WEST VIRGINIA Department of Health & Human Resources BUREAU FOR MEDICAL SERVICES

Traumatic Brain Injury Waiver (TBIW) Program
Person-Centered Assessment

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

1. DEMOGRAPHICS

Last Name:	First Name:	Middle Initial:	DOB:
Date of Assessment:	Financial Eligibility Effective Date:		
TMH Participant: Y/N			
Current PAS Date:	Medical Re-evaluation Request due by:		
Current Rancho Los Amigos Scale Date:	**Check the Rancho Los Amigos Scale Used:** ☐ Adult Rancho Los Amigos Levels of Cognitive Functioning. ☐ Child Rancho Los Amigos Pediatric Level of Consciousness Scale		
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(AD) ☐ Veteran ☐ Spouse of Veteran/AD ☐ None If yes, are you receiving any in home care from VA services? Explain:			
Detailed directions to member's home:			

2. INSURANCE AND HEALTH CARE INFORMATION

Medicaid #:	**Medicare #:** **Document if member has Part A, B, C, D; Provider Name (Highmark, Humana, etc.), Phone**			**Other Health Information:**	
	Type	**Name**	**Phone**	**Name**	**Phone**
	A				
	B				
	C				
	D				

WEST VIRGINIA Department of Health & Human Resources BUREAU FOR MEDICAL SERVICES

Traumatic Brain Injury Waiver (TBIW) Program
Person-Centered Assessment

When present, place an X in the column below marked "yes". A copy verifying relationship, decision or decision-making authority must be included in the member's file. Please indicate if the member was unable to provide a copy of the document.

Yes	Type	Yes	Type
	Legal Guardian		**Durable POA**
	Medical POA		**Conservator**
	Legal POA		
	Healthcare Surrogate		**Living Will**
Name of Person(s) with Legal Representation (Example MPOA):		**Phone(s):**	

Do you have a DNR: ☐ **YES** ☐ **NO**

Do you have a Living Will: ☐ **YES** ☐ **NO**

Additional notes for Insurance and Health Care Information:

____

____

____

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

(If needed, add another sheet with physician/specialist information)

3. MEDICAL NEEDS ASSESSMENT <u>any needs identified in this section must be addressed and documented during the monthly case manager contact.</u>

- Do you have a Primary Care Physician who coordinates your healthcare? ☐ **YES** ☐ **NO***
- Do you think you need referrals to physicians, specialists, or medical testing? ☐ **YES** ☐ **NO***
- Do you need assistance with making medical appointments? ☐ **YES** ☐ **NO***
  If so, who currently helps you? ______________________________
  (If yes, the Case Manager should review and address this on #6 during the CM monthly contact)

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
☐ Other Medical services (please explain): ______________________________

MEDICATION NAME	DOSE/METHOD	FREQUENCY	PRESCRIBING PHYSICIAN

What is the name (s) of the Pharmacy (ies) where you get your medication (s) filled? _______________
* If more than one pharmacy is listed, the CM should ask if the Pharmacies are aware that prescriptions are filled at another Pharmacy.
Have you ever requested one of the Pharmacies to review all your medications to look for drug interactions? ☐ YES ☐ NO

Any recent medication changes? ☐ YES ☐ NO If yes, what, and why? ________________________
____

How much does your medication cost 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? ____________________________________

Additional notes for Medical Needs:
____
____
____

4. ENVIRONMENTAL NEEDS/RISKS ASSESSMENT -*Tell me about your home and neighborhood.*
(Any identified needs should be addressed and documented during the monthly case manager contact)

Home Location	Type of Home			Own or Rent
☐ **Rural** ☐ **Urban**	☐ **Apartment**	☐ **House**	☐ **Single Story**	☐ **Own Home** ☐ **Live with Homeowner**
	☐ **Mobile Home**	☐ **Multi Family**	☐ **2 or more floors**	☐ **Rent** ☐ **HUD Subsidy**

WEST VIRGINIA Department of Health & Human Resources BUREAU FOR MEDICAL SERVICES

Traumatic Brain Injury Waiver (TBIW) Program
Person-Centered Assessment

Who Lives with You?

