



OFF-YEAR ASSESSMENT

Background Information

Member Name: _____ SID: _____ DOB: _____ Service Type: _____
First Name MI Last Name

CM/SW Name: _____ Anniversary Date: _____ Assessor: _____ Assessment Date: _____
First Name Last Name

Medical Conditions/Diagnoses

- | | |
|----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |

Risk Factors (YES-NO-UNKNOWN)

	Is the member in need of a primary healthcare provider?
	Is the member in need of a dentist?
	Is the member in need of a specialist?
	Has the member had problems not taking or not receiving medications on time?
	Have there been issues with medications not being re-evaluated timely?
	Has the member had significant medication changes in the past year?
	In the past year, has the member gone to an emergency room? If yes, how many times? _____ If yes, explain in notes.

Notes

Any risk factor marked 'Yes' must be addressed in the member's Crisis Intervention Plan

Activities of Daily Living (IMPROVED-DECREASED FUNCTION-STAYED SAME-NOT A CONCERN)

	Eating	How have the changes in the member's condition impacted the member's service needs?	
	Bathing	Additional types of services	Type: _____
	Dressing	Fewer types of services	Eliminate: _____
	Hygiene	Increased frequency	Increase: _____ to _____
	Toileting	Decreased frequency	Decrease: _____ to _____
	Mobility in home	Have there been any increases or decreases in the availability of the member's natural supports?	
	Mobility out of home	Additional supports	Type: _____
	Positioning	Fewer supports	Eliminate: _____
	Transferring	Increased frequency	Increase: _____ to _____
	Communicating	Decreased frequency	Decrease: _____ to _____

Are there areas member has expressed interest in and could benefit from services not currently in place? If yes, explain in notes.

Risk Factors (YES-NO-UNKNOWN)

	Is the member at risk of choking or other problems when eating?
	Is the member's health at risk due to poor nutrition (e.g., eating disorder, refusal to eat, inability to afford nutritious food, etc.)?
	Would member's health be at risk if a paid provider or natural support person did not show up to provide scheduled services?

Notes

Any risk factor marked 'Yes' must be addressed in the member's Crisis Intervention Plan

Instrumental Activities of Daily Living (not required for children) (IMPROVED-DECREASED FUNCTION-STAYED SAME-NOT A CONCERN)

	Preparing meals	How have the changes in the member's condition impacted the member's service needs? (Enter in notes)	
	Shopping	Additional types of services	Type: _____
	Transportation	Fewer types of services	Eliminate: _____
	Managing medications	Increased frequency	Increase: _____ to _____
	Housework	Decreased frequency	Decrease: _____ to _____
	Managing money	Have there been any increases or decreases in the availability of the member's natural supports?	
	Telephone use	Additional supports	Type: _____
	Employment	Fewer supports	Eliminate: _____
		Increased frequency	Increase: _____ to _____
		Decreased frequency	Decrease: _____ to _____

Risk Factors (YES-NO-UNKNOWN)

	Is the member without means of communication in an emergency?	
	Is the member able to respond to emergencies independently?*	*If member is never alone, check here for N/A: <input type="checkbox"/>

Notes

Any risk factor marked 'Yes' must be addressed in the member's Crisis Intervention Plan

Cognitive Function and Memory/Learning (IMPROVED-DECREASED FUNCTION-STAYED SAME-NOT A CONCERN)

	Cognitive function	How have the changes in the member's condition impacted the member's service needs?	
	Judgment/decision-making	Additional types of services	Type: _____
	Memory/learning Behavior concerns	Fewer types of services	Eliminate: _____
		Increased frequency	Increase: _____ to _____
		Decreased frequency	Decrease: _____ to _____
		Have there been any increases or decreases in the availability of the member's natural supports?	
		Additional supports	Type: _____
		Fewer supports	Eliminate: _____
		Increased frequency	Increase: _____ to _____
		Decreased frequency	Decrease: _____ to _____

Risk Factors (YES-NO-UNKNOWN)

	Does the member need to be supervised at all times?
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Notes:

Any risk factor marked 'Yes' must be addressed in the member's Crisis Intervention Plan

Behavior Concerns (IMPROVED-DECREASED FUNCTION-STAYED SAME-NOT A CONCERN)

	Injurious	How have the changes in the member's condition impacted the member's service needs?	
	Destructive	Additional types of services	Type: _____
	Socially offensive	Fewer types of services	Eliminate: _____
	Other serious	Increased frequency	Increase: _____ to _____
		Decreased frequency	Decrease: _____ to _____
	Have there been any increases or decreases in the availability of the member's natural supports?		
	Additional supports	Type: _____	
	Fewer supports	Eliminate: _____	
	Increased frequency	Increase: _____ to _____	
	Decreased frequency	Decrease: _____ to _____	

Risk Factors (YES-NO-UNKNOWN)

	Has the member refused or spit out medications?
	Has the member misused prescription or OTC medications (e.g., taken too many at once)?
	Has the member ingested foreign objects or been diagnosed with PICA?
	Has alcohol or substance use caused the member any problems?
	Has the member left or attempted to leave home or other supervised activities without permission or when it would be unsafe to do so?
	Is the member non-compliant with medical appointments or treatments?

Notes:

Any risk factor marked 'Yes' must be addressed in the member's Crisis Intervention Plan

Additional Information (IMPROVED-DECREASED FUNCTION-STAYED SAME-NOT A CONCERN)

If the member currently receives any skilled service, check all that apply below.

- PT OT ST
- Full thickness wound
- Daily tracheostomy/NG suctioning
- Daily intermittent catheterization
- IV drug therapy (put doctor order in notes
Due to inadequate nutrition
- Nephrostomy care (put doctor order in notes
Has the need for these services changed? _____
- Therapist frequency _____
- Home exercise plan frequency _____
- Daily wound care
- Ventilator/respirator >6/24 hours
- Daily catheter irrigations
- Tube feeding
- Medical oversight
- Medical oversight
- IV infusion (put doctor order in notes)

Describe any other changes in member's condition(s) that may impact the member's service need. (Enter in notes) _____

Risk Factors (YES-NO-UNKNOWN)

	Is there any evidence of neglect by a caregiver?
	Is there any evidence of self-neglect?

Notes:

Any risk factor marked 'Yes' must be addressed in the member's Crisis Intervention Plan