AGED AND DISABLED WAIVER- PERSONAL OPTIONS ASSESSMENT

ADW Participant's Name: Date of Assessment:

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

First Name		Last Name	
Medicaid ID		PPL ID	
Date of Birth		Resource Consultant	
Current PAS Date:	Current Anchor Date:	Other Agencies: Case Management/Dual Service (PC):	

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

Home Phone:	Cell Phone:	Other Contact Name/Phone:
Detailed Directions to Home:		

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:	

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		

ADW Participant's Name: Date of Assessment:

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:		

ADW Participant's Name: Date of Assessment:

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
_____	_____
Program Representative	Date
_____	_____
Case Manager (if present)	Date
_____	_____
Other	Date
_____	_____
Other	Date

***Directions**: The Case Manager is not required to attend the PPL Enrollment Meeting. All Service Plans, Assessments and Personal Attendant Log will be shared between the Case Manager, Resource Consultant and the member.*

ADW Participant's Name: Date of Assessment: