MAP 351
(Rev. 7/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
MEDICAID WAIVER ASSESSMENT

SECTION I – MEMBER DEMOGRAPHICS

Name *(last, first, middle)*	Date of birth *(mo., day, yr.)*		Medicaid Member ID #
Street address	County code	Sex *(check one)* ☐Male ☐Female	Marital status *(check one)* ☐Divorced ☐Married ☐Separated ☐Single ☐Widowed
City, state and zip code	Emergency contact *(name)*		Emergency contact *(phone #)*
Member phone number	Is member able to read and write ☐Yes ☐No		Member's height_____ Member's weight

SECTION II – MEMBER WAIVER ELIGIBILITY

Type of program applied for *(check one)*
☐ Home and Community Based Waiver
☐ Acquired Brain Injury Waiver
☐ Acquired Brain Injury/Long Term Care Waiver
☐ Supports for Community Living Waiver
☐ Michelle P. Waiver
☐ Consumer Directed Option ☐ Blended

Adjudicated ☐ /Nonadjudicated ☐_____
Type of application *(check one)*
☐ Certification ☐ Re-certification ☐ Re-application

Member admitted from *(check one)*
☐Home ☐Hospital ☐Nursing facility ☐ ICF/MR/DD
☐Other:_____

Certification period *(enter dates below)*
Begin date_____ End date_____
Certification number:_____

Has member's freedom of choice been explained and verified by a signature on the MAP 350 Form ☐Yes ☐No

Has member been informed of the process to make a complaint ☐Yes ☐No (*see instructions*)

Physician's name	Physician's license number (enter 5 digit #)	Physician's phone number

Enter member's primary diagnosis: HCB (ICD-9 code); SCL (DSM code); ABI (ICD-9 and/or DSM)

Enter all diagnoses including DSM or ICD-9 codes:
AXIS I: (mental illness)_____
AXIS II: (MR/DD)_____
AXIS III: (Medical)_____

Is the member diagnosed with one of the following?
☐ Mental Retardation/ IQ=_____(Date-of-onset_____)
☐ Developmental Disability (Date-of-onset_____)
☐ Mental Illness (Date-of-onset_____)
☐ Brain Injury
Cause of Brain Injury:_____
Date of Brain Injury:_____
Rancho Scale_____

SECTION III – ASSESSMENT PROVIDER INFORMATION

Assessment/Reassessment provider name:	Provider number	Provider phone number
Street address	City, state and zip code	
Provider contact person		

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SECTION IV SELF ASSESSMENT

***For SCL, MP and ABI waivers only *add additional pages as needed**

Community Inclusion (what do you like to do or where would you like to go in the community, where do you go for recreation, do you not get to go somewhere that you would like to)

Relationships (How do you stay in contact with your friends and family, do you need assistance in making or keeping friends, who are your friends)

Rights (do you understand your rights, are any of your rights restricted, do you know what is abuse or neglect)

Dignity and Respect (how are you treated by staff, do you have a place you can go to be with friends or to be alone or have privacy)

Health (who are your doctors ,do you have any health concerns, what medicine do you take, how do they make you feel,)

Lifestyle (do you have a job, do you want to work, do you want to go to school, do you go to the bank, do you have spending money to carry)

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SECTION V – ACTIVITIES OF DAILY LIVING	
1) Is member independent with **dressing/undressing** ☐Yes ☐No*(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires hands-on assistance with upper body ☐ Requires hands-on assistance with lower body ☐ Requires total assistance	Comments:
2) Is member independent with **grooming** ☐Yes ☐No*(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues Requires hands-on assistance with ☐ oral care ☐shaving ☐ nail care ☐hair ☐ Requires total assistance	Comments:
3) Is member independent with **bed mobility** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Occasionally requires hands-on assistance ☐ Always requires hands-on assistance ☐ Bed-bound ☐ Required bedrails	Comments:
4) Is member independent with **bathing** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires hands-on assistance with upper body ☐ Requires hands-on assistance with lower body ☐ Requires Peri-Care ☐ Requires total assistance	Comments:
5) Is member independent with **toileting** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Bladder incontinence ☐ Bowel incontinence ☐ Occasionally requires hands-on assistance ☐ Always requires hands-on assistance ☐ Requires total assistance ☐ Bowel and bladder regimen	Comments:
6) Is member independent with **eating** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires assistance cutting meat or arranging food ☐ Partial/occasional help ☐ Totally fed (by mouth) ☐ Tube feeding (type and tube location)	Comments:

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7) Is member independent with **ambulation** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Dependent on device ☐ Requires aid of one person ☐ Requires aid of two people ☐ History of falls (number of falls, and date of last fall)	Comments:
8) Is member independent with **transferring** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Hands-on assistance of one person ☐ Hands-on assistance of two people ☐ Requires mechanical device ☐ Bedfast	Comments:

SECTION VI - INSTRUMENTAL ACTIVITIES OF DAILY LIVING

1) Is member able to prepare **meals** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for meal preparation ☐ Requires supervision or verbal cues ☐ Requires assistance with meal preparation ☐ Requires total meal preparation	Comments:
2) Is member able to **shop** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for shopping to be done ☐ Requires supervision or verbal cues ☐ Requires assistance with shopping ☐ Unable to participate in shopping	Comments:
3) Is member able to perform light **housekeeping** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for light housekeeping duties to be performed ☐ Requires supervision or verbal cues ☐ Requires assistance with light housekeeping ☐ Unable to perform any light housekeeping	Comments:
4) Is member able to perform heavy **housework** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for heavy housework to be performed ☐ Requires supervision or verbal cues ☐ Requires assistance with heavy housework ☐ Unable to perform any heavy housework	Comments:

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5) Is member able to perform **laundry** tasks ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for laundry to be done ☐ Requires supervision or verbal cues ☐ Requires assistance with laundry tasks ☐ Unable to perform any laundry tasks	Comments:
6) Is member able to plan/arrange for pick-up, delivery, or some means of gaining possession of **medication(s)** and take them independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for medication to be obtained and taken correctly ☐ Requires supervision or verbal cues ☐ Requires assistance with obtaining and taking medication correctly ☐ Unable to obtain medication and take correctly	Comments:
7) Is member able to handle **finances** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for someone else to handle finances ☐ Requires supervision or verbal cues ☐ Requires assistance with handling finances ☐ Unable to handle finances	Comments:
8) Is member able to use the **telephone** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Requires adaptive device to use telephone ☐ Requires supervision or verbal cues ☐ Requires assistance when using telephone ☐ Unable to use telephone	Comments:
SECTION VII-NEURO/EMOTIONAL/BEHAVIORAL	
1) Does member exhibit **behavior** problems ☐Yes ☐No *(If yes, check below all that apply and explain the frequency in comments)* ☐ Disruptive behavior ☐ Agitated behavior ☐ Assaultive behavior ☐ Self-injurious behavior ☐ Self-neglecting behavior	Comments:_____ Date of functional analysis:_____and/or Date of behavior support plan:_____

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Name ***(last, first)***	**Medicaid Number**
2) Is member **oriented** to person, place, time ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Forgetful ☐ Confused ☐ Unresponsive ☐ Impaired Judgment	Comments:
3) Has member experienced a major change or crisis within the past twelve months ☐Yes ☐No (*If yes, describe*)	Description:
4) Is the member actively participating in social and/or community activities ☐Yes ☐No (*If yes, describe*)	Description:
5) Is the member experiencing any of the following *(For each checked, explain the frequency and details in the comments section)* ☐Difficulty recognizing others ☐Loneliness ☐Sleeping problems ☐Anxiousness ☐Irritability ☐Lack of interest ☐Short-term memory loss ☐Long-term memory loss ☐Hopelessness ☐Suicidal behavior ☐Medication abuse ☐Substance abuse ☐ Alcohol Abuse	Comments:

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6) Cognitive functioning (Participant's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands) ☐ Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. ☐ Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions. ☐ Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility. ☐ Required considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time. ☐ Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.	Comments:
7) When Confused (Reported or Observed): ☐ Never ☐ In new or complex situations only ☐ On awakening or at night only ☐ During the day and evening, but not constantly ☐ Constantly ☐ NA (non-responsive)	Comments:
8) When Anxious (Reported or Observed): ☐ None of the time ☐ Less often than daily ☐ Daily, but not constantly ☐ All of the time ☐ NA (non-responsive)	Comments:
9) Depressive Feelings (Reported or Observed): ☐ Depressed mood (e.g., feeling sad, tearful) ☐ Sense of failure or self-reproach ☐ Hopelessness ☐ Recurrent thoughts of death ☐ Thoughts of suicide ☐ None of the above feelings reported or observed	Comments:

