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

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

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

☐ Take Me Home WV Participant

1. DEMOGRAPHICS

Last Name:	First Name:	Middle Initial:	DOB:
Date of Assessment:		Financial Eligibility Effective Date:	
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			
Detailed directions to participant's home:			

2. INSURANCE AND HEALTH CARE INFORMATION

Medicaid #:	Medicare #:
Medicare Part A Effective Date:	Medicare Part B Effective Date:
Medicare Plan:	Drug Plan Name:

Check any that apply. A copy of the document must be included in participant's file.

☐ Guardian ☐ Conservator ☐ Committee
☐ Guardian Ad Litem ☐ Medical POA ☐ Medical Surrogate
☐ Durable POA ☐ General POA ☐ Living Will
☐ Do Not Resuscitate

Legal Representative Name:	Phone:
Address:	
Primary Care Physician Name:	Phone:
Pharmacy Name:	Phone:

* Items marked with an asterisk must be included in the person-centered service plan.

Participant Name: _____

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

Specialist Name:	Phone:

Additional notes for Insurance and Health Care Information: _____
_____
_____

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

School participant attends:	Grade in current school year:
Address:	Phone #:
Receives services in school setting: Yes/No Receives services from school at 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: _____
_____
_____

4. GOALS AND CURRENT RESOURCES (PARTICIPANT'S ABILITIES AND SUPPORTS)

What kinds of services and help are you expecting from this program?*

Do you manage your finances (pay bills, go to bank, make purchases, balance checkbook, make simple purchases, handle money matters, etc.)? ☐ **YES** ☐ **NO**

If No, who assists you? _____

* Items marked with an asterisk must be included in the person-centered service plan.

Participant Name: _____

If No, do you need someone to assist you? ☐ **YES** ☐ **NO** ☐ **NA**

Do you need assistance to use 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? _____

Do you currently have someone who assists you with activities such as bathing, grooming, preparing meals, etc.? ☐ **YES*** ☐ **NO**
If yes, who assists you? _____

Activity	Name	Paid (formal) or friends/family (informal) support
Bathing*		
Dressing*		
Grooming*		
Walking*		
Wheeling*		
Transferring/repositioning*		
Toileting*		
Medication prompting/supervision*		
Activity	**Name**	**Paid (formal) or friends/family (informal) support**
Meal preparation*		
Laundry*		
Dishes*		
Take out trash*		
*Essential errands such as banking, picking up prescriptions, grocery shopping, paying bills, post office, local DHHR office Describe:		
*Community Activities such as going to a restaurant for a meal, to a park, local library, shopping, getting a haircut Describe:		

* Items marked with an asterisk must be included in the person-centered service plan.

Participant Name: _____

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

*Once you are on this program will these individuals/agencies continue to provide you with these services? ☐ **YES** ☐ **NO**

Note any that will not continue supports: _____

Additional notes for Goals and Current Resources: _____

_____

_____

5. ENVIRONMENTAL NEEDS ASSESSMENT (any identified needs should be addressed and documented during the monthly case manager contact)

Location: ☐ Urban ☐ Suburban ☐ Rural

Type of home: ☐ Apartment ☐ Single Family Home ☐ Duplex

☐ Single Story ☐ Multiple Family Home ☐ Two or more floors

Is the home you live in owned or rented? ☐ Owned ☐ Rented

By: ☐ Myself/Spouse ☐ Parents ☐ Other: _____

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

Who Lives with You?

☐ I live alone

Name	Relationship

What changes to your home would make it easier for you to get in/out of the home or to do activities in your home? List Home Modifications:*

Does the home have:		Comments/Follow-up Plan
Running water	☐ **YES** ☐ **NO**	
Adequate heat	☐ **YES** ☐ **NO**	
Air conditioning	☐ **YES** ☐ **NO**	
Working cook stove	☐ **YES** ☐ **NO**	
Working refrigerator	☐ **YES** ☐ **NO**	
Telephone access	☐ **YES** ☐ **NO**	

* Items marked with an asterisk must be included in the person-centered service plan.

Participant Name: _____

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

Does the home have:		Comments/Follow-up Plan
Smoke alarm/detector	☐ YES ☐ NO	
Carbon monoxide alarm/detector	☐ 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	
Barriers to access, inside or outside (Such as stairs, narrow doorways, etc.)	☐ YES ☐ NO	
Room temperature appropriate to season	☐ YES ☐ NO	
Apparent natural gas leak	☐ YES ☐ NO	
Rodent or insect infestation	☐ YES ☐ NO	
Excessive number of pets	☐ YES ☐ NO	

Do you have any pets? ☐ **YES** ☐ **NO** If yes, what type and how many:

Are any of these pets a potential danger to others? ☐ **YES*** ☐ **NO**
If yes, which pets and how are they a danger:*

Note any other safety and/or sanitation hazards found in the home such as insects, rodents present, no trash pickup, soiled living area, etc.

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***

* Items marked with an asterisk must be included in the person-centered service plan.

Participant Name: _____

Additional notes for Environmental Needs: _____

_____

_____

6. 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? ☐ **YES** ☐ **NO***

What is your Physician's number? _____

When is the last time you saw your Physician? _____

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): _____

Do you need assistance in making an appointment for these services? ☐ **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)

MEDICATION NAME	REASON FOR MEDS	DOSE/METHOD	FREQUENCY	PRESCRIBING PHYSICIAN

Any recent medication changes? ☐ **YES** ☐ **NO**

If yes, what and why? _____

How much does your medication cost you per month? _____

Have you made any changes in the way you eat because of an illness or medical condition?

* Items marked with an asterisk must be included in the person-centered service plan.

Participant Name: _____

☐ **YES** ☐ **NO**

How many meals do you eat each day? _____

Do you eat at least one serving of fruits or vegetables daily? ☐ **YES** ☐ **NO**

Do you eat at least one serving of dairy products daily? ☐ **YES** ☐ **NO**

Do you drink more than two alcoholic beverages daily? ☐ **YES** ☐ **NO** ☐ **NA**

Do you have problems with your teeth or mouth which make it hard for you to eat? ☐ **YES** ☐ **NO**

Do you have enough money to buy the food you need? ☐ **YES** ☐ **NO*** (If no, this should be addressed and documented during the CM monthly contact #8)

Do you take three or more prescriptions daily? ☐ **YES** ☐ **NO**

Have you gained or lost more than 5 lbs. in the last 6 months without wanting to? ☐ **YES** ☐ **NO**

Are you able to do your own grocery shopping and cooking? ☐ **YES** ☐ **NO** ☐ **NA**

Are you on a special diet? ☐ **YES** ☐ **NO**

Do you drink 6-8 cups of non-alcoholic beverages each day? ☐ **YES** ☐ **NO** ☐ **NA**

Do you have a good appetite? ☐ **YES** ☐ **NO**

Do you have any problems with constipation or diarrhea? ☐ **YES** ☐ **NO**

Additional notes for Medical Needs: _____
_____
_____

7. SOCIAL NEEDS ASSESSMENT (PARTICIPANT PREFERENCES)* Any identified social needs must be addressed on the Person-Centered Service Plan

How often are you able to leave your home?

☐ Daily ☐ 1 to 6 times a week ☐ 2 to 3 times a month
☐ Monthly ☐ Rarely ☐ Never
☐ Other: _____

What prevents you from leaving your home?

☐ Do not want to
☐ Physically unable to do so
☐ No access to transportation
☐ Other: _____

How do you spend your days?

What types of activities do you enjoy, such as shopping, playing cards, reading, going to school events, playing with friends, etc.?

* Items marked with an asterisk must be included in the person-centered service plan.

Participant Name: _____

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

Activity	Barrier to participating in activity

Would these activities be of interest to you if these barriers can be removed? ☐ **YES** ☐ **NO**

Describe any work history, education, or training that is important to know about you.

Additional notes for Social Needs: _____
_____
_____

8. EMOTIONAL NEEDS ASSESSMENT

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 have any trouble going to sleep? ☐ **YES*** ☐ **NO**

Do you have trouble staying asleep at night? ☐ **YES*** ☐ **NO**

How many hours do you usually sleep at night? _____

Do you nap during the day? ☐ **YES*** ☐ **NO**

How often during the day do you nap? _____

Do you feel you cannot think clearly? ☐ **YES** ☐ **NO**

Do you ever cry for no reason? ☐ **YES** ☐ **NO**

Do you belong to any groups you enjoy participating in? ☐ **YES*** ☐ **NO**

If yes, what groups?*

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

* Items marked with an asterisk must be included in the person-centered service plan.

Participant Name: _____

What makes you feel happy?

Additional notes for Emotional Needs: _____
_____
_____

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

MEDICAL RISKS/NEEDS		**COMMENTS**
Oxygen	☐ YES ☐ NO	
Smoking	☐ YES ☐ NO	
Morbid obesity (as it relates to mobility and transport)	☐ YES ☐ NO	
Alcohol/substance abuse	☐ YES ☐ NO	
Bed Sores	☐ YES ☐ NO	
FALL RISKS		**COMMENTS**
History of falls	☐ YES ☐ NO	
Have you fallen in the last 6 months?	☐ YES ☐ NO	**(How many times?)**
Vertigo, dizziness, numbness, or tingling	☐ YES ☐ NO	
Unsteady gait	☐ YES ☐ NO	
Stairs (outside or inside)	☐ YES ☐ NO	
Use of cane, walker, wheelchair	☐ YES ☐ NO	
Inability to evacuate the home	☐ YES ☐ NO	
Cluttered living environment and/or numerous throw rugs	☐ YES ☐ NO	
BEHAVIORAL RISKS		**COMMENTS**
Wandering	☐ YES ☐ NO	
Resistance to care or assistance	☐ YES ☐ NO	
Changes in behavior (describe)	☐ YES ☐ NO	
Depression	☐ YES ☐ NO	
Suicidal thoughts	☐ YES ☐ NO	
Homicidal thoughts	☐ YES ☐ NO	
Take medications as prescribed	☐ YES ☐ NO	
Follows special diet	☐ YES ☐ NO	
COGNITIVE FUNCTIONAL IMPAIRMENTS		**COMMENTS**
Memory problems	☐ YES ☐ NO	
Difficulty Organizing self	☐ YES ☐ NO	
Difficulty with Initiation	☐ YES ☐ NO	

* Items marked with an asterisk must be included in the person-centered service plan.

Participant Name: _____

Impaired Concentration	☐ YES ☐ NO	
Difficulty Attending to task	☐ YES ☐ NO	
Difficulty Sequencing	☐ YES ☐ NO	
Response 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: _____
_____
_____

10. ADDITIONAL IDENTIFIED PARTICIPANT NEEDS Any identified needs must be addressed and documented during the monthly case manager contact)

NEED IDENTIFIED		Comments/Follow-up Plan
Housing	☐ YES ☐ NO	
Hearing aids	☐ YES ☐ NO	
Home modifications	☐ YES ☐ NO	
Dentures	☐ YES ☐ NO	
Weatherization	☐ YES ☐ NO	
Advance Directives	☐ YES ☐ NO	
Legal services	☐ YES ☐ NO	
Utility assistance	☐ YES ☐ NO	
Food stamps	☐ YES ☐ NO	
Transportation Assistance	☐ YES ☐ NO	
Assistive technology	☐ YES ☐ NO	
Medical appointments	☐ YES ☐ NO	
Debt counseling	☐ YES ☐ NO	
Eyeglasses/contacts	☐ YES ☐ NO	
Magnifying glass	☐ YES ☐ NO	
Home repairs	☐ YES ☐ NO	
Personal Emergency Response System	☐ YES ☐ NO	
Special Education Services at school	☐ YES ☐ NO	
Other	☐ YES ☐ NO	

Additional notes for Additional Needs: _____
_____
_____

11. MEDICAL EQUIPMENT NEEDS* Medical Equipment Unmet Needs must be reflected on the Person-Centered Service Plan, and reviewed/documented during the monthly case manager contact.

* Items marked with an asterisk must be included in the person-centered service plan.

Participant Name: _____

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

Medical Equipment already in place must be reflected on the Person-Centered Service Plan pages 2-3 and identified as a personal attendant staff training need.

MEDICAL EQUIPMENT	HAS ALREADY	NEEDS TO OBTAIN	PERSON RESPONSIBLE FOR OBTAINING
Wheelchair			
Walker			
Cane			
Crutches			
Braces (leg, back, etc.)			
Wheelchair ramp			
Hoyer lift			
Bedside commode			
Elevated commode seat			
Scooter chair			
Lift chair			
Hand-held shower			
Shower chair			
Hospital bed			
Glucometer			
Speech aids			
Catheter			
External Urinary Device			
Ostomy equipment			
Other			

Additional notes for Medical Equipment Needs: _____
_____
_____

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

☐ All ☐ Most ☐ Half ☐ Some ☐ A few ☐ None

Who else provided responses? _____

Case Manager Observations/Recommendations: _____
_____
_____
_____
_____
_____
_____

* Items marked with an asterisk must be included in the person-centered service plan.

Participant Name: _____

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

_____
_____

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.

_____ _____
Participant/Legal Representative 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:
Participant/Legal Representative	
Personal Attendant Agency/PPL	
Other:	
Other:	
Other:	

* Items marked with an asterisk must be included in the person-centered service plan.

Participant Name: _____

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

Copies of this assessment must be provided to the participant/legal representative and Personal Attendant Agency/PPL within 7 business days of the approval by the UMC

* Items marked with an asterisk must be included in the person-centered service plan.

Participant Name: _____