



## Emergency Needs Assessment

Background Information			
Member Name (first, MI, last)	SID	DOB (MMDDYYYY)	Service Type
CM/SW Name (first, last)		Anniversary Date (MMDDYYYY)	
Assessor		Assessment Date (MMDDYYYY)	

Medical Conditions/Diagnoses	
1. _____	2. _____
3. _____	4. _____
5. _____	6. _____
7. _____	8. _____
9. _____	10. _____

Risk Factors
<ul style="list-style-type: none"> <li>--- Is the member in need of a primary healthcare provider?</li> <li>--- Is the member in need of a dentist?</li> <li>--- Is the member in need of a specialist?</li> <li>--- Has the member had problems not taking or not receiving medications on time?</li> <li>--- Have there been issues with medications not being re-evaluated timely?</li> <li>--- Has the member had significant medication changes in the past year?</li> <li>--- In the past year, has the member gone to an emergency room? If yes, how many times? <span style="float: right;">If yes, explain in notes.</span></li> </ul>
Notes: _____

## Activities of Daily Living

- 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

- 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: \_\_\_\_\_

## Instrumental Activities of Daily Living (not required for children)

- Preparing meals            How have the changes in the member's condition impacted the member's service needs?
- 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**

- 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:

Notes: \_\_\_\_\_

**Cognitive Function and Memory/Learning**

- 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      Fewer types of services      Eliminate: \_\_\_\_\_
- Orientation      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**

- Does the member need to be supervised at all times?

Notes: \_\_\_\_\_

## Behavior Concerns

- 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: \_\_\_\_\_
- Uncooperative                Increased frequency                    Increase: \_\_\_\_\_ to \_\_\_\_\_
- Other serious                 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

- 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: \_\_\_\_\_

## Additional Information

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

PT    OT    ST

How often seen by therapist?

Home exercise plan frequency:

Full thickness wound

Daily wound care

Is assistance needed?    Yes    No

Daily tracheostomy/NG suctioning

Ventilator/respirator >6/24 hours

Daily intermittent catheterization

Daily catheter irrigations

For inadequate nutrition:

IV drug therapy (put doctor order in notes)

Tube feeding

Nephrostomy care (put doctor order in notes)

IV infusion

Has the need for these services changed?

Document frequency, doctor orders, and summarize the medical oversight needed for each of the checked items in the notes field below.

## Risk Factors

--- 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\*\*\*

## Reason and Rationale

Significant change for the member has occurred in at least three of the five domains:    Yes    No

Significant change for the member is likely to continue:    Yes    No

The member is in need of a full assessment:    Yes    No

Reason and rationale: