THE GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH CARE FINANCE

Medicaid Personal Care Aide Assessment Instrument

1

☐ SOC ☐ Resumption ☐ Recert

Name & Vital Information

Beneficiary Name: ______________________________ Phone: ______________
(Last) (First) (Middle Initial)

Address: ____
(Street) (City) (State) (Zip Code)

Medicaid #: ______________ Medicare #: ______________ SSN: ______________

Date of Birth: ______________ Sex: __________

Marital Status: ______Married ______Widowed ______Separated ______Single ______Unknown

Special instructions (ie. knock hard on door, key in security code, intersection cross street)

Pets?

Primary Caregiver

Name: ______________________ Relationship: ______________________
Address: ______________________ Phone: (H) ______________ (W) ______________
Name: ______________________ Relationship: ______________________
Address: ______________________ Phone: (H) ______________ (W) ______________

Physician

Name of Primary Physician: ______________________ Phone: ______________

Address: ____

Initial Contact

Referral Source: ____
(Name) (Relation to Beneficiary) (Phone)

Reason for referral

Beneficiary Name:	Medicaid Number:

Current Services

Do you currently receive any of the following services?

No	Yes	*Check All Services That Apply*	Provider/Frequency:
____	____	Adult Day Care	
____	____	Adult Protective Services	
____	____	Personal Care Aide	
____	____	Congregate Meals/Senior Center	
____	____	Financial Management/Counseling	
____	____	Friendly Visitor/Telephone Reassurance	
____	____	Habilitation/Supported Employee	
____	____	Home Delivered Meals	
____	____	Rehabilitation Services	
____	____	Housing	
____	____	Legal	
____	____	Mental Health (Inpatient/Outpatient)	
____	____	Substance Abuse	
____	____	Transportation	
____	____	Vocational Rehab/Job Counseling	
____	____	Other:	

Financial Resources

Do you currently receive income from?

No	Yes		Amount:
____	____	Pension	
____	____	Social Security	
____	____	SSI/SSDI	
____	____	VA Benefits	
____	____	Wages / Salary	
____	____	Other:	

Does anyone cash your check, pay your bills or manage your business?

No	Yes		Names
____	____	Legal Guardian	
____	____	Power of Attorney	
____	____	Representative Payee	
____	____	Other,	

Do you receive any benefits or entitlements?

No	Yes	
____	____	Food Stamps
____	____	Energy Assistance
____	____	Subsidized Housing

Beneficiary Name:	Medicaid Number:

Physical Environment

Where do you currently reside? Does anyone live with you?

	Alone	Spouse	Other	Names of Person(s) in Household
House: Own				
House: Rent				
House: Other				
Apartment				
Rented Room				

	Name of Provider (Place)	Admission Date
Mental Health Group Homes		
Group Home for the Elderly		

Where you currently reside, are there any problems?

No	Yes	*Check All Problems That Apply*
____	____	Barriers to Access
____	____	Electrical Hazards
____	____	Fire Hazards / No Smoke Alarm
____	____	Insufficient Heat / Air Conditioning
____	____	Insufficient Hot Water / Water
____	____	Poor Toilet Facilities (Inside/Outside)
____	____	Defective Stove, Refrigerator, Freezer
____	____	Defective Washer / Dryer
____	____	Poor Bathing Facilities
____	____	Structural Problems
____	____	Telephone Not Accessible
____	____	Unsafe Neighborhood
____	____	Unsafe / Poor Lighting
____	____	Unsanitary Conditions
____	____	Other: _____

Describe Problems:

Beneficiary Name: **Medicaid Number:**

2 FUNCTIONAL STATUS (Check only one block for each level of functioning)

ADLS	Needs Help?		MH Only (Mechanical Help)	HH Only (Human Help)		MH & HH		Performed by Others			Is Not Performed
	No	Yes		Supervision	Physical Assistance	Supervision	Physical Assistance				
Bathing											
Dressing											
Toileting											
Transferring											
Taking Medications by self											
								Spoon Fed	Syringe/ Tube Fed	Fed by IV	
Eating / Feeding											

Continence	Needs Help?	
	No	Yes
Bowel		
Bladder		

Incontinent	External Device/ Indwelling/ Ostomy Self Care	External Device Not Self Care	Indwelling Catheter Not Self Care	Ostomy Not Self Care

Comments:

Ambulation	Needs Help?	
	No	Yes
Walking		
Wheel Chair		
Climbing Stairs		
Mobility		

MH Only (Mechanical Help)	HH Only (Human Help)		MH & HH		Performed by Others	Is Not Performed
	Supervision	Physical Assistance	Supervision	Physical Assistance		
					Confined Moves About	Confined Does not Moves About

IADLS	Needs Help?	
	No	Yes
Meal Preparation		
Housekeeping		
Laundry		
Money Management		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Beneficiary Name:	Medicaid Number:

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admission: In the past 12 months have you been admitted to a hospital, nursing home or rehabilitation facility?

No	Yes		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Rehabilitation Facility			

Do you have any advance directives?