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10) Member Behaviors (Reported or Observed): ☐ Indecisiveness, lack of concentration ☐ Diminished interest in most activities ☐ Sleep disturbances ☐ Recent changes in appetite or weight ☐ Agitation ☐ Suicide attempt ☐ None of the above behaviors observed or reported	Comments:
11) Behaviors Demonstrated at Least Once a Week: ☐ Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24-hours, significant memory loss so that supervision is required. ☐ Impaired decision-making: failure to perform usual ADL's, inability to inappropriately stop activities, jeopardizes safety through actions. ☐ Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc. ☐ Physical aggression: aggressive or combative to self and others (e.g. hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects). ☐ Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions). ☐ Delusional, hallucinatory, or paranoid behavior. ☐ None of the above behaviors demonstrated.	Comments:
12) Frequency of Behavior Problems (Reported or Observed) such as wandering episodes, self abuse, verbal disruption, physical aggression, etc.: ☐ Never ☐ Less than once a month ☐ Once a month ☐ Several times each month ☐ Several times a week ☐ At least daily	Comments:

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13) Mental Status: ☐ Oriented ☐ Forgetful ☐ Depressed ☐ Disoriented ☐ Lethargic ☐ Agitated ☐ Other	Comments:
14) Is this member receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse? ☐ Yes ☐ No	Comments:
SECTION VIII-CLINICAL INFORMATION	
1) Is member's **vision** adequate *(with or without glasses)* ☐Yes ☐No ☐Undetermined *(If no, check below all that apply and comment)* ☐ Difficulty seeing print ☐ Difficulty seeing objects ☐ No useful vision	Comments:
2) Is member's **hearing** adequate *(with or without hearing aid)* ☐Yes ☐No ☐Undetermined *(If no, check below all that apply, and comment)* ☐ Difficulty with conversation level ☐ Only hears loud sounds ☐ No useful hearing	Comments:
3) Is member able to **communicate** needs ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Speaks with difficulty but can be understood ☐ Uses sign language and/or gestures/communication device ☐ Inappropriate context ☐ Unable to communicate	Comments:
4) Does member maintain an adequate **diet** ☐Yes ☐No *(If no, check all that apply and comment)* ☐ Uses dietary supplements ☐ Requires special diet (low salt, low fat, etc.) ☐ Refuses to eat ☐ Forgets to eat ☐ Tube feeding required *(Explain the brand, amount, and frequency in the comments section)* ☐ Other dietary considerations *(PICA, Prader-Willie, etc.)*	Comments:

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5) Does member require **respiratory** care and/or equipment ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Oxygen therapy (Liters per minute and delivery device) ☐ Nebulizer (Breathing treatments) ☐ Management of respiratory infection ☐ Nasopharyngeal airway ☐ Tracheostomy care ☐ Aspiration precautions ☐ Suctioning ☐ Pulse oximetry ☐ Ventilator (list settings)	Comments:
6) Does member have history of a **stroke(s)** ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Residual physical injury(ies) ☐ Swallowing impairments ☐ Functional limitations (Number of limbs affected)	Comments:
7) Does member's **skin** require additional, specialized care ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Requires additional ointments/lotions ☐ Requires simple dressing changes (i.e. band-aids, occlusive dressings) ☐ Requires complex dressing changes (i.e. sterile dressing) ☐ Wounds requiring "packing" and/or measurements ☐ Contagious skin infections ☐ Ostomy care	Comments:
8) Does member require routine lab work ☐Yes ☐No *(If yes, what type and how often)*	Comments:
9) Does member require specialized genital and/or urinary care ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Management of reoccurring urinary tract infection ☐ In-dwelling catheter ☐ Bladder irrigation ☐ In and out catheterization	Comments:
10) Does member require specific, physician-ordered vital signs evaluation necessary in the management of a condition(s) ☐Yes ☐No *(If yes, explain in the comments section)*	Comments:
11) Does member have total or partial paralysis ☐Yes ☐No *(If yes, list limbs affected and comment)*	Comments:

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Name ***(last, first)***	**Medicaid Number**
12) Does member require assistance with changes in body position ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ To maintain proper body alignment ☐ To manage pain ☐ To prevent further deterioration of muscle/joints/skin	Comments:

13) Does member require 24 hour caregiver ☐Yes ☐No

14) Does member require respite services ☐Yes ☐No *(If yes, how often)*

15) Does the member require intravenous fluids, intravenous medications or intravenous alimentation ☐Yes ☐No *(If yes, check below all that apply and list solution, location, amount, rate, frequency and prescribing physician)*

☐ **Peripheral IV** Solution:	Location	Amount/dosage	Rate
Frequency:		Prescribing physician	
☐ **Central line** Solution:	Location	Amount/dosage	Rate
Frequency		Prescribing physician	
16) Drug allergies *(list)*		**17)** Other allergies *(list)*	

