LDSS-3139 (3/79)

DEPARTMENT OF HEALTH

OFFICE OF HEALTH SYSTEMS MANAGEMENT

HOME ASSESSMENT ABSTRACT

GENERAL INSTRUCTIONS:

THIS FORM MUST BE COMPLETED FOR ALL LONG TERM HOME HEALTH CARE PROGRAM PATIENTS AND ALL MEDICAID PATIENTS RECEIVING HOME HEALTH AIDE OR PERSONAL CARE SERVICES. PORTIONS AS INDICATED MUST BE COMPLETED BY RESPECTIVE PERSONNEL FOR THE ABOVE MENTIONED PURPOSES. FOR MORE INFORMATION, SEE DETAILED INSTRUCTIONS.

ABBREVIATIONS:

CHHA – CERTFIED HOME HEALTH AGENCY
LTHHCP – LONG TERM HOME HEALTH CARE PROGRAM
RN – REGISTERED NURSE
SSW – SOCIAL SERVICE WORKER
INSTRUCTION PAGE 1:
TO BE COMPLETED BY RN – PARTS 1, 2, 3
TO BE COMPLETED BY SSW – PARTS 1, 2, 3, 4, 5, 6

1. REASON FOR PREPARATION

☐ ADMISSION TO LTHHCP
☐ INITIAL EVALUATION FOR HOME HEALTH AIDE
☐ INITIAL EVALUATION FOR PERSONAL CARE
☐ REASSESSMENT FROM _____ TO _____
☐ LTHHCP ☐ CHHA ☐ PERSONAL CARE
☐ OTHER, SPECIFY _____

2. PATIENT NAME

RESIDENT ADDRESS APT. NO.

CITY STATE ZIP TEL. NO.

ADDRESS WHERE PRESENTLY RESIDING TEL. NO.

DIRECTIONS TO CURRENT ADDRESS

SOCIAL SERVICES DISTRICT FIELD OFFICE

4. NEXT OF KIN/GUARDIAN

STREET

CITY STATE ZIP

RELATION TEL NO.

3. CURRENT LOCATION/DIAGNOSIS OF PATIENT

☐ HOSP. ☐ HRF ☐ HOME
☐ SNF ☐ DCF ☐ OTHER (SPECIFY)

NAME OF FACILITY/ORGANIZATION

STREET

CITY STATE ZIP TEL NO.

DATE ADMITTED PROJECTED DISCHARGE DATE

DIAGNOSIS

5. NOTIFY IN EMERGENCY

NAME

CITY STATE ZIP

RELATION TEL NO.

PATIENT INFORMATION

6. DATE OF BIRTH _____ AGE _____

LANGUAGE(S) SPOKEN/UNDERSTANDS _____

SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ MARRIED ☐ SEPARATED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ UNKNOWN

LIVING ARRANGEMENTS:

☐ ONE FAMILY HOUSE ☐ HOTEL
☐ MULTI-FAMILY HOUSE ☐ APT.
☐ FURNISHED ROOM ☐ BOARDING HOUSE
☐ SENIOR CIT. HOUSING ☐ IF WALK-UP (# FLIGHTS ___)
☐ OTHER, SPECIFY _____

LIVES WITH: ☐ SPOUSE ☐ ALONE ☐ OTHER _____

SOCIAL SECURITY NO. _____

MEDICARE NO. PART A _____
PART B _____

MEDICAID NO. _____ ☐ PENDING

BLUE CROSS NO. _____

WORKMENS COMP. _____

VETERANS CLAIM NO. _____

VETERANS SPOUSE ☐ YES ☐ NO

OTHER (SPECIFY) _____

SOURCE OF INCOME/OTHER BENEFITS

☐ SOCIAL SECURITY
☐ PUBLIC ASSIST.
☐ VETERANS BENEFITS
☐ PENSION
☐ FOOD STAMPS
☐ S.S.I.
☐ OTHER (SPECIFY) _____

AMOUNT OF AVAILABLE FUNDS AFTER PAYMENT OF RENT, TAXES UTILITIES, ETC. _____

7. To be completed by S S W
OTHERS IN HOME/HOUSEHOLD: Indicate days/hours that these persons will provide care to patient.
If none will assist explain in narrative.

	NAME	Age	Relationship	Days/Hours at Home	Days/Hours will Assist
1.					
2.					
3.					
4.					

8. To be completed by S S W
SIGNIFICANT OTHERS OUTSIDE OF HOME: Indicate days/hours when persons below will provide care to patient.

	Name	Address	Age	Relationship	Days/Hours Assisting
1.					
2.					
3.					
4.					
5.					

9. To be completed by S S W
COMMUNITY SUPPORT: Indicate organization/persons serving patient at present or has provided a service in the past six (6) months.

	Organization	Type of Service	Presently Receiving	Contact Person	Tel No.
1.					
2.					
3.					
4.					

10. To be completed by S S W and R.N.
PATIENT TRAITS:

	Yes	No	?N/A	If you check No. ?N/A, describe
Appears self directed and/or independent				
Seems to make appropriate decisions				
Can recall med routine/recent events				
Participates in planning/treatment program				
Seems to handle crises well				
Accepts diagnosis				
Motivated to remain at home				

11. To be completed by S S W and R.N. as appropriate
FAMILY TRAITS:

	Yes	No	?	
a. Is motivated to keep patient home				If no, because
b. Is capable of providing care (physically & emotionally)				If no, because
c. Will keep patient home if not involved with care				Because
d. Will give care if support service given				How much
e. Requires instruction to provide care				In what – who will give

12. To be completed by R.N.

Home/Place where care will be provided:	Yes	No	?	If problem, describe
Neighborhood secure/safe				
Housing adequate in terms of: Space				
Convenient toilet facilities				
Heating adequate and safe				
Cooking facilities & refrigerator				
Laundry facilities				
Tub/shower/hot water				
Elevator				
Telephone accessible & usable				
Is patient mobile in house				
Any discernible hazards (please circle)				Leaky gas, poor wiring, unsafe floors, steps, other (specify)
Construction adequate				
Excess use of alcohol/drugs by patient/ caretaker; smokes carelessly.				
Is patient's safety threatened if alone?				
Pets				

ADDITIONAL ASSESSMENT FACTORS: _____

13. To be completed by R.N.

RECOVERY POTENTIAL ANTICIPATED		COMMENTS
Full recovery	☐	
Recovery with patient management residual	☐	
Limited recovery managed by others	☐	
Deterioration	☐	

14. To be completed by R.N. – S S W to complete "D" as appropriate
FOR THE PATIENT TO REMAIN AT HOME – SERVICES REQUIRED

SERVICES REQUIRED	YES	NO	TYPE/FREQ/DUR	WHO WILL PROVIDE AGENCY/FAMILY	AGENCY FREQUENCY
A. Bathing					
Dressing					
Toileting					
Admin. Med.					
Grooming					
Spoon feeding					
Exercise/activity/walking					
Shopping (food/supplies)					
Meal preparation					
Diet Counseling					
Light housekeeping					
Personal laundry/household linens					
Personal/financial errands					
Other					
B. Nursing					
Physical Therapy					
Home Health Aide					
Speech Pathology					
Occupational Therapy					
Personal Care					
Homemaking					
Housekeeping					
Clinic/Physician					
Other 1.					
2.					
C. Ramps outside/inside					
Grab bars/hallways/bathroom					
Commode/special bed/wheelchair					
Cane/walker/crutches					
Self-help device, specify					
Dressings/cath. equipment, etc.					
Bed protector/diapers					
Other					
D. Additional Services (Lab, O^2, medication)					
Telephone reassurance					
Diversion/friendly visitor					
Medical social service/counseling					
Legal/protective services					
Financial management/conservatorship					
Transportation arrangements					
Transportation attendant					
Home delivered meals					
Structural modification					
Other					

15. To be completed by S S W and R.N

DMS Predictor Score _____ Override necessary ☐ Yes ☐ No

Can patient's health/safety needs be met through home care now? ☐ Yes ☐ No

If no, give specific reason why not _____

Institutional care required now? ☐ Yes ☐ No If yes, give specific reason why.

Level of institutional care determined by your professional judgment: ☐ SNF ☐ HRF ☐ DCF

Can the patient be considered at a later time for home care? ☐ Yes ☐ No ☐ N/A

16. To be completed by S S W
SUMMARY OF SERVICE REQUIREMENTS
Indicate services required, schedule and charges (allowable charge in area)

Services	Provided by	Hrs./Days/Wk.	Date Effective	Est. Dur.	Unit Cost	Payment by			
						MC	MA	Self	Other
Physician									
Nursing									
Home Health Aide									
Physical Therapy									
Speech Pathology									
Resp. Therapy									
Med. Soc. Work									
Nutritional									
Personal Care									
Homemaking									
Housekeeping									
Other (Specify)									
Medical Supplies/Medication 1.									
2.									
3.									
Medical Equipment 1.									
2.									
3.									
Home Delivered Meals									
Transportation									
Additional Services 1.									
2.									
			SUBTOTAL						
Structural Modification									
Other (Specify) 1.									
2.									

SUBTOTAL _____

TOTAL COST _____

17. To be completed by S S W and R.N.

Person who will relieve in case of emergency

Name	Address	Telephone	Relationship

Narrative: Use this space to describe aspects of the patients care not adequately covered above.

Assessment completed by:

R.N.	Agency
Date Completed	Telephone No.
Local DSS Staff	District
Date Completed	Telephone No.
Supervisor DSS	District
Date	Telephone No.

Authorization to provide services:

Local DSS Commissioner or Designee — Date