No	Yes		*Location*
		Living Will,	
		Durable Power of Attorney for Health Care,	
		Other,	

Diagnoses & Medication Profile

Diagnosis(es) causing patient's disability(ies) and other pertinent diagnoses or surgical procedures:

Current Diagnoses	Date of Onset

Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.		
2.		
3.		
4.		
5.		
6.		

Do you have any problems with medicine(s)?

No / Yes

- ☐ ☐ Adverse reactions / allergies
- ☐ ☐ Cost of medication
- ☐ ☐ Getting to the pharmacy
- ☐ ☐ Taking them as instructed / prescribed
- ☐ ☐ Understanding directions / schedule

How do you take your medications?

Check one below

- ☐ Without Assistance
- ☐ Administered/Monitored by family member
- ☐ Administered/Monitored by professional nursing staff

Describe help:

Name of helper:

Beneficiary Name:	Medicaid Number:

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment	Impairment Record Date of Onset/Type of Impairment		Complete Loss	Date of Last Exam
		Compensation	No Compensation		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?

_____ Within normal limits or instability corrected
_____ Limited motion
_____ Instability uncorrected or immobile

Have you ever broken or dislocated any bones, had an amputation or lost any limbs, or lost voluntary movement of any part of your body parts?

Missing Limbs

_____ None
_____ Finger(s)/Toe(s)
_____ Arm(s)
_____ Leg(s)
_____ Combination

Previous Rehab Program?
_____ No/Not Completed
_____ Yes

Date of Amputation?
_____ 1 Year or Less
_____ More than 1 Year

Paralysis/Paresis

☐ None
☐ Partial
☐ Total

Describe: _____

Previous Rehab Program?
_____ No/Not Completed
_____ Yes

Onset of Paralysis?
_____ 1 Year or Less
_____ More than 1 Year

Nutrition

Height: _____ (inches) **Weight:** _____ (lbs.) **Recent Weight Gain/Loss:** _____ No _____ Yes
Describe:

Are you on any special diet(s)?

None
_____ Low Fat / Cholesterol
_____ No / Low Salt
_____ No / Low Sugar
_____ Combination / Other
_____ Doctor recommended calorie intake

Do you take dietary supplements?

_____ None
_____ Occasionally
_____ Daily, Not Primary Source
_____ Daily, Primary Source
_____ Daily, Sole Source

Do you have any problems that make it hard to eat?

No	Yes	
☐	☐	Food Allergies
☐	☐	Inadequate Food
☐	☐	Nausea / Vomiting / Diarrhea
☐	☐	Problems Following Special Diets
☐	☐	Problems Swallowing
☐	☐	Taste Problems
☐	☐	Tooth or Mouth Problems

Comments:

Beneficiary Name: **Medicaid Number:**

Current Medical Services

Rehabilitation Therapies: Do you receive any therapy prescribed by a doctor?

No	Yes	*Frequency*
☐	☐	Occupational
☐	☐	Physical
☐	☐	Respiratory
☐	☐	Speech
		Other:

Special Medical Procedures: Do you receive any special nursing care?

No	Yes	*Site, Type, Frequency*
☐	☐	Bowel/Bladder Training Physical
☐	☐	Dialysis
		Dressing/Wound Care Respiratory
☐	☐	Eyecare
☐	☐	Glucose/Blood Sugar
		Infections/IV Therapy
☐	☐	Oxygen
		Radiation/Chemotherapy
☐	☐	Restraints (Physical/Chemical)
		ROM Exercise
☐	☐	Trach Care/Suctioning
		Ventilator
☐	☐	Other:

Do you have pressure ulcers?

	Location/Size
_____ None 0	
_____ Stage I	
_____ Stage II	
_____ Stage III	
_____ Stage IV	

Emotional Status

In the past month, how often did you . . . ?	Rarely/ Never	Some of the Time	Often	Most of the Time	Unable to Assess
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you don't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living ... or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite ... that is, eat too much or too little?					

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?

_____ No _____ Yes

Name	Admit Date	Length of Stay/Reason

Beneficiary Name:	Medicaid Number:

Medical/Nursing Needs:

Based on client's overall condition, Registered Nurse(RN) should evaluate the need for Personal Care Aide Services(PCA).

Are there any ongoing social, medical and/or home health needs? _____ No _____ Yes

If yes, describe ongoing social, medical and/or home health needs:

1. Evidence of medical instability.
2. Need for PCA services.
3. Need for home health skilled services (i.e. RN, home health aide, physical therapy, and/or occupational therapy).
4. Need for other supportive services (i.e. referral to ADRC, housing, adult protective services, legal, mental health and/or medical social worker).

Comments:

Vital Signs: BP: _____ Pulse: _____ Resp: _____ Temp: _____

Pain Management: Scale 0-10

Pain Score: _____

Intervention:

Other Comments: _____

_____

_____

_____

_____

Name of RN: _____ Home Health Agency: _____
(first) (middle) (last)

Address: _____ Phone: _____

RN Signature: _____ Date: _____

Patient Signature: _____