Community-Based Care Member Assessment

☐ Agency-Directed Services ☐ Consumer-Directed Services *Assessment Date:* ___________

☐ Initial Visit ☐ Routine Visit ☐ Six-Month Re-assessment

Member's Name: ______________________ Date of Birth: ______________
Medicaid ID #: ______________________ Start of Care: ______________
Member's Address: Current ______________________ Agency Name: ______________
Member's Phone: ( ) ______________________ Provider ID #: ______________

FUNCTIONAL STATUS

ADLs	Needs No Help	MH Only	Human Help		MH & Human Help		Always Performed By Others	Is Not Performed At All
			Supervise	Phys. Asst.	Supervise	Phys. Asst.		
Bathing								
Dressing								
Toileting								
Transferring								
Eating/Feeding								

CONTINENCE	Continent	Incontinent < Weekly	Incontinent Self Care	Incontinent Weekly or >	External Device Not Self Care	Indwelling Cath Not Self Care	Ostomy Not Self Care
Bowel							
Bladder							

MOBILITY

Needs No Help	MH Only	Human Help		MH & Human Help		Confined Moves About	Confined Does Not Move About
		Supervise	Phys. Asst.	Supervise	Phys. Asst.		

ORIENTATION

Oriented	Disoriented-Some Spheres/Sometimes	Disoriented-Some Spheres/All Times	Disoriented-All Spheres/Sometimes	Disoriented-All Spheres/All Times	Semi-Comatose/ Comatose

Spheres Affected: Source of Info:

BEHAVIOR

Appropriate	Wandering/Passive < Than Weekly	Wandering/Passive Weekly or >	Abusive/Aggressive/ Disruptive< Weekly	Abusive/Aggressive/ Disruptive > Weekly	Semi-Comatose/ Comatose

Describe Inappropriate Behavior:

Source of Info:

JOINT MOTION
___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

MED. ADMINISTRATION
___ Without assistance 0
___ Administered/monitored by lay person 1
___ Administered/monitored by professional nursing staff 2

MEDICAL/NURSING INFORMATION

Diagnoses: ______________________
Medications: ______________________
Current Health Status/Condition: ______________________
____
Current Medical Nursing Needs: ______________________
____
Therapies/Special Medical Procedures: ______________________
____
Hospitalizations: Date(s):______________Reason(s):______________________
____
Critical Incidents: ☐ Yes ☐ No
Description/Action: If yes, what was the nature of the critical incident and what steps were taken as a result?
____
____

SUPPORT SYSTEM

Waiver services the member is receiving, and the provider agency, at the time of the visit (check all that apply):
☐ Agency Personal Care: ________________________________ ☐ CD Personal Care ________________________________
☐ Agency Respite ____________________________________ ☐ CD Respite ____________________________________
☐ ADHC ____________________________________(*if applicable*) Hours:____________________________________
☐ PDN ____________________________________ (*if applicable*) Hours: ____________________________________
Hours the aide/attendant provides care to the member: Total Weekly Hours: _________________ Days per Week: _____________
Specific Hours the aide/attendant is in the member's home: ____
Does the aide/attendant live with the member: ☐ Yes ☐ No; Relationship to member: _____________________________
Other Medicaid/non-Medicaid funded services received: (example: services through the Veterans Administration) _______________
____
Who is the primary care giver(s): ____
Is the primary caregiver (PCG) paid or unpaid? ☐ Paid ☐ Unpaid
Type of care the PCG provides to the member: ____
____
How often does the PCG see the member? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____________________
Who other than the member is authorized to sign the aide/attendant records? ____

Is the member in need of supervision or PERS at all times to be maintained safely? : ☐ Yes ☐ No
Is the member receiving supervision? ☐ Yes ☐ No If yes, has he/she been informed of PERS (if applicable)? ☐ Yes ☐ No
Is the member receiving PERS? ☐ Yes ☐ No If applicable, is he/she receiving a Medication Monitor? ☐ Yes ☐ No

If the member has PERS and/or Medication Monitoring, answer the following questions:

Is the member 14 years of age or older? ☐ Yes ☐ No
Is PERS adequate to meet the member's needs? ☐ Yes ☐ No
Is there a time when the telephone service is disconnected? ☐ Yes ☐ No
Is the member pleased with the service from the PERS provider? ☐ Yes ☐ No

CONSUMER-DIRECTED SERVICES:

Person directing/managing the care: ______________________________ Relationship to member: _______________________
Person providing the care: ________________________________ Relationship to member: __________________________

SERVICE FACILITATOR (SF) / RN/ LPN SUPERVISION

Dates of RN/LPN supervisory / SF visits for the last 6 months: ____
Did the member/caregiver agree to frequency of visits, and is it documented in the member's file?
☐ Yes ☐ No Frequency of supervisory visits (pick one choice) ☐ 30 days ☐ 60 days ☐ 90 days
Supervisory Visit for Personal Care: ☐ Yes ☐ No Supervisory Visit for Respite Care: ☐ Yes ☐ No **(check all that apply)**
Does the aide document accurately the care provided? (Agency-Directed only) ☐ Yes ☐ No
Does the Service Plan reflect the needs of the member? ☐ Yes ☐ No
If No to either, please describe follow-up: ____
____

CONSISTENCY AND CONTINUITY

Number of days of no service in the last 6 months: (Do not include hospitalizations) ___________________________________
Number of aides/attendants assigned to the case in the last 6 months: Regular Aides/Attendants: _______________
Sub-Aides/Attendants: _____________________
Has the member or caregiver had any problems with the care provided in the last six months? ☐ Yes ☐ No If yes, please describe problem(s) and the follow-up taken: ____
____
Is the member satisfied with the service he/she is receiving by the provider agency? ☐ Yes ☐ No If no, please describe and the follow-up taken: ____
____

Date of most recent DMAS-225: Patient Pay Amount (if applicable):

Aide/Attendant Present During Visit? ☐ Yes ☐ No Name of Aide/Attendant: ______________________________

SF / NURSING NOTES: *(if additional space is needed, use the back or add attachment)*
____
____
____
____

Member/Caregiver Signature ____ **DATE:** ____________________

RN /LPN/ SF SIGNATURE: ____ **DATE:** ____________________

This form contains patient-identifiable information and is intended for review and use of no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal Laws. If you have obtained this form by mistake, please send it to: DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219. **Do not alter or revise this form in any manner.**

INSTRUCTIONS FOR COMPLETION OF THE DMAS-99

Agency-directed services must have use this form for all RN/LPN supervisory visits conducted for Personal and Respite Care services. The instruction for filling out the DMAS-99 may vary with the type of visit that is conducted. Check the appropriate box at the top of page one. Whether the service is agency-directed or consumer-directed, the Initial and the Six-Month Re-assessment visit require the entire DMAS-99 to be filled out completely. The Routine Supervisory Visit may allow an update of the previous routine supervisory visit's information.

Detailed instructions for filling out the DMAS-99 for agency-directed and consumer-directed services are provided below. If you have further questions, please contact the Office of Community Living at: cccpluswaiver@dmas.virginia.gov.

AGENCY-DIRECTED SERVICES
THE INITIAL VISIT

This form must include: the member's name, address, date of birth, phone number, the Medicaid ID number, the start of care date, and the provider agency's name and provider/NPI number.

FUNCTIONAL STATUS: Must be completed in detail on the initial visit and during the six-month reassessment visit. The member's dependence or independence in an ADL should be noted by placing a check mark in the appropriate box under each category. Apply the definitions provided in the Virginia Uniform Assessment Instrument (UAI) User's Manual when assessing the member and completing this section. If there is any doubt in the member's ability to perform a task, the RN/LPN should ask the member to demonstrate the completion of that task. Shaded areas indicate the member is independent in that function. "Independent" means that the member does not need an aide to assist with any part of the task. Under JOINT MOTION, it should be noted which joints are limited (if applicable). Under MED. ADMINISTRATION, note who administers the member's medications.