☐ I live alone

Name	Relationship

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

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

Does the current residence have?		Comments/Follow up Plan
Running water	☐ **YES** ☐ **NO**	
Adequate heat/Air	☐ **YES** ☐ **NO**	
Working kitchen stove	☐ **YES** ☐ **NO**	
Working refrigerator	☐ **YES** ☐ **NO**	
Telephone access	☐ **YES** ☐ **NO**	
Alarms (Smoke or Carbon Monoxide)	☐ **YES** ☐ **NO**	
Firearms not locked up	☐ **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**	
Apparent natural gas leak	☐ **YES** ☐ **NO**	
Rodent or insect infestation	☐ **YES** ☐ **NO**	
Barriers to access, inside or outside- (Stairs, narrow doorways, etc.)	☐ **YES** ☐ **NO**	

Do you have any pets?	☐ **YES** ☐ **NO**	If yes: Type? ___________________________ How many? ___________________________
Are any of the pets a potential danger to others?	☐ **YES*** ☐ **NO**	If yes: Which pets? ______________________ How are they a danger? *:_________________
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***	If no: What is the reason: ________________

Note any safety and/or sanitation hazards found in the home, e.g., insects, rodents, soiled living area, no trash pick-up, etc.

____
____
____

5. SOCIAL NEEDS/RISKS ASSESSMENT (MEMBEr PREFERENCES) * -*Tell me about yourself. Who you are and what you do is important to your services. *Any identified social needs must be addressed on the Person-Centered Service Plan.*

Questions	Answers	Comments
Are you able to leave your home? How often?		
What prevents you from leaving your home?		
How do you spend your days?		
What community activities do you enjoy, such as shopping, playing cards, reading, going to school events, playing with friends, etc.?		
What type of work, education or training did you have in the past?		

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

ACTIVITY	BARRIER TO MEMBER IN ACTIVITY

Additional Notes for Social Needs:

____
____
____

6. EMOTIONAL NEEDS ASSESSMENT -**Any identified emotional needs must be addressed on the Person-Centered Service Plan.*

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?

____

Do you:		Comments
Have trouble going to sleep?	☐ **YES*** ☐ **NO**	
Have trouble sleeping all night? How many hours do you sleep at night? ___________	☐ **YES*** ☐ **NO**	
Nap during the day? How often do you nap during the day? __________	☐ **YES*** ☐ **NO**	
Feel you cannot think clearly?	☐ **YES** ☐ **NO**	
Cry for no reason?	☐ **YES** ☐ **NO**	
Belong to any groups you enjoy participating in? If yes, what groups? ____________________ __________________________	☐ **YES*** ☐ **NO**	

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

What makes you feel happy? ____
____

Additional Notes for Emotional Needs:
____
____
____

7. EDUCATIONAL INFORMATION: *Personal Attendant Services are not intended to replace supports/services a child would receive from the school system during a school day/year. *If the member is receiving school services the school system must be included in the Person-Centered Service Plan, reviewed, and documented during the monthly case manager contact. TBIW services cannot be accessed during homeschool instruction times.*

School Attending:	Grade in Current School Year:
School Address:	School Phone Number:
Receives services in school setting:	☐ **YES** ☐ **NO**
Receives services from school in home setting:	☐ **YES** ☐ **NO**
Home schooled by parent:	☐ **YES** ☐ **NO**

NEED IDENTIFIED		SERVICES RECEIVED
Individualized Education Plan (IEP)	☐ **Has already**	

	☐ **Needs to obtain***	
504 Plan	☐ **Has already** ☐ **Needs to obtain***	
After High School Transition	☐ **Has already** ☐ **Needs to obtain***	
Referral to Division of Rehabilitation Services (DRS)	☐ **Has already** ☐ **Needs to obtain***	

Additional Notes for Education Information:

____
____
____

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

GOAL(S) *What kinds of services and help are you expecting from this program?* *	**FINANCE** *Do you manage your own finances (bill payment, banking, purchases, etc.)?* ☐ **Yes** ☐ **No** *Do you need assistance with these activities?* ☐ **Yes** ☐ **No** *If no, do you need someone to assist you?* ☐ **Yes** ☐ **No** ☐ **NA**
INFORMAL SUPPORT: *Do you currently have someone who assists you with bathing, dressing, etc.?* ☐ **Yes** ☐ **No** *If so, who?* ______________________________ *Phone:* __________________________________	**FORMAL SUPPORT:** *Do you currently have an agency or services that assists you with activities such as bathing, dressing or meals?* ☐ **Yes*** ☐ **No** *If so, who?* ______________________________ *Phone:* __________________________________
Do you need assistance with using the telephone? ☐ **Yes** ☐ **No** ☐ **NA** *What assistance do you need?* ____	*Do you need assistance with housekeeping?* ☐ **Yes** ☐ **No** ☐ **NA** *What assistance do you need?* ____
Do you need assistance with home maintenance? ☐ **Yes** ☐ **No** ☐ **NA** *What assistance do you need?* ____	

ACTIVITY	NAME	PAID (FORMAL) SUPPORT	FRIENDS/FAMILY (INFORMAL) SUPPORT

Bathing*			
Dressing*			
Grooming*			
Walking*			
Wheeling*			
Transferring/Repositioning*			
Toileting*			
Medication Prompting/Supervision*			
Meal Preparation*			
Laundry*			
Dishes*			
Take out trash*			
*Essential Errands: Banking, picking up prescriptions, grocery shopping, paying bills, post office, local DHHR office Describe: ___________________________			
*Community Activities: Going to a restaurant for a meal, to a park, local library, shopping, getting a haircut Describe: ___________________________			

*Once you are on this program will these individuals/agencies continue to provide these services?

☐ **YES** ☐ **NO**

Note any that will not continue supports:

____

____

Additional Notes for Goals and Current Resources:

____

____

____

9. ADDITIONAL IDENTIFIED PARTICIPANT NEEDS* *Any identified risk needs **MUST** be addressed and documented during the monthly case manager contact.*

NEEDS IDENTIFIED **COMMENTS/FOLLOW UP PLAN**

NEEDS IDENTIFIED		COMMENTS/FOLLOW UP PLAN
Housing	☐ **YES** ☐ **NO**	
Hearing Aids	☐ **YES** ☐ **NO**	
Dentures	☐ **YES** ☐ **NO**	
Home Modifications	☐ **YES** ☐ **NO**	
Weatherization	☐ **YES** ☐ **NO**	
Advanced Directives	☐ **YES** ☐ **NO**	
Legal Services	☐ **YES** ☐ **NO**	
Utility Assistance	☐ **YES** ☐ **NO**	
Transportation Assistance	☐ **YES** ☐ **NO**	
SNAP Program	☐ **YES** ☐ **NO**	
Assistive Technology	☐ **YES** ☐ **NO**	
Medical Appointments	☐ **YES** ☐ **NO**	
Debt Counseling	☐ **YES** ☐ **NO**	
Vision Needs	☐ **YES** ☐ **NO**	
Home Repairs	☐ **YES** ☐ **NO**	
Personal Emergency Response Unit	☐ **YES** ☐ **NO**	
Special Education Services at School	☐ **YES** ☐ **NO**	
Other:	☐ **YES** ☐ **NO**	

Additional Notes for Additional Needs:
____
____
____

10.MEDICAL EQUIPMENT NEEDS* *Medical Equipment UNMET NEEDS must be reflected on the Person-Centered Service Plan and reviewed/documented during the Case Manager's Monthly Contact.*

