AGED AND DISABLED WAIVER- RN ASSESSMENT

ADW Participant's Name: ______________________________ Date of Assessment: ________________

Initial	6 Month	Annual	Post Hospital	Change in Needs
Last Name:			**First Name:**	
Date of Assessment:			**Current PAS Date:**	

1. **NURSING ASSESSMENT** ***Conditions:*** *Mark an X in the box for all that applies.* ***Specific Status:*** *For specifics, describe the status of the condition. Example: If you marked tremors, you could describe "hand tremors."*

Nursing Assessment		Condition(s)			Specific Status
NEUROMUSCULAR *Musculoskeletal, Neurological, Orientation, Mobility/Posture/Gait* ___***No Problem***		Language- Expressive		Language-Receptive	
		No communication		Weakness	
		Intellectual or developmental delay		Paralysis	
		Orientation/Memory		Tremors	
		Tingling, Pain, Numbness, Neuropathy		Unsteady Gait, Mobility	
		Other:		Seizures	
CARDIO-PULMONARY *Cardiovascular, Respiratory* ___***No Problem***		Shortness of breath		C-Pap, Bi-Pap	
		Chest discomfort		Oxygen	
		Inhaler, Nebulizer		Ventilator	
		Edema: (describe location)		Other:	
GI/GU *Gastrointestinal, Renal, Incontinence (Bowel/Bladder), Diet, Weight Change* ___ ***No Problem***		Appetite (Good, Fair, Poor)		Difficulty chewing	
		Special diet- Type:		Difficulty swallowing	
		Total Incontinence		History of choking	
		Partial incontinence		Weight gain	
		Catheter		Weight loss	
		Dialysis, port, shunt		Dental- carries, lost or broken teeth, dental prosthesis	
		Ostomy		Other:	
Integumentary *Skin, Sensory, Dental* ___ ***No Problem***		Pale		Jaundice	*Describe type, drainage and location of any decubitus, skin or foot care.*
		Cyanotic		Ruddy/Red	
		Warm/Dry		Decubitus (describe in specific status)	
		Rash		Cuts	
		Surgical wounds		Pain or Pressure	
		Protective or preventive foot care		Other:	
Other *Hearing, Vision, Mental Health, Substance Abuse, Challenging Behaviors* ___ ***No Problem***		Hearing		Vision	
		Substance Abuse (describe in specific status)		Mental Illness (describe in specific status)	
		Challenging behaviors (describe in specific status)		Other:	
Comments:					

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2. FUNCTIONAL ASSESSMENT *(Based upon what I can do, how do I need the PA to assist me?)*

Levels of Assistance: I = Independent; S = Supervision; P = Partial; T = Total

Functional Assessment	**Level of Assist**	**Describe Any Specific Directions for the Personal Assistant**
Bathing		
Grooming		
Dressing		
Ambulation		
Transfer/Repositioning		
Toileting		
Medication Prompting		
Meal Preparation *Special Directions:*		
Laundry		
Environmental (housekeeping, dishes, trash, etc.)		
Transportation For:		
Essential Errands: Describe in Comment Section		
Community Activities: Describe in Comment Section		

Comments:

Describe any other treatments and/or healthcare provided for the ADW participant.

Describe any RN recommendations based upon findings from the Nursing Assessment *(referrals to physicians, home health services, etc.):*

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3. **CHANGES IN NEEDS** *(Reminder: Document changes in needs below when requesting a change in level of service. RN Contact Form may include additional information for changes in levels of service).*

Has the ADW participant's needs for assistance changed since the last completed PAS? (Please include any hospitalizations, nursing home admissions, respite admissions, etc. Since last assessment).

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.

____ _____________

ADW Participant/Legal Representative Signature **Date**

____ _____________

Personal Assistant RN Signature **Date**

Comments: (Example: Justification of personal assistant hours such as a person with shortness of breath will take longer for an activity or a higher acuity level).

Copy of the assessment was provided to the ADW participant and Case Management Agency on: ____________