MEDICAL/NURSING INFORMATION: All of these blanks must be completed on the Initial and Six-month assessments. DIAGNOSES- All diagnoses contributing to the health needs of the member should be noted on this visit. Remember that the member may have developed another medical complication requiring the documentation of another diagnosis. MEDICATIONS: List the member's medications. CURRENT HEALTH STATUS/CONDITION- Note information such as weight loss or gain (if pertinent), medication changes, MD visits, including for what reason, and whether the member's condition has improved, declined, or remained stable. The RN/LPN must assess this issue by asking pointed questions, (e.g., Have you seen the doctor since I was here last time? Did the doctor change your medication? Have you been having any dizzy spells? Have you been able to eat all of your meals without vomiting afterward? Are you still having headaches? Are you checking your sugar four times a day?). CURRENT MEDICAL NURSING NEEDS- Include any information that should be monitored by the RN/LPN or the doctor, such as, blood sugar levels, wounds, weight loss, malnutrition, dehydration, respiratory distress, immobility issues, circulatory problems, blood-work for medication adjustments. This is not asking for a summary of the member's ADL functioning. THERAPIES / SPECIAL MEDICAL PROCEDURES- This must be addressed on the initial assessment and six-month reassessment. Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the member is receiving Home Health skilled services, note frequency of visits, the agency providing services, and the reason(s) & disciplines for visits. HOSPITALIZATIONS- Include the dates of admission and discharge, and the reason(s) for the admission. CRITICAL INCIDENTS: Critical Incidents are any actual, alleged or suspected event or situation that creates a significant risk or serious harm to the physical/mental health, safety, and/or well-being of a Medicaid waiver member. Examples may include: abuse, neglect, exploitation, theft, medical error, deviation from standards of care, serious injury, medical error, etc. Identify any critical incidents that occurred in the last 3 months. Describe the nature of the incident including the date, circumstances, and actions as a result of the incident.

SUPPORT SYSTEM: Must be completed in detail on these visits. Any changes in the hours on the Plan of Care, support system and/or the need for supervision should be noted. WAIVER SERVICES - List all that the member is receiving. Check the box and write the name of the provider agency supervising/rendering the service. TOTAL WEEKLY HOURS AND DAYS PER WEEK- This should reflect the hours and days on the current plan of care. OTHER MEDICAID/NON FUNDED SERVICES- List those services that the member is receiving, which may include, but not be limited to, Meals on Wheels, companion services, Adult Day Health Care, etc. WHO WILL BE RESPONSIBLE FOR SIGNING THE AIDE RECORDS- If the member is cognitively impaired, note who this includes, i.e., family, friends, authorized representative, and/or significant other. If someone other than the member will be signing the aide record, that person should be instructed to sign his/her own name, not the member's name. If the person signing the aide record(s) is not the primary caregiver, the nurse should note on the DMAS-99 that this person has authorization to sign for the member. IS THE MEMBER IN NEED OF SUPERVISION- If the supervision is provided solely by the member's caregivers, the Request for Supervision Form is *not* required. If, however, supervision hours are provided on the member's plan of care, the Request for Supervision Form (DMAS 100) must be on file in the member's record. If the member requires supervision at all times and the caregivers are not available at all times, has the member been informed about the Personal Emergency Response System (PERS), as a covered service in the waiver?

The member must be assessed to determine there are no cognitive deficits in order for PERS to be used appropriately. If the member has PERS, the related questions in this section must be answered.

RN/LPN SUPERVISION: Dates of RN/LPN supervisory visits for the last six months must be completed on the six - month reassessment. The accuracy of the agency aide documentation must be noted with every routine supervisory visit and should directly correlate with whether the aide is following the member's plan of care. If not, the nurse should document the reason for not following the plan of care. The frequency of the supervisory visit that was agreed upon between the RN/LPN and the member must be documented. This frequency can be from 30 to 90 days, for members without a cognitive impairment as defined by DMAS policy. If the RN/LPN's plan of care is not being followed by the aide due to inaccuracies on the plan of care, or the plan of care is not meeting the member's needs, answer one or both questions as "NO". Any **"NO" answers** must be explained including how the plan of care will be changed to meet the member's needs.

CONSISTENCY AND CONTINUITY: The number of no service days within the last six months must be indicated on the six-month reassessment. Do not include days the member /caregiver requested to be without service or days the member was hospitalized. Note how many aides have been assigned over the past six months as well as how many substitute aides were utilized. If the member or caregiver(s) has been dissatisfied with the aide, RN/LPN, agency, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed).

Record the date and patient pay amount (if applicable) from the most recent DMAS 225 (Medicaid LTC Communication Form).

The RN/LPN should sign his/her full name and title clearly and legibly and include the date the home visit was conducted. DMAS will look for the date by the RN/LPN's signature when conducting utilization review. The DMAS-99 must be filed in the member's record within five days of the date of the last visit. If an aide was present in the home at the time of the visit, note the aide's full name and whether the aide is regularly assigned or is being utilized as a substitute aide on this day.

NURSING NOTES: Nurses may utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.

AGENCY-DIRECTED ROUTINE RN SUPERVISORY VISITS:

The member's address, date of birth, start of care date, and phone number may be omitted on the routine reassessment, if desired.

FUNCTIONAL STATUS: If the RN/LPN determines that there has been no change in the functional status, a line may be drawn through all of the Functional Status boxes and "No Change" written.

MEDICAL/NURSING INFORMATION: This area must be completed on every ROUTINE visit. If the diagnoses have not changed, NO CHANGE may be written on this line during the ROUTINE visit. New diagnoses may be added as indicated on the ROUTINE reassessment note. Current health status/condition must be addressed on every routine supervisory visit and note information such as weight loss or gain (if pertinent) medication changes, MD visits-including for what reason, and whether the member's condition has improved, declined, or remained stable since the last reassessment. Current Medical Nursing Needs, must be updated on the ROUTINE reassessment note if indicated. Medical Nursing Needs must be present if the member meets the nursing facility criteria. Therapies/Special Medical Procedures: Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the member is receiving Home Health, note frequency of visits, agency providing services, and reason for visits. Hospitalizations: Include the dates of admission and discharge, and the reason for the admission. CRITICAL INCIDENTS: Critical Incidents are any actual, alleged or suspected event or situation that creates a significant risk or serious harm to the physical/mental health, safety, and/or well-being of a Medicaid waiver member. Examples may include: abuse, neglect, exploitation, theft, medical error, deviation form standards of care, serious injury, medical error, etc. **SUPPORT SYSTEM:** Any changes regarding hours on the plan of care, support system and/or need for supervision should be noted. Total Weekly Hours and Days per Week should reflect the hours and days on the current plan of care. Other Medicaid/Non Funded Services the member is receiving may include (but not be limited to) meals on wheels, companion services, Adult Day Health Care, etc. If the member is cognitively impaired, who will be responsible for signing the aide records must be noted and may include family, friends, authorized representative and/or significant other. If the member is in need of supervision at all times but supervision is provided solely by the member's caregivers, the Request for Supervision Form is *not* required. If supervision hours are provided on the member's plan of care, the Request for Supervision Form (DMAS 100) must be on file in the member's record. If the member requires supervision at all times but caregivers are not available at all times, has the member been informed about PERS, as a covered service in the waiver? The member must be assessed to determine there are no cognitive deficits in order for PERS to be used appropriately. If the member has PERS, the related questions in this section must be answered.
RN/LPN SUPERVISION: The accuracy of the aide documentation must be noted on every routine supervisory visit and should directly correlate with whether the aide is following the member plan of care, or if not, documenting the reason(s) for not following the plan of care. If the RN's plan of care is not being followed by the aide due to inaccuracies on the plan of care, or the plan of care is not meeting the member's needs, answer one or both questions as "NO". Any **"**NO" answers must be explained including any changes to the plan of care to meet the member's needs.

CONTINUITY & CONSISTENCY: If the member or caregiver(s) has been dissatisfied with the aide, SF, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed).

Note the date and patient pay amount (if applicable) from the most recent DMAS 225 (Medicaid LTC Communication Form).

The SF should sign his/her full name and title clearly and legibly and include the date the home visit was conducted. DMAS will look for the date by the SF's signature when conducting utilization review. The DMAS-99 must be filed in the member's record within five days of the date of the last visit. If the member or caregiver(s) has been dissatisfied with the aide, agency, or hours, describe the problem and the follow-up taken. **NURSING NOTES**: Nurses may utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.

CONSUMER-DIRECTED SERVICES
THE INITIAL AND SIX-MONTH REASSESSMENT VISIT

It must include: the member's name, address, date of birth, phone number, the Medicaid ID number, the start of care date, and the provider agency's name and provider number.

FUNCTIONAL STATUS: Must be completed in detail on the initial visit and during the six-month reassessment visit. The member's dependence or independence in an ADL should be noted by placing a check mark in the appropriate box under each category. Apply the definitions provided in the Virginia Uniform Assessment Instrument (UAI) User's Manual when assessing the member and completing this section. If there is any doubt in the member's ability to perform a task, the SF (Services Facilitator) should ask the member to demonstrate the completion of that task. Shaded areas indicate the member is independent in that function. "Independent" means that the member does not need an attendant to assist with any part of the task. Under JOINT MOTION, it should be noted which joints are limited (if applicable). Under MED. ADMINISTRATION, note who administers the member's medications.

MEDICAL/NURSING INFORMATION: All of these blanks must be completed on the initial and six-month assessments. DIAGNOSES- All diagnoses contributing to the health needs of the member should be noted on this visit. Remember that the member may have developed another medical complication requiring the documentation of another diagnosis. CURRENT HEALTH STATUS/CONDITION- Note information such as weight loss or gain (if pertinent), medication changes, MD visits, including for what reason, and whether the member's condition has improved, declined, or remained stable. The SF must assess this issue by asking pointed questions, (e.g., Have you seen the doctor since I was here last time? Did the doctor change your medication? Have you been having any dizzy spells? Have you been able to eat all of your meals without vomiting afterward? Are you still having headaches? Are you checking your sugar four times a day?). CURRENT MEDICAL NURSING NEEDS- Include any information that should be monitored by the SF or the doctor, such as, blood sugar levels, wounds, weight loss, malnutrition, dehydration, respiratory distress, immobility issues, circulatory problems, blood-work for medication adjustments. This is not asking for a summary of the member's ADL functioning. THERAPIES / SPECIAL MEDICAL PROCEDURES- This must be addressed on the initial assessment and six-month reassessment. Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the member is receiving Home Health skilled services, note frequency of visits, the agency providing services, and the reason(s) & disciplines for visits. HOSPITALIZATIONS- Include the dates of admission and discharge, and the reason(s) for the admission. CRITICAL INCIDENTS: Critical Incidents are any actual, alleged or suspected event or situation that creates a significant risk or serious harm to the physical/mental health, safety, and/or well-being of a Medicaid waiver member. Examples may include: abuse, neglect, exploitation, theft, medical error, deviation form standards of care, serious injury, medical error, etc.

SUPPORT SYSTEM: Must be completed in detail on these visits. Any changes in the hours on the Plan of Care or the support system should be noted. TOTAL WEEKLY HOURS AND DAYS PER WEEK- This should reflect the hours and days on the current plan of care. OTHER MEDICAID/NON FUNDED SERVICES- This must be filled out. PERSON PROVIDING THE CARE- The full name of the attendant providing the care. PERSON DIRECTING THE CARE – If the member has someone managing his/her POC, the person's full name. The person directing the care and the attendant cannot be the same person.

SERVICE FACILITATOR SUPERVISION: Dates of Services Facilitator's routine visits for the last six months must be completed on the six-month reassessment. Document if the attendant is following the member plan of care, or if not, documenting the reason for not following the plan of care. If the Services Facilitator's plan of care is not being followed by the attendant due to inaccuracies on the plan of care, or the plan of care is not meeting the member's needs, answer "NO", and explain, including how the plan of care will be changed to meet the member's needs if it needs to be.

CONSISTENCY AND CONTINUITY: The number of no service days within the last six months must be indicated on the six-month reassessment. Do not include days the member /caregiver requested to be without service or days the member was hospitalized. Note how many attendants have been provided care over the past six months. If the member or caregiver(s) has been dissatisfied with the attendant, service facilitator, facilitator agency, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed).

Record the date and patient pay amount (if applicable) from the most recent DMAS-225 (Medicaid LTC Communication Form)

The Services Facilitator should sign his/her full name and title clearly and legibly and include the date the home visit was conducted. DMAS will look for the date by the Services Facilitator's signature when conducting utilization review. The DMAS-99 must be filed in the member's record within five days of the date of the last visit. If an attendant was present in the home at the time of the visit, note the attendant's full name.

SERVICE FACILITATOR NOTES: Utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.

CONSUMER-DIRECTED ROUTINE FACILITATOR ROUTINE VISITS:

The member's address, date of birth, start of care date, and phone number may be omitted on the routine reassessment, if desired.

FUNCTIONAL STATUS: If it is determined that there has been no change in the functional status, a line may be drawn through all of the Functional Status boxes and "No Change" written.

MEDICAL/NURSING INFORMATION: This area must be completed on every ROUTINE visit. If the diagnoses have not changed, NO CHANGE may be written on this line during the ROUTINE visit. New diagnoses may be added as indicated on the ROUTINE reassessment note. Current health status/condition must be addressed monthly and note information such as weight loss or gain (if pertinent) medication changes, MD visits-including for what reason, and whether the member's condition has improved, declined, or remained stable since the last reassessment. Current Medical Nursing Needs, must be updated monthly on the ROUTINE reassessment note if indicated. Medical Nursing Needs must be present if the member meets the nursing facility criteria. Therapies/Special Medical Procedures: Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the member is receiving Home Health, note frequency of visits, agency providing services, and reason for visits. Hospitalizations: Include the dates of admission and discharge, and the reason for the admission. After hospitalizations, respond to the three critical incident questions. Critical Incidents are any actual, alleged or suspected event or situation that creates a significant risk or serious harm to the physical/mental health, safety, and/or welfare of a Medicaid waiver member. Examples may include: physical, sexual, verbal, and psychological/emotional abuse, mistreatment or neglect, or exploitation (including financial). As a State Mandated Reporter, these incidents must be reported to the local DSS agency or State Hotline for further investigation.

SUPPORT SYSTEM: Any changes regarding hours on the plan of care or the support system should be noted. Total Weekly Hours and Days per Week should reflect the hours and days on the current plan of care. Other Medicaid/Non Funded Services should be filled out.

SERVICE FACILITATOR SUPERVISION: Document if the attendant is not following the plan of care and the reason(s) why. If the Services Facilitator's plan of care is not being followed by the assistant due to inaccuracies on the plan of care, or the plan of care is not meeting the member's needs, answer "NO", and explain, including how the plan of care will be changed to meet the member's needs if it needs to be.

CONTINUITY & CONSISTENCY: If the member or caregiver(s) has been dissatisfied with the attendant, services facilitator, services facilitation agency, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed).

Note the date and patient pay amount (if applicable) from the most recent DMAS-225 (Medicaid LTC Communication Form).

The member/caregiver should sign his/her full name at the time of the visit with either the RN or service facilitator and include the complete date the home visit was conducted.

The RN or the service facilitator should sign his/her full name and title clearly and legibly and include the complete date the home visit was conducted. DMAS will look for the date by the services facilitator's signature when conducting utilization review. The DMAS-99 must be filed in the member's record within five days of the date of the last visit. If an assistant was present in the home at the time of the visit, note the assistant's full name and whether the assistant is regularly assigned or is being utilized as a substitute assistant on this day.

SERVICES FACILITATOR NOTES: Utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.