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

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

**REVIEW DATE: _____**

☐ **6 Month**

☐ **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?*

# Traumatic Brain Injury Waiver (TBIW) Program
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**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** | ☐ | **Emergency Contact(list below_** |
| ☐ | **Healthcare Surrogate** | | |
| **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**

## 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** | | | | |

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

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| Name: | | Name: | |
|---|---|---|---|
| Specialty: | Phone: | Specialty: | Phone: |

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

**3. MEDICAL NEEDS ASSESSMENT**

- 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 not, who currently helps you? _____

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? _____

| 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 requested by Member ☐

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

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

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

| 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 Kepro: ____

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** | |

| Does the current residence have? | | Comments/Follow up Plan |
|---|---|---|
| | | |

| | | |
|---|---|---|
| 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: _____ |

**5. SOCIAL NEEDS ASSESSMENT**

| 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 |
|---|---|

| | |
|---|---|
| | |
| | |

**6. 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: | | 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?
_____
_____

**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 | FORMAL (PAID) SUPPORT |
|---|---|
| Do you currently have someone who assists you with ADL's/IADL's (listed in chart below)? ☐ **Yes** ☐ **No**<br><br>If so, list the name below. Phone:<br>_____ | Do you currently have an agency or services that assists you with ADL's/IADL's (listed in chart below)?<br>☐ **Yes** ☐ **No**<br><br>If so, list the name below. Phone:<br>_____ |

| ADL/IADL ACTIVITY | NAME / AGENCY | PAID (FORMAL) SUPPORT | FRIENDS/FAMILY (INFORMAL) SUPPORT |
|---|---|---|---|
| Food and Liquid intake | | | |
| Meal Preparation | | | |
| Bathing | | | |
| Dressing | | | |
| Grooming | | | |
| Walking | | | |
| Wheeling | | | |
| Transferring/Repositioning | | | |
| Toileting | | | |
| Medication Prompting/Supervision | | | |
| Meal Preparation | | | |

| ADL/IADL ACTIVITY | NAME / AGENCY | PAID (FORMAL) SUPPORT | FRIENDS/FAMILY (INFORMAL) SUPPORT |
|---|---|---|---|
| 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 | |
| Alcohol or Substance Abuse | ☐ YES ☐ NO | |
| Morbid Obesity as R/T Mobility and Transport | ☐ YES ☐ NO | |
| Decubitus/Skin Break downs | ☐ YES ☐ NO | |
| Nutrition and/or Special Diet | ☐ YES ☐ NO | |
| Trouble Going to Sleep | ☐ YES ☐ NO | Medication to Assist? _____ |
| Trouble Staying Asleep | ☐ YES ☐ NO | If yes, how many hours do you sleep? _____ |
| Nap During the Day | ☐ YES ☐ NO | If yes, how often? _____ |
| Seizures | ☐ YES ☐ NO | Controlled<br>Last Seizure_____ |
| Chronic Health Concerns | ☐ YES ☐ NO | |
| Inability to evacuate the home | ☐ YES ☐ NO | |
| Access to medical care | ☐ YES ☐ NO | |
| Inability to evacuate the home | ☐ YES ☐ NO | |
| Treatment Compliance | ☐ YES ☐ NO | |
| ER Visits and/or hospitalization | ☐ YES ☐ NO | |
| Aspiration | ☐ YES ☐ NO | |

| | | |
|---|---|---|
| Allergic Reactions | ☐ **YES** ☐ **NO** | Please list ☐<br>Epi Pen ☐ **YES** ☐ **NO** |
| Other | ☐ **YES** ☐ **NO** | Please list |

**MEDICATIONS** **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** | |
| Medications 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 | ☐ **YES** ☐ **NO** | |
| Unsteady gait | ☐ **YES** ☐ **NO** | |
| Numbness / tingling | ☐ **YES** ☐ **NO** | |
| Swelling in legs / feet | ☐ **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, medication, diet, etc.) | ☐ **YES** ☐ **NO** | |
| 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:** _____ |
| 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 PARTICIPANT NEEDS**

| | | |
|---|---|---|
| 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 | |

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

| | | |
|---|---|---|
| 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 | |
| Environmental Accessibility Adaption (Home) | ☐ YES ☐ NO | |
| Environmental Accessibility Adaption (Vehicle) | ☐ YES ☐ NO | |
| Other: | ☐ YES ☐ NO | |

**All service needs and risks listed in this assessment must be addressed on the Member's Person-Centered Service Plan.**

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 |
| | |
| | |
| | |

*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

| Copies of this assessment were provided to: | Date copy was provided: |
|---|---|
| Member | |
| Legal Representative | |

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 in the UMC web portal . Servicing Providers are responsible for retrieving all necessary Assessment , Service Planning documents and authorizations from the UMC web portal.

# 6 Month Assessment Review

☐ Person-Centered Assessment completed on __/__/____ was reviewed with no changes note

☐ Person-Centered Assessment reviewed with changes noted - (List Changes/Revisions Below)

| Changes / Revisions Noted During Review | | |
|---|---|---|
| **Assessment Page Number** | **Changes / Revisions That Were Made** | **Date Change / Revision Occurred** |
| | | |
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WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

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

| Changes / Revisions Noted During Review | | |
|---|---|---|
| **Assessment Page Number** | **Changes / Revisions That Were Made** | **Date Change / Revision Occurred** |
| | | |
| | | |

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

| Name | Relationship |
|---|---|
| | Case Manager |
| | Member |
| | |
| | |
| | |

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_____ _____

Member or Court Appointed Legal Guardian-Signature Date

_____ _____

Case Manager Signature Date

| Copies of this assessment were provided to: | Date copy was provided: |
|---|---|
| Member | |
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