DMAS 99 Community-Based Care Member Assessment

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

☐ Initial Visit	☐ Routine Visit/ Supervisory Visit	☐ Six-Month Re-assessment
Member's Name:		Date of Birth:
Member's Current Address:		Medicaid ID#:
		Member's Phone #:
Provider Name & 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

COMMENTS:

MEDICAL/NURSING INFORMATION

Diagnoses: _____
Medications: _____
Current Health Status/Condition: _____
_____
Current Medical Nursing Needs: _____
_____
Therapies/Special Medical Procedures: _____
_____
Has the member had a physician visit within the last 12 months (including medical, psychological and/or psychiatric visits)?
☐ Yes ☐ No Date of most recent visit: _____ Name of Physician: _____
Hospitalizations: Date(s):_____Reason(s):_____
_____
_____

CRITICAL INCIDENTS

☐ Yes ☐ No 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 currently 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: _____
Does the member have an aide/attendant who is a Legally Responsible Individual to the member?☐ Yes ☐ No

Other Medicaid/non-Medicaid funded services received: (example: services through the Veterans Administration)
_____

Who is the primary care giver(s): _____
Primary Caregiver Contact Number: _____
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

<u>If the member has PERS and/or Medication Monitoring, answer the following questions</u>:
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:
Employer of Record Name: _____ Relationship to member: _____
Employer of Record Present During Visit?: ☐ Yes ☐ No : _____

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
If frequency is 30 or 60 days, document the specific needs that requires the frequency: _____
_____
Supervisory Visit for Personal Care: ☐ Yes ☐ No Supervisory Visit for Respite Care: ☐ Yes ☐ No **(check all that apply)**
Does the aide/attendant document accurately the care provided? ☐ 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 from the provider agency? ☐ Yes ☐ No If no, please describe and the follow up taken:

_____
_____
_____
_____

Nursing/Service Facilitation Notes:
(Including names of any aides/attendants present)

Member/Caregiver SIGNATURE: _____ **DATE:** _____

Printed Name: _____ _____

RN /LPN/ SF SIGNATURE: _____ **DATE:** _____

Printed Name: _____

Aide should not be signing in lieu of member or caregiver representative, unless an LRI

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 to: DMAS, Office of Community Living, 600 E Broad St, Suite 1300, Richmond, VA 23219.

Do not alter or revise this form in any manner.

INSTRUCTIONS FOR COMPLETION OF THE DMAS-99

Use the DMAS-99 for RN/LPN supervisory visits and Service Facilitator routine or reassessment visits for Personal Care and Respite Care services. Check the correct service type and visit type at the top of page one.

Initial visits and six-month reassessments require the entire form to be completed. Routine/supervisory visits may document changes since the last visit unless a section requires a full update. Attach additional pages when more space is needed.

******Please refer to the CCC Plus Waiver Manual when in doubt.****** Questions may also be sent to the Office of Community Living at cccpluswaiver@dmas.virginia.gov.

AGENCY-DIRECTED SERVICES INITIAL VISIT & REASSESSMENTS

MEMBER AND PROVIDER INFORMATION: Enter the member name, address, date of birth, phone number, Medicaid ID number, assessment date, provider agency name, and provider/NPI number.

FUNCTIONAL STATUS: Complete this section in detail. Check the box that best describes the member's level of help for each ADL, mobility, continence, orientation, behavior, joint motion, and medication administration area. Use the LTSS Screening Manual Chapter 4. If ability is unclear, ask the member to demonstrate the task when appropriate. Use comments to explain needs, changes, or concerns.

MEDICAL/NURSING INFORMATION: Complete each line. List diagnoses, medications, current health status, current medical/nursing needs, therapies, special procedures, physician visits, and hospitalizations. Include changes since the last visit, such as medication changes, new symptoms, weight changes, wounds, blood sugar concerns, respiratory issues, therapy services, home health services, or hospital admission and discharge dates.

CRITICAL INCIDENTS: Answer yes or no for any incident that occurred within last 3 months. If yes, describe the incident, date, what happened, and follow-up actions. Critical incidents include actual, alleged, or suspected events that may cause serious risk or harm, such as abuse, neglect, exploitation, theft, serious injury, medical error, or a deviation from standards of care. Follow required reporting procedures when applicable.

SUPPORT SYSTEM: Document waiver services, provider names, approved hours, days per week, specific aide hours, whether the aide lives with the member, LRI status, other Medicaid or non-Medicaid supports, the primary caregiver, who may sign aide records, supervision needs, PERS, and medication monitoring when applicable.

RN/LPN SUPERVISION: List supervisory visit dates for the last six months. Document the agreed supervisory frequency, whether the aide documentation is accurate, whether the aide is following the plan of care, and whether the plan of care reflects the member's needs. Explain any "No" answer and the follow-up taken.

CONSISTENCY AND CONTINUITY: For the last six months, record days of no service, excluding hