COMMONWEALTH COORDINATED CARE (CCC) PLUS WAIVER

PRIVATE DUTY NURSING (RN) INITIAL HOME ASSESSMENT

Individual's Name_____ **Assessment Date** _____

Nursing Agency's Name_____ Date of Supervisor's Initial Visit _____

Primary Caregiver's Name_____ Medicaid # _____

Primary Diagnoses _____ Provider NPI# _____

Document Brief Medical History:

_____

_____

_____

TECHNOLOGY / NURSING NEEDS (Circle Answer)

Oxygen: continuous intermittent PRN

IV / TPN: continuous 8-16 hrs./day 4-7 hrs. <4 hrs.

Ventilator CPAP BIPAP: continuous intermittent PRN

Enteral feedings: continuous Q 2 hrs. Q3hrs. Q 4 hrs.+

Trach Change: weekly >weekly

Specific Trach (Site Care) Orders: _____

Oral Supplements/ Tube Feeding Orders: _____
(Type, frequency, and amount)

Trach Suctioning & Frequency: Q HR. Q 1-4 hrs. Q 4 hrs. +

Other Wound Care Dressings: _____ Q 8 hrs. or less >Q 8 hrs.
(Specify type, frequency and location)

List Scheduled Medications:

_____

_____

_____

Peritoneal dialysis (frequency and length): _____

Catheterization: Q 4 hrs. Q 8 hrs. Q12 hrs. QD PRN Nebulizer Treatments: _____ QID TID BID QD PRN

Specialized monitor I/O (reason):_____Frequency: _____

Other Skilled Home Health Intermittent Visiting Nurse provided? Yes ❒ No ❒ If Yes, specify name of agency and reason for skilled visits: _____

HEALTH, SAFETY, AND WELFARE ISSUES IDENTIFIED? Yes ❒ No ❒ If Yes, explain and notify the LDSS & DMAS.

Individual's ability to signal or alert in case of an emergency? Yes ❒ No ❒

_____

_____

THERAPIES (PT/OT/SLP, name of provider, frequency, location): _____

FAMILY'S NURSING SHIFT PREFERENCES: _____

NAMES OF NURSES STAFFING / SHIFTS COVERED:

_____

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HOME ASSESSMENT

Describe Family's/Primary Caregiver Willingness and Ability to Care for the Individual (Indicate training received, note type and amount of care family/primary caregiver is committed to provide and variations in their schedule; notify DMAS Health Care Coordinator)

_____

_____

Describe General Condition of the Home Environment and Any Concerns (e.g. cleanliness, pests, family pets in home, etc.)

_____

Is the home setting appropriate to meet the individual's needs? Yes ❒ No ❒ **(If not, notify DMAS immediately)**

Home Physical Standards	Adequate	Inadequate (note needed changes)
Large battery light at bedside		
Working smoke alarm / fire extinguisher		
Plumbing supports water and sewage		
Adequate heating system		
Adequate cooling system		
Telephone service		
Durable Medical Equipment (backup DME)		

PDN CCC PLUS WAIVER SERVICES

Check the PDN CCC Plus Waiver Services Requested by the Family / Caregiver or Waiver Individual as follows:

Private Duty Nursing	❒	Respite Care	❒	Environmental Modifications	❒
Assistive Technology	❒	Transition Services	❒	Personal Care Services	❒

Most recent CMS-485 and DMAS-103 forms completed and sent to DMAS Health Care Coordinator (Date): _____

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FAMILY / CAREGIVER INFORMATION

Primary Caregiver: _____Relationship to Individual_____
(If custody is not held by the primary caregiver, identify name, address and telephone # of custodian of care)

_____

Current Employment of Primary Caregivers

Name: _____
Employer:_____
Phone # of employer:_____
Work hours_____

Name:_____
Employer:_____
Phone # of employer:_____
Work hours_____

Total Number of Individuals in Home_____

Name of Primary Decision Maker _____

NAMES OF HOUSEHOLD MEMBERS	AGE	RELATIONSHIP TO WAIVER INDIVIDUAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Identify All Other Trained Back-up Caregivers (Give name, phone and relationship):

_____

_____

Are There Additional Caregiver Responsibilities? (Care of elderly parent or employment outside of home, etc.):

_____

In case of an emergency, how is this handled by the family? _____

Additional Comments:
_____

RN Supervisor's Signature _____ Date Completed _____