17) Does the member use any medications ☐Yes ☐No *(If yes, list below) *add additional pages if needed*

Name of medication	**Dosage/Frequency/Route**	**Administered by**

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18) Is any of the following adaptive equipment required *(If needs, explain in the comments)*

Dentures	☐Has	☐Needs	☐N/A
Hearing aid	☐Has	☐Needs	☐N/A
Glasses/lenses	☐Has	☐Needs	☐N/A
Hospital bed	☐Has	☐Needs	☐N/A
Bedpan	☐Has	☐Needs	☐N/A
Elevated toilet seat	☐Has	☐Needs	☐N/A
Bedside commode	☐Has	☐Needs	☐N/A
Prosthesis	☐Has	☐Needs	☐N/A
Ambulation aid	☐Has	☐Needs	☐N/A
Tub seat	☐Has	☐Needs	☐N/A
Lift chair	☐Has	☐Needs	☐N/A
Wheelchair	☐Has	☐Needs	☐N/A
Brace	☐Has	☐Needs	☐N/A
Hoyer lift	☐Has	☐Needs	☐N/A

Comments:

19) Please describe in detail any information regarding health, safety and welfare/crisis issues:

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SECTION IX-ENVIRONMENT INFORMATION

1) Answer the following items relating to the member's physical environment *(Comment if necessary)*

Sound dwelling	☐Yes	☐No
Adequate furnishings	☐Yes	☐No
Indoor plumbing	☐Yes	☐No
Running water	☐Yes	☐No
Hot water	☐Yes	☐No
Adequate heating/cooling	☐Yes	☐No
Tub/shower	☐Yes	☐No
Stove	☐Yes	☐No
Refrigerator	☐Yes	☐No
Microwave	☐Yes	☐No
Telephone	☐Yes	☐No
TV/radio	☐Yes	☐No
Washer/dryer	☐Yes	☐No
Adequate lighting	☐Yes	☐No
Adequate locks	☐Yes	☐No
Adequate fire escape	☐Yes	☐No
Smoke alarms	☐Yes	☐No
Insect/rodent free	☐Yes	☐No
Accessible	☐Yes	☐No
Safe environment	☐Yes	☐No
Trash management	☐Yes	☐No

Comments:

2) Provide an inventory of home adaptations **<u>already present</u>** in the member's dwelling. *(Such as wheelchair ramp, tub rails, etc.)*

SECTION X – HOUSEHOLD INFORMATION

1) Does the member live alone ☐Yes ☐No
If yes, does the member receive any assistance from others ☐Yes ☐No *(Explain)*

Comments:

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2)Household Members *(Fill in household member info below)*			
a) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
b) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
c) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
d) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		

SECTION XI-ADDITIONAL SERVICES

1) Has the member had any hospital, nursing facility or ICF/MR/DD admissions in the past 12 months?
☐Yes ☐No *(If yes, please list below)*

a-Facility name	Facility address	
Reason for admission	Admission date	Discharge date
b-Facility name	Facility address	
Reason for admission	Admission date	Discharge date

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2) Does the member receive services from other agencies *(Example: Both Waiver and Non-waiver Services.)* ☐Yes ☐No
(If yes, list services already provided and to be provided in accordance with a plan of care by an agency/organization, include Adult Day Health Care and traditional Home health services covered by Medicare/Third party insurance)

a-Service(s) received	Agency/worker name	Phone number
Agency address	Frequency	Number of units
b-Service(s) received	Agency/worker name	Phone number
Agency address	Frequency	Number of units
c-Service(s) received	Agency/worker name	Phone number
Agency address	Frequency	Number of units

SECTION XII-CONSUMER DIRECTED OPTION

Has the member been provided information on Consumer Directed Option (CDO) and their right to choose CDO, traditional or blended services? ☐ Yes ☐ No **If no, give reason:**

Has the member chosen Consumer Direction Option? ☐Yes ☐No If yes, include form MAP 2000

SECTION XIII-SIGNATURES

Person(s) performing assessment or reassessment:

Signature:	Title:	Date / /
Signature:	Title:	Date / /

Verbal Level of Care Confirmation:

Date: / /	Time: am/pm

Assessment/Reassessment forwarded to Support Broker/Case Management provider:

Date Forwarded: / /	Time Forwarded: am/pm
Name of Person Forwarding:	Title of Person Forwarding:

Receipt of assessment/reassessment by Support Broker/case management provider:

Date Received: / /	Time Received: am/pm
Name of Person Logging Receipt:	Title of Person Logging Receipt:

QIO Signature:	Level of Care Date / /	Approval dates From: / / To: / /