Medical Equipment		PERSON RESPONSIBLE FOR OBTAINING*
Wheelchair	☐ **Has already** ☐ **Needs to obtain***	
Walker	☐ **Has already** ☐ **Needs to obtain***	
Cane	☐ **Has already** ☐ **Needs to obtain***	
Crutches	☐ **Has already** ☐ **Needs to obtain***	
Braces (Leg, back, etc.)	☐ **Has already** ☐ **Needs to obtain***	
Wheelchair Ramp	☐ **Has already** ☐ **Needs to obtain***	
Hoyer Lift	☐ **Has already**	

	☐ **Needs to obtain***	
Bedside Commode	☐ **Has already** ☐ **Needs to obtain***	
Elevated Commode Seat	☐ **Has already** ☐ **Needs to obtain***	
Scooter Chair	☐ **Has already** ☐ **Needs to obtain***	
Lift Chair	☐ **Has already** ☐ **Needs to obtain***	
Shower Chair	☐ **Has already** ☐ **Needs to obtain***	
Hand Held Shower	☐ **Has already** ☐ **Needs to obtain***	
Hospital Bed	☐ **Has already** ☐ **Needs to obtain***	
Glucometer	☐ **Has already** ☐ **Needs to obtain***	
Speech Aids	☐ **Has already** ☐ **Needs to obtain***	
Catheter	☐ **Has already** ☐ **Needs to obtain***	
External Urinary Device	☐ **Has already** ☐ **Needs to obtain***	
Ostomy Equipment	☐ **Has already** ☐ **Needs to obtain***	
Other:	☐ **Has already** ☐ **Needs to obtain***	

Additional Notes for Medical Equipment Needs:
____
____
____

11. RISK ASSESSMENT*-*Any identified risk/needs **MUST** be addressed on the Person-Centered Service Plan and discussed/documented during the monthly case manager contact.*

MEDICAL RISKS **COMMENTS**

Use Oxygen	☐ **YES** ☐ **NO**	
Smoking	☐ **YES** ☐ **NO**	
Alcohol or Substance Abuse	☐ **YES** ☐ **NO**	
Morbid Obesity as R/T Mobility and Transport	☐ **YES** ☐ **NO**	
Decubitus	☐ **YES** ☐ **NO**	

FALL RISKS

Outside/Inside stairs	☐ **YES** ☐ **NO**	
Ambulation equipment	☐ **YES** ☐ **NO**	
Inability to evacuate the home	☐ **YES** ☐ **NO**	

Cluttered living environment and/or numerous throw rugs	☐ **YES** ☐ **NO**	
Use of cane, walker, wheelchair	☐ **YES** ☐ **NO**	
History of falls	☐ **YES** ☐ **NO**	
Have you fallen in the last 8 months?	☐ **YES** ☐ **NO**	**If yes, how many times?** ________
Vertigo, dizziness, numbness, or tingling	☐ **YES** ☐ **NO**	
Unsteady gait	☐ **YES** ☐ **NO**	

BEHAVIORAL RISKS

Wandering	☐ **YES** ☐ **NO**	
Resistance to care	☐ **YES** ☐ **NO**	
Changes in Behavior	☐ **YES** ☐ **NO**	**If yes, Describe:** ______________________________
Depression	☐ **YES** ☐ **NO**	
Suicidal/Homicidal Thoughts	☐ **YES** ☐ **NO**	
Take medications as prescribed	☐ **YES** ☐ **NO**	
Follows Special Diet	☐ **YES** ☐ **NO**	

COGNITIVE FUNCTIONAL IMPAIRMENTS

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**	
Responses 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**

Additional Notes for Risk Assessment:
____
____
____

What amount of questions did the program member answer by him/herself?

☐ All ☐ Most ☐ Half ☐ Some ☐ A Few ☐ None

Who else provided responses? ____

Case Manager Observations/Recommendations:
____
____
____
____
____
____
____
____
____
____
____
____
____

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 or Court Appointed Legal Guardian-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 Agency/PPL	
Other:	
Other:	
Other:	

Copies of this assessment must be provided to the member or court appointed legal guardian and Personal Attendant Agency/PPL within 7 business days of the approval by the UMC