes in the way you eat because of an illness or medical condition? ☐ YES ☐ NO

How many meals do you eat each day? _____

Do you eat at least one serving of fruits or vegetables daily? ☐ YES ☐ NO
Do you eat at least one serving of dairy products daily? ☐ YES ☐ NO
Do you drink more than two alcoholic beverages daily? ☐ YES ☐ NO
Do you have problems with your teeth or mouth which make it hard for you to eat? ☐ YES ☐ NO
Do you have enough money to buy the food you need? ☐ YES ☐ NO
Do you take three or more prescriptions daily? ☐ YES ☐ NO
Have you gained or lost more than 5 lbs. in the last 6 months without wanting to? ☐ YES ☐ NO
Are you able to do your own grocery shopping and cooking? ☐ YES ☐ NO
Are you on a special diet? ☐ YES ☐ NO
Do you drink 6-8 cups of non-alcoholic beverages each day? ☐ YES ☐ NO
Do you have a good appetite? ☐ YES ☐ NO
Do you have any problems with constipation or diarrhea? ☐ YES ☐ NO

6. SOCIAL NEEDS ASSESSMENT (MEMBER PREFERENCES)

How often are you able to leave your home?

☐ Daily ☐ 1 to 6 times a week ☐ 2 to 3 times a month
☐ Monthly ☐ Rarely ☐ Never
☐Other: _____

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What prevents you from leaving your home?

- ☐ Do not want to
- ☐ Physically unable to do so
- ☐ No access to transportation
- ☐ Other: _____

How do you spend your days?

_____

_____

What types of activities do you enjoy, such as shopping, playing cards, reading, etc.?

_____

_____

Are there activities you enjoy but you have not been able to do? ☐ YES ☐ NO

Activity	Barrier to participating in activity

Would these activities be of interest to you if these barriers can be removed? ☐ YES ☐ NO

Comments:

_____

_____

Describe any work history, education, or training that is important to know about you.

_____

_____

7. EMOTIONAL NEEDS ASSESSMENT

Have you had any major changes or losses in your life in the past year (death of a loved one/pet, loss of job, divorce, illness, moving, retirement, change in financial status, etc.)? ☐ YES ☐ NO
If yes, what and when?

_____

_____

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Do you have any trouble going to sleep? ☐ YES ☐ NO

Do you have trouble staying asleep at night? ☐ YES ☐ NO

How many hours do you usually sleep at night? _____

Do you nap during the day? ☐ YES ☐ NO

How often during the day do you nap _____

Do you feel you cannot think clearly? ☐ YES ☐ NO

Do you ever cry for no reason? ☐ YES ☐ NO

Do you belong to any groups you enjoy participating in? ☐ YES ☐ NO

If yes, what group?

_____

_____

Who can you talk to about your feelings, problems, or concerns?

_____

_____

What makes you feel happy?

_____

_____

Case Manager Observations:

_____

8. RISK ASSESSMENT

MEDICAL RISKS/NEEDS		COMMENTS
Oxygen	☐ YES ☐ NO	
Smoking	☐ YES ☐ NO	
Morbid obesity (as it relates to mobility and transport)	☐ YES ☐ NO	

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MEDICAL RISKS/NEEDS		COMMENTS
Alcohol/substance abuse	☐ YES ☐ NO	
Bed Sores	☐ YES ☐ NO	
FALL RISKS		**COMMENTS**
History of falls	☐ YES ☐ NO	
Have you fallen in the last 6 months?	☐ YES ☐ NO	**(How many times?)**
Vertigo, dizziness, numbness, or tingling	☐ YES ☐ NO	
Unsteady gait	☐ YES ☐ NO	
Stairs (outside or inside)	☐ YES ☐ NO	
Use of cane, walker, wheelchair	☐ YES ☐ NO	
Inability to evacuate the home	☐ YES ☐ NO	
Cluttered living environment and/or numerous throw rugs	☐ YES ☐ NO	
BEHAVIORAL RISKS		**COMMENTS**
Wandering	☐ YES ☐ NO	
Resistance to care or assistance	☐ YES ☐ NO	
Changes in behavior (describe)	☐ YES ☐ NO	
Depression	☐ YES ☐ NO	
Suicidal thoughts	☐ YES ☐ NO	
Homicidal thoughts	☐ YES ☐ NO	
Take medications as prescribed	☐ YES ☐ NO	
Follows special diet	☐ YES ☐ NO	

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COGNITIVE FUNCTIONAL IMPAIRMENTS		COMMENTS
Memory problems	☐ YES ☐ NO	
Difficulty Organizing self	☐ YES ☐ NO	
Difficulty with Initiation	☐ YES ☐ NO	
Impaired Concentration	☐ YES ☐ NO	
Difficulty Attending to task	☐ YES ☐ NO	
Difficulty Sequencing	☐ YES ☐ NO	
Response to change in routine	☐ YES ☐ NO	
Lack of Awareness of own deficits	☐ YES ☐ NO	
Distractibility	☐ YES ☐ NO	
Impulsivity	☐ YES ☐ NO	

Are there any other issues you feel may be a risk to your health or safety? ☐ YES ☐ NO

_____

_____

9. ADDITIONAL IDENTIFIED MEMBER NEEDS

NEED IDENTIFIED		COMMENT
Housing	☐ YES ☐ NO	
Hearing aids	☐ YES ☐ NO	
Home modifications	☐ YES ☐ NO	
Dentures	☐ YES ☐ NO	
Weatherization	☐ YES ☐ NO	
Advance Directives	☐ YES ☐ NO	
Legal services	☐ YES ☐ NO	

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NEED IDENTIFIED		COMMENT
Utility assistance	☐ YES ☐ NO	
Food stamps	☐ YES ☐ NO	
Transportation Assistance	☐ YES ☐ NO	
Assistive technology	☐ YES ☐ NO	
Medical appointments	☐ YES ☐ NO	
Debt counseling	☐ YES ☐ NO	
Eyeglasses/contacts	☐ YES ☐ NO	
Magnifying glass	☐ YES ☐ NO	
Home repairs	☐ YES ☐ NO	
Personal Emergency Response System	☐ YES ☐ NO	
Other	☐ YES ☐ NO	
Other	☐ YES ☐ NO	

10. <u>MEDICAL EQUIPMENT NEEDS</u>

MEDICAL EQUIPMENT	HAS ALREADY	NEEDS TO OBTAIN	PERSON RESPONSIBLE FOR OBTAINING
Wheelchair			
Walker			
Cane			
Crutches			
Braces (leg, back, etc.)			
Wheelchair ramp			
Hoyer lift			
Bedside commode			
Elevated commode seat			
Scooter chair			
Lift chair			
Hand-held shower			
Shower chair			

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MEDICAL EQUIPMENT	HAS ALREADY	NEEDS TO OBTAIN	PERSON RESPONSIBLE FOR OBTAINING
Hospital bed			
Glucometer			
Speech aids			
Catheter			
External Urinary Device			
Ostomy equipment			
Other			

Who was present during the assessment?

Name	Relationship

By signing, I certify that the reported information is complete and accurate. I understand that payment for the services certified on this form will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under Medicaid Fraud.

_____ _____
Member/Legal Representative Signature Date

_____ _____
Case Manager Signature Date

Start time of the assessment: _____

End time of the assessment: _____

Copies of this assessment were provided to:	Date copy was provided:
Member/Legal Representative	
Personal Attendant	
Cognitive Rehabilitation Therapist	