PERSONAL CARE SERVICES PROGRAM
MEMBER ASSESSMENT

Member Name:_____

Date:_____

□Initial □6-Month □Annual

1. DEMOGRAPHICS

Last Name:		First Name:
DOB:	Date of Assessment:	Financial Eligibility Effective Date:
Current PAS Date:		Anchor Date:
Physical Address:		
City:	County:	Zip Code:
Mailing Address:		
City:	County:	Zip Code:
Home Phone:	Cell Phone:	Other Phone:
Detailed Directions to Member's Home:		

2. REPRESENTATIVE INFORMATION

Check any that apply. A copy showing either the relationship or the document needs to be included in the member's file.

□ Legal Guardian	□ Durable POA	□ POST Form
□ Committee	□ Conservator	□ Document in Chart
□ Medical POA	□ DNR	□ Deemed Incompetent
□ Healthcare Surrogate_____		

Name: Phone Number:

3. ENVIRONMENTAL ASSESSMENT

Location:	Urban □	Rural □	
Type of Home: Check all that apply	Apartment □	Mobile Home □	House□
	Multi-Family □	Single Story □	Two or more floors □

Who lives with you? No One □

Name	Phone Number (s)	Relationship

Member Name:_____
Date:_____

4. REVIEW OF SYSTEMS
ANY ABNORMAL FINDINGS MUST HAVE COMMENTS SECTION COMPLETED

NEUROMUSCULAR (Check Findings)

Level of Consciousness:	□Alert □Disoriented □Lethargic □Other Comments: _____
Oriented to:	□Person □Place □Time Comments: _____
Challenging Behaviors	□N/A □Physically □Verbally □Socially inappropriate/Disruptive Comments:_____
Communication:	□Verbal □ Writes Messages □American Sign Language □Braille □Signs, Gestures, or Sounds □Communication Board or Device Comments: _____
Speech:	□Clear □Unclear □Aphasic Comments: _____
Vision:	□WNL □Contacts □Eye Glasses □Corrective Lenses for Reading Only □Needs large Print □Sees Objects □Sees Shadows □Blind Comments: _____
Hearing:	□WNL □ Requires Repeats Deaf: □right □left □Total □ Hearing Aids □Implants Comments: _____
Neurological:	□WNL □Difficulty with Receptive Language □Difficulty with Expressive Language □Seizures: Type:_____ Frequency:_____Date of Last Seizure: _____ □Memory □Confusion □Disorientation Comments: _____
Sensation:	□WNL □Pain □Tingling □Numbness Location: _____ Comments: _____
Strength:	□WNL □Paralysis □Weakness □Location: _____ Comments:_____
Posture:	□Upright □Bent Forward □Scoliosis Comments: _____
Gait:	□Steady □Unsteady □1 or □2 Person Assist Comments: _____
CARDIO-PULMONARY (Check Findings)	
Respiratory:	□ WNL □Shortness of Breath: □Rest or □Exertion □Labored Coughing: □Productive □Non-Productive □Wheezing

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Respiratory Equipment and Treatment:	☐N/A ☐Oxygen_____L/Min ☐Nasal Cannula ☐Mask ☐Ventilator ☐C-PAP ☐BI-PAP **Person responsible for C/or Bi-PAP cleaning:_____** ☐ Tracheostomy Care **Person responsible for care of the ventilator, tracheostomy care and suctioning:_____** ☐Inhalers ☐Nebulizer Comments:_____
Cardiac:	☐Chest Discomfort ☐Palpitations ☐Lips/nail beds dusky Comments: _____
Cardiac Devices:	☐Pacemaker ☐Defibrillator ☐Date Inserted: _____ How often checked_____Who Checks It _____ Comments _____
GI/GU (Check Findings)	
Intake:	☐Difficulty Chewing ☐Difficulty Swallowing ☐History of Choking Appetite ☐Good ☐Fair ☐Poor Comments:_
Dental:	Teeth: ☐Carries ☐Loose ☐Broken ☐Dental Prosthesis ☐Edentulous Comments:_____
Diet:	☐Normal ☐Special Diet:_____ ☐Dietary Supplements (Type/Frequency) _____ ☐Feeding Tube: ☐Pump/Continuous Feed ☐ Rate:_____ ☐Intermittent Feed ☐Frequency/Amount_____ Person Responsible for tube feedings and care of feeding tube:_____ Comments:
Bowel:	☐Normal ☐Diarrhea ☐Constipation Incontinent Ostomy: ☐N/A ☐Partial ☐Total Supplies Used:_____ Comments:_____
Urinary:	☐Normal Incontinent: ☐Partial ☐Total Catheter: ☐Foley ☐Texas Dialysis: ☐Shunt ☐Port ☐Ostomy Supplies Used: _____ Comments: _____
Recent Weight Change:	☐N/A ☐Weight Gain Since Previous Assessment Amount: _____ ☐Weight Loss Since Previous Assessment Amount: _____ Comments: _____

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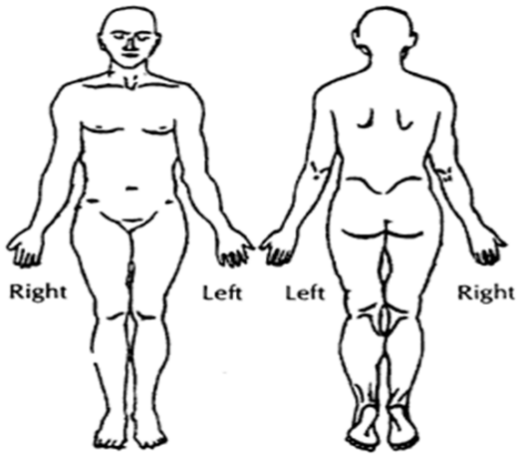
INTEGUMENTARY (Check Findings)	
Skin Color:	☐WNL ☐Pale ☐Jaundice ☐Cyanotic ☐Ruddy/Red Comments:
Skin:	☐Warm/Dry ☐Rash ☐Pressure Ulcers ☐Stasis Ulcers ☐Abrasions ☐Burns ☐Bruises ☐Open Lesions ☐Cuts ☐Surgical Wounds ☐Skin Desensitized to Pain ☐Pressure ☐Unexplained injury to skin: (describe)_____ ☐Protective/Preventive Foot Care: (describe)_____

DOCUMENT ANY ABNORMAL SKIN FINDINGS BELOW AND PROVIDE A DETAILED DESCRIPTION IN THE COMMENTS SECTIONS



COMMENTS:_____

_____

_____

_____

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Describe any other treatments and/or healthcare provided for the member:

Medical Equipment in the home: (check all that apply)

Ramp ☐ Hoyer Lift ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Bedside Commode ☐

Elevated Commode Seat ☐ Scooter Chair ☐ Lift Chair ☐ Hand Held Shower ☐ Shower Chair ☐ Glucometer☐

Hospital Bed ☐ Other: _____

Needed Medical Equipment: _____

Has the member's needs for assistance changed since the last completed PAS? (Please include any hospitalizations since last assessment).

Comments:

Who was present during the assessment?

Name	Relationship

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MEMBER ACTIVITIES:

I=Independent S=Supervision P=Partial T=Total

Activity	Level of Assistance	Comments
Personal Care Tasks		
Bath:		
Skin Care:		
Hair:		
Nails:		
Mouth Care:		
Dressing:		
Ambulation:		
Wheeling:		
Transfer:		
Toileting:		
Positioning: Turn Every ___Hr(s)		
Assistance with Medications:		
Meals: __B__L__D__Snacks Diet: Special Directions:		
Environmental Tasks cannot be more than one-third (1/3) of total time.		
Bed Making:		
Laundry:		
Vacuum/Sweep:		
Mop:		
Dishwashing:		
Dust:		
Straighten:		
Other:		
Essential Errands:		
Community Activities: Describe PC services needed during community activities		

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ATTACHMENT A
MEDICATION PROFILE

Member _____ DOB _____

Dx _____ Allergies _____

Pharmacy _____ PCP _____

Other Specialists:_____

Review Date	New Chg. D/C	Medication/Dose	Frequency	Reason	Physician	RN Signature

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Date:_____

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.

Member or Legal Representative (if applicable) Signature Date

Personal Care Services Program RN Signature Date

Copy of this Assessment was provided to member on _____
(Date)