□Initial □6-Month □Annual

1. **DEMOGRAPHICS**

Last Name:		First Name:
DOB:	Date of Assessment:	Financial Eligibility Effective Date:
Current PAS Date:		Anchor Date:
Physical Address:		
City:	County:	Zip Code:
Mailing Address:		
City:	County:	Zip Code:
Home Phone:	Cell Phone:	Other Phone:
Detailed Directions to Member's Home:		

2. LEGAL REPRESENTATIVE INFORMATION

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

□ Member would not or could not provide a copy.

□ Legal Guardian	□ Durable POA	□ POST Form
□ Committee	□ Conservator	□ Document in Chart
□ Medical POA	□ DNR	□ Deemed Incompetent

Name: Phone Number:

3. ENVIRONMENTAL ASSESSMENT

Location:	Urban □	Rural □	
Type of Home: Check all that apply	Apartment □	Mobile Home □	House□
	Multi-Family □	Single Story □	Two or more floors □

Who lives with you? No One □

Name	Phone Number (s)	Relationship

4. REVIEW OF SYSTEMS

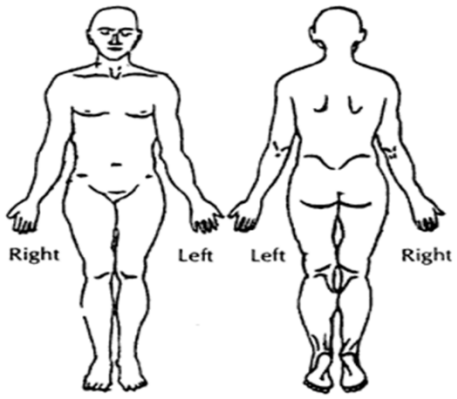
NEUROMUSCULAR (Check Findings)	
Level of Consciousness:	□Alert □Disoriented □Lethargic □Stuporous Comments: _____
Oriented to:	□Person □Place □Time Comments: _____
Challenging Behaviors	□N/A □Physically □Verbally □Socially inappropriate/Disruptive Comments:_____
Communication:	□Verbal □ Writes Messages □American Sign Language □Braille □Signs, Gestures, or Sounds □Communication Board or Device Comments: _____
Speech:	□Clear □Unclear □Aphasic Comments: _____
Vision:	□WNL □Contacts □Eye Glasses □Corrective Lenses for Reading Only □Needs large Print □Sees Objects □Sees Shadows □No Vision Comments: _____
Hearing:	□WNL □ Requires Repeats Deaf: □right □left □Total □ Hearing Aids □Implants Comments: _____
Neurological:	□WNL □Difficulty with Receptive Language □Difficulty with Expressive Language □Seizures: Type: _____ Date of Last Seizure: _____ (Frequency)_____ □Memory □Confusion □Disorientation Comments: _____
Sensation:	□WNL □Pain □Tingling □Numbness Location: _____ Comments: _____
Strength:	□WNL □Paralysis □Weakness □Location: _____ Comments: _____
Posture:	□Upright □Bent Forward □Scoliosis Comments: _____
Gait:	□Steady □Unsteady □1 or □2 Person Assist Comments: _____
CARDIO-PULMONARY (Check Findings)	
Respiratory:	□WNL Shortness of Breath: □Rest or □Exertion □Labored Coughing: □Productive □Non-Productive □Wheezing
Respiratory Equipment and Treatment:	□N/A □Oxygen _____L/Min □Ventilator □C-PAP □BI-PAP □Inhalers □Nebulizer □Tracheostomy Care Comments:_____
Cardiac:	□Chest Discomfort □Palpitations □Lips/nail beds dusky Comments: _____
Cardiac Devices:	□Pacemaker □Defibrillator □Date Inserted: _____ How often checked_____ Who Checks It _____ Comments _____

GI/GU (Check Findings)	
Intake:	☐Difficulty Chewing ☐Difficulty Swallowing ☐History of Choking Appetite ☐Good ☐Fair ☐Poor Comments:_____
Dental:	☐Carries Teeth: ☐Loose ☐Broken ☐Dental Prosthesis ☐Edentulous Comments:_____
Diet:	☐Normal ☐Special Diet: _____ ☐Dietary Supplements (Type) _____ ☐Feeding Tube Comments:_____
Bowel:	☐Normal ☐Diarrhea ☐Constipation Incontinent Ostomy: ☐N/A ☐Partial ☐Total Supplies Used:_____ Comments:_____
Urinary:	☐Normal Incontinent: ☐Partial ☐Total Catheter: ☐Foley ☐Texas Dialysis: ☐Shunt ☐Port ☐Ostomy Supplies Used: _____ Comments: _____
Recent Weight Change:	☐N/A ☐Weight Gain Since Previous Assessment Amount: _____ ☐Weight Loss Since Previous Assessment Amount: _____ Comments: _____

Member Name: _____

Date: _____

INTEGUMENTARY (Check Findings)	
Skin Color:	☐WNL ☐Pale ☐Jaundice ☐Cyanotic ☐Ruddy/Red Comments: _____
Skin:	☐Warm/Dry ☐Rash ☐Pressure Ulcers ☐Stasis Ulcers ☐Abrasions ☐Burns ☐Bruises ☐Open Lesions ☐Cuts ☐Surgical Wounds ☐Skin Desensitized to ☐Pain ☐Pressure ☐Unexplained injury to skin: (describe)_____ ☐Protective/Preventive Foot Care: (describe)_____



Describe any other treatments and/or healthcare provided for the member:

Medical Equipment in the home: (check all that apply)

Ramp ☐ Hoyer Lift ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Bedside Commode ☐

Elevated Commode Seat ☐ Scooter Chair ☐ Lift Chair ☐ Hand Held Shower ☐ Shower Chair ☐ Glucometer ☐

Hospital Bed ☐ Other:_____

Needed Medical Equipment: _____

_____

5. MEMBER ACTIVITIES

I=Independent S=Supervision P=Partial T=Total

Activity	Level of Assist	Comments
Personal Care Tasks		
Bath:		
Skin Care:		
Hair:		
Nails:		
Mouth Care:		
Dressing:		
Ambulation:		
Transfer:		
Toileting:		
Position: Turn Every ___Hr(s)		
Assistance with Medications:		
Meals: ☐B ☐ L ☐ D Snacks Diet: Special Directions:		
Environmental Tasks cannot be more than one-third (1/3) of total time.		
Bed Making:		
Laundry:		
Vacuum/Sweep		
Mop:		
Dishwashing:		
Dust:		
Straighten:		
Other:		
Essential Errands:		
Community Activities: Describe PC services needed during community activities		

Member Name: _____

Date: _____

Has the member's needs for assistance changed since the last completed PAS? (Please include any hospitalizations since last assessment).

Comments:

Who was present during the assessment?

Name	**Relationship**

Arrival Time:	**Departure Time:**	**Total Time:**

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**

Personal Care RN Signature **Date**

Copy of this Assessment was provided to member on _____
(Date)

Member Name: _____

Date: _____

ATTACHMENT A
MEDICATION PROFILE

Member: _____ DOB: _____

Dx: _____ Allergies _____

Pharmacy: _____ PCP: _____

Other Specialists: _____

Review Date	New Chg. D/C	Medication/Dose	Frequency	Reason	Physician	RN Signature