AGED AND DISABLED WAIVER- PERSONAL OPTIONS ASSESSMENT

ADW Participant's Name: Date of Assessment:

Instructions: For Personal Options, complete this form. If participant has Case Manager, complete Person Centered Assessment.

Initial	6 Month	Annual	Change in Needs/ Level of Service	Dual Services

First Name		Last Name	
Medicaid ID		PPL ID	
Date of Assessment		Resource Consultant	
Current PAS Date:	Current Anchor Date:	Medical Reevaluation (MNER Due By: Up to 90 days before and no later than 45 days prior to the anchor date):	

Physical Address:			
City:	State:	Zip Code:	County:
Mailing Address:			
City:	State:	Zip Code:	County:

Home Phone:	Cell Phone:	Other Phone:
Detailed Directions to Home:		

WHAT ARE YOUR GOALS, PREFERENCES AND SUPPORTS?	
GOAL(S): What kinds of services and help are you expecting from this program (document in the ADW person's words.)?	FINANCE: *Do you manage your own finances (bill payment, banking, purchases, etc.)? Yes No* *Do you need assistance with these activities? Yes No*
INFORMAL SUPPORT: Do you currently have someone who assists you with bathing, dressing, etc.? Yes No *If so, who?* Phone:	*FORMAL SUPPORT: Do you have an agency or service helping you with activities such as bathing, dressing or meals? Yes No* *If so, what agency or company?* Phone:
Have you had any recent changes in your needs, hospitalizations or nursing home admissions?	
What community activities do you enjoy?	
Do you have an opportunity to interact with others or leave your home?	

MY HEALTHCARE		
Coordination of Healthcare: *Complete this area in full.*	Yes	No
Do you have a Primary Care Physician who coordinates your healthcare?		
Do you think you need referrals to physicians, specialists or medical testing?		
Do you need assistance with making medical appointments?		

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LEGAL REPRESENTATIVE: *Check type of legal representative, if you have one. Please provide a copy to your Resource Consultant.*

Yes	Type	Yes	Type	Yes	Type
	Legal Guardian		Durable POA		POST Form
	Medical POA		Conservator		Document in Chart
	Legal POA		DNR		Deemed Incompetent
	Healthcare Surrogate		Living Will		Deemed Incapacitated
Name of Legal Representative(s):					Phone(s): Date copy provided to RC:

Medical Equipment: *What do you have in place? Check all that apply.*

	Ramp		Wheelchair (manual or power)		Lift Chair
	Hoyer Lift		Bedside Commode		Hand Held Shower
	Walker		Elevated Commode Seat		Shower Chair
	Crutches		Scooter Chair		Glucometer
	Hospital Bed		Oxygen		Other:

Other:

What Medical Equipment do you need now or need replaced?

Primary Care Physician	Other: *Specialists, Physical, Speech or Occupational Therapist, Counselors/Psychiatrist, etc.*
Name: Specialty: Phone:	Name: Specialty: Phone:
Other: *Specialists, Physical, Speech or Occupational Therapist, Counselors/Psychiatrist, etc.*	Other: *Specialists, Physical, Speech or Occupational Therapist, Counselors/Psychiatrist, etc.*
Name: Specialty: Phone:	Name: Specialty: Phone:
Other: *Specialists, Physical, Speech or Occupational Therapist, Counselors/Psychiatrist, etc.*	Other: *Specialists, Physical, Speech or Occupational Therapist, Counselors/Psychiatrist, etc.*
Name: Specialty: Phone:	Name: Specialty: Phone:

WHAT MEDICAL CONDITIONS AFFECT MY AREAS OF NEED AND ASSISTANCE?

Decubitus		Angina		Paralysis		I/DD		Diabetes		Mental Disorder	
Arthritis		Dyspnea (difficulty breathing)		Contractures		Pain		Alzheimer's/ Dementia		Terminal DX	
Aphasia		Dysphasia (difficulty swallowing)		Other:		Other:		Other:		Other:	

ADW Participant's Name: Date of Assessment:

WHAT ARE THE SERVICES AND RESOURCES THAT YOU NEED? *Check box or List Provider Name and Phone Number Below.*					
	Housing		Food Stamps		Utility Assistance
	Hearing Aids		Medical Appointments		Weatherization
	Home Modifications		Debit Counseling		Legal Services

Advanced Directives Provider and Phone #	
Personal Emergency Response System and Phone #	
Home Delivered Meals Provider and Phone #	
Eye Glasses Provider and Phone #	
Dental Provider and Phone #	
Incontinent Supply Provider and Phone #	
Durable Medical Equipment Provider and Phone #	
Assistive Technology Provider and Phone #	
Therapy Provider and Phone #	
Nursing (ADW Skilled Nursing or Home Health Skilled Nursing)	
Hospice	
Transportation (ADW Transportation or Nonemergency Medical Transportation, NEMT, Community Transportation Resources)	
Personal Attendant Services (ADW or DRS)	
Dual Services (Personal Care Services)	
Other	
Other	

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WHAT ARE MY POTENTIAL RISKS THAT NEED ADDRESSED?	
RISK(S) *Describe the identified risks on the assessment needing addressed.*	RISK PLAN(S) *Describe how the risk(s) will be addressed.*
HEALTH SAFETY: *Nutrition, appetite, medications, emergency plans, phone access personal response system.* Do you have adequate assistance with accessing water and preparing nutritious meals? Do you know what medications you are taking, their purpose and how to properly take them? Do you have access to a telephone or other method of seeking assistance in an emergency? Other:	
HOME SAFETY- INDOOR: *Accessibility, falls, firearms, poisonous materials, pests, pests infestations.* Can you walk easily through your home, free of possible hazards such as exposed wiring, overloaded outlets, loose or rotten flooring, leaking roofs or plumbing issues? Do you have adequate heat, water and sewage services? Do you have smoke alarms, carbon monoxide detectors and fire extinguishers in the home? Other:	
HOME SAFETY- OUTDOORS*: Steps, ramps, access, neighbors, neighborhood safety.* Do you feel safe in your home and neighborhood? Can you easily access our home going inside and outside? Other:	
SOCIAL: *Isolation, abusive or neglectful situation.* Do you talk or visit regularly with people in the community? Do you ever feel lonely or isolated? Do you ever feel that someone is taking advantage of you or could harm you? Do you ever feel that your caregiver is not providing the care that you need? Other:	
COMMUNITY: *Knowledge of area resources and ability to integrate into the community.* Are you aware of services available in your area for meals on wheels, transportation, energy assistance, home weatherization, or other services? Do you need help to apply? Other:	
BEHAVIORAL: *Mental health issues, difficulty communicating needs and preferences, drug or alcohol abuse, unable to make own decisions.* Do you have difficulty talking with others and communicating your needs and desires? Do you ever feel extremely anxious, nervous, sad or unable to cope with problems in your life? Do you have a current or past problem with alcohol or drug abuse? Does anyone in your home have a problem with alcohol or drug abuse that would negatively affect your health or well-being? Other:	
FINANCIAL: *Handle expenditures and deposits, personal budget, handle payment for groceries or other personal goods.* Do you have someone to assist you with paying bills, balancing your check book and making required purchases when needed? Other:	

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PERSONAL ATTENDANT SERVICES

Describe how you would like your employee to provide supports to address your area of need.
Assistance levels = prompting (P), supervised assist (S), physical assist (PA), total care (T), 1 or 2 person assistance).
Assistance Needed = Describe how the assistance will be performed, by whom, when and how long.

Areas to be addressed	**Assistance Level (P, S, PA, T)**	**Assistance Needed - Employee Instructions** **Describe how the assistance is to be performed, by whom, when and how long.**
Meals: Diet/Special Directions List: Breakfast, Lunch, Dinner, Snacks		
Bathing		
Dressing		
Grooming: Hair Care, Skin Care, Nail Care, Mouth Care		
Toileting, Bladder or Bowel Care		
Orientation		
Vision or Hearing		
Communication		
Transferring/Walking/ Wheeling		
Positioning: Turn Every ___hrs. Up in chair		
Medication Prompt		
Light Housekeeping: Bed-Making, Vacuum/Sweep, Mop, Dust, Dishes, Straighten, Trash		
Laundry		
Essential Errands What, where and when Example: Grocery, pharmacy, etc.		
Community Activities What, where and when Example:		

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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.

_____ _____

ADW Participant Date

_____ _____

Resource Consultant Date

_____ _____

Other Date