WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

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

☐ **Initial** ☐ **Annual** **Date of Assessment: _____**

1. DEMOGRAPHICS

Last Name:	First Name:	Middle Initial:
Date of Birth	TMH Participant: ☐ YES ☐ NO	Anchor Date:
Physical Address:		
City/State/ZIP:	Phone:	
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married		
Race: ☐ Asian ☐ Hispanic ☐ Black ☐ Native American ☐ Caucasian ☐ Other		
Detailed directions to member's home:		

Member's GOAL(S) *What kinds of services and help are you expecting from this program?*

ADVANCED DIRECTIVES: *Please indicate all advanced directives currently in place. 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**
Name of Person(s) with Legal Representation (IE. MPOA):		**Phone(s):**	
Do you have a DNR: ☐ **YES** ☐ **NO**		Do you have a Living Will: ☐ **YES** ☐ **NO**	

If you do not have an advanced directive currently, do you wish to develop one? ☐ **YES** ☐ **NO**

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2. INSURANCE 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				

3. MEDICAL NEEDS ASSESSMENT

What do you think are your most serious medical conditions?

How do these medical conditions affect you?

- 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? _____
- Do you need transportation to medical appointments? ☐ **YES** ☐ **NO**
  How do you currently get to your medical appointments? _____

Primary Care Physician		Other: Specialists (i.e., Neurologist, Orthopedics, etc.), 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:

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

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- Place a checkmark next to the type of services you need and currently **<u>are not</u>** receiving so your case manager can follow up:

☐ 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

☐ Please check this box if medication list is continued on additional page

- What is the name (s) of the Pharmacy where you get your medication(s) filled? _____

Medical Equipment	Has Already	Needs to Obtain	PERSON RESPONSIBLE FOR OBTAINING	Comments *(Condition of equipment, needing repairs, equipment company used, etc.)*
Wheelchair				
Walker				
Cane				
Crutches				
Braces (Leg, back, etc.)				
Wheelchair Ramp				
Hoyer Lift				
Bedside Commode				
Elevated Commode Seat				
Scooter Chair				
Lift Chair				
Shower Chair				
Hand-held Shower				
Grab Bars				
Hospital Bed				
Glucometer				
Speech Aids				
Catheter				
External Urinary Device				
Ostomy Equipment				
Other:				

☐ No Medical Equipment Needs – Member has all necessary medical equipment to meet his/her needs

4. ENVIRONMENTAL NEEDS ASSESSMENT *-Tell me about your home and neighborhood.*

Home Location	Type of Home		Levels	Own or Rent
☐ **Rural** ☐ **Urban**	☐ **Apartment**	☐ **House**	☐ **Single Story**	☐ **Own Home** ☐ **Live with Homeowner**
☐ **Isolated –** (No visible neighbors)	☐ **Mobile Home**	☐ **Multi Family**	☐ **2 or more floors**	☐ **Rent** ☐ **HUD Subsidy**

Who Lives with You?	Name	Relationship
☐ I live alone		

- Member Controlled Setting Assessment (MCS) Criteria Met? ☐ **YES** ☐ **NO**
  If yes, date the MCS assessment was completed: _____
  If no, date that CM informed UMC: _____

- **Environmental Accessibility Adaptation (Home)** – What changes/modifications/adaptations to your home would make it easier for you to get in/out of the home or to do activities in your home?

- **Environmental Accessibility Adaptation (Vehicle)** – What changes/modifications/adaptations to your vehicle would make it easier for you to get in/out of the vehicle or make the vehicle accessible for you?

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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	**Pest Eradication**
Barriers to Access, Inside or Outside- (Stairs, Narrow Doorways, etc.)	☐ YES ☐ NO	
Home Repairs Needed	☐ YES ☐ NO	
Weatherization Needed	☐ YES ☐ NO	
Utility Assistance	☐ 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, when and why? _____ _____
Do you ever feel unsafe in your neighborhood?	☐ YES ☐ NO	If yes: With whom, when and why? _____ _____
Are you satisfied with your living conditions?	☐ YES ☐ NO	If no: What is the reason: _____
Do you need assistance with obtaining housing?	☐ YES ☐ NO	
Do you receive housing assistance (i.e., HUD, subsidized, section 8, etc.)	☐ YES ☐ NO	If so, what? _____

5. SOCIAL NEEDS ASSESSMENT

Do you feel your social needs are being met?	☐ **YES** ☐ **NO**	If not, why? _____
Are you a social person?	☐ **YES** ☐ **NO**	
Do you feel lonely?	☐ **YES** ☐ **NO**	If yes, how often? _____
Are you able to leave your home?	☐ **YES** ☐ **NO**	If so, how often? _____ Where do you go? _____ If NO, what prevents you from leaving your home? _____
Do you feel that you get to go into the community as much as you like?	☐ **YES** ☐ **NO**	
Do you need help from your personal attendant to do things in your community?	☐ **YES** ☐ **NO**	
Do you have family members who live nearby?	☐ YES ☐ NO	If yes, how often, when you want, do you get together with those family members who live nearby? _____
Do you have friends who live nearby?	☐ YES ☐ NO	If yes, how often when you want, do you get together with those friends who live nearby? _____

- What type of work, education or training did you have in the past? _____
- How do you spend your days? _____
- What community activities do you enjoy? *(i.e., shopping, playing cards, going to the movies, going to school events, playing with friends, etc.)* _____

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

ACTIVITY	BARRIER TO MEMBER IN ACTIVITY

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6. EMOTIONAL NEEDS ASSESSMENT

- Have you had an emotional event in your life in the past six months (any major changes, 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 sleeping issues (going/staying)?	☐ **YES** ☐ **NO**	Medication to Assist? ☐ **YES** ☐ **NO**
Feel you cannot think clearly?	☐ **YES** ☐ **NO**	
Cry for no reason?	☐ **YES** ☐ **NO**	
Belong to any group(s) you enjoy participating in?	☐ **YES** ☐ **NO**	If yes, what group(s)? _____
See a psychiatrist/therapist?	☐ **YES** ☐ **NO**	If yes, how often? _____
Take any prescribed mood-altering medication?	☐ **YES** ☐ **NO**	If so, what? _____

- When feeling down, what makes you feel better? _____
- Who can you talk to about your feelings, problems, or concerns?

  _____

7. EDUCATIONAL NEEDS: ☐ NA

Personal Attendant Services are not intended to replace supports/services a child would receive from the school system during a school day/year. 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	**HAS ALREADY**	**NEEDS TO OBTAIN**	**SERVICES RECEIVED**
Individualized Education Plan (IEP)			
504 Plan			
After High School Transition			
Referral to Division of Rehabilitation Services (DRS)			
Other Special Education Program			

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

INFORMAL (UNPAID) SUPPORT Do you currently have someone who assists you with ADL's/IADL's (listed in chart below)? ☐ **Yes** ☐ **No** If so, list the name below. Phone: _____	**FORMAL (PAID) SUPPORT** Do you currently have an agency or services that assists you with ADL's/IADL's (listed in chart below)? ☐ **Yes** ☐ **No** If so, list the name below. Phone: _____		
ADL/IADL ACTIVITY	**NAME / AGENCY**	**FORMAL - PAID SUPPORT**	**INFORMAL - FRIENDS/FAMILY SUPPORT**
Food and Liquid intake			
Meal Preparation			
Bathing			
Dressing			
Grooming			
Walking			
Wheeling			
Transferring/Repositioning			
Toileting			
Medication Prompting/Supervision			
Meal Preparation			
Laundry			
Dishes			
Take out trash			
Transportation *(medical, errands & activities)*			
Finances *(bill payment, banking, purchases, etc.)*			
Essential Errands: Banking/paying bills, picking up prescriptions, grocery shopping, post office, DHHR			
Community Activities: Going to a restaurant, park, local library, shopping, hair salon/barber			

9. RISK ASSESSMENT

MEDICAL RISKS		COMMENTS
Use Oxygen	☐ YES ☐ NO	
Smoking	☐ YES ☐ NO	
Morbid Obesity as R/T Mobility and Transport	☐ YES ☐ NO	
Decubitus/Skin Break Downs	☐ YES ☐ NO	Location: _____ Treatment: _____
Nutrition and/or Special Diet	☐ YES ☐ NO	
Nap During the Day	☐ YES ☐ NO	If yes, how often? _____
Seizures	☐ YES ☐ NO	☐ Controlled ☐ Uncontrolled Date of Last Seizure: _____
Chronic Health Concerns	☐ YES ☐ NO	
Inability to Evacuate the Home	☐ YES ☐ NO	
Limited/No Access to Medical Care	☐ YES ☐ NO	Reason: _____
Treatment Non-Compliance	☐ YES ☐ NO	Describe: _____
ER Visits and/or hospitalization	☐ YES ☐ NO	
Aspiration	☐ YES ☐ NO	
Allergic Reactions	☐ YES ☐ NO	Please list reaction: _____ Epi Pen ☐ YES ☐ NO
Vision Needs (Glasses)	☐ YES ☐ NO	
Dental Issues (Dentures, Chipped/Missing Teeth)	☐ YES ☐ NO	
Hearing Issues / Hearing Aids	☐ YES ☐ NO	Please list: _____

MEDICATION RISKS		COMMENTS
Multiple Prescriptions	☐ YES ☐ NO	
Medication Complications	☐ YES ☐ NO	
Psychotropic Medications	☐ YES ☐ NO	
Use of OTC or Herbal Medicines	☐ YES ☐ NO	
Medication Compliance	☐ YES ☐ NO	
Medication Allergies	☐ YES ☐ NO	

FALL RISKS		COMMENTS
Outside/Inside Stairs	☐ YES ☐ NO	
Cluttered Living Environment	☐ YES ☐ NO	
Throw Rugs	☐ YES ☐ NO	
Use of Cane, Walker, Wheelchair	☐ YES ☐ NO	
History of Falls / Fallen in the last 6 months	☐ YES ☐ NO	If yes, how many times? ____
Vertigo / Dizziness / Light-Headed	☐ YES ☐ NO	
Unsteady Gait	☐ YES ☐ NO	
Numbness / Tingling	☐ YES ☐ NO	
Swelling in Legs / Feet	☐ YES ☐ NO	
Use of Prosthetic, Braces, etc.	☐ YES ☐ NO	
Physical Impairment Causing Limp or Dragging of Foot	☐ YES ☐ NO	

BEHAVIORAL RISKS		COMMENTS
Endangering Self or Self-Neglect	☐ YES ☐ NO	
Destruction of Property	☐ YES ☐ NO	
Wandering	☐ YES ☐ NO	
Resistance to Care (ADL's, diet, etc.)	☐ YES ☐ NO	Describe: _____
Changes in Behavior	☐ YES ☐ NO	Describe: _____
Depression	☐ YES ☐ NO	
Cry for No Reason	☐ YES ☐ NO	
Suicidal/Homicidal Thoughts	☐ YES ☐ NO	
Verbal Aggression/Agitation	☐ YES ☐ NO	
Physical Aggression/Agitation	☐ YES ☐ NO	
Socially Inappropriate	☐ YES ☐ NO	Describe: _____
Alcohol or Substance Abuse	☐ YES ☐ NO	

COGNITIVE FUNCTIONING IMPAIRMENTS		COMMENTS
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	
Word Finding Difficulty	☐ YES ☐ NO	
Responses to change in routine	☐ YES ☐ NO	
Lack of awareness of own deficits	☐ YES ☐ NO	
Distractibility	☐ YES ☐ NO	
Impulsivity	☐ YES ☐ NO	

10. ADDITIONAL IDENTIFIED NEEDS

IDENTIFIED NEED	HAS	NEEDS	NA	COMMENTS
Legal Services				If so, why? _____
SNAP Program				
Assistive Technology				If so, what? _____
Debt/Financial Counseling				
Personal Emergency Response Unit				
Other:				

All identified services, support, service needs and risks listed in this assessment must be addressed on the member's Person-Centered Service Plan.

Follow Up Needed by Case Manager

☐ NA – All of the member's identified needs are met at this time.

☐ _____

☐ _____

☐ _____

☐ _____

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By signing, I certify that I had complete input into the assessment, discussed my goals and preferences and was able to choose who I wanted to participate in my assessment.

Name	Relationship
	Case Manager
	Member / Legal Guardian

I also certify that the reported information is complete and accurate. I understand that payment for the TBIW 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

Agency Name: _____

Agency phone: _____

Copies of this assessment were provided to:	Date copy was provided:
Member / Legal Guardian ☐ **YES** ☐ **NO**	

Copies of this assessment must be provided to the member or court appointed legal guardian. It is the Case Management Agency's responsibility to create and upload the Assessment and Service Planning Documents onto the UMC web portal. Servicing Providers are responsible for retrieving all necessary Assessment, Service Planning documents and authorizations from the UMC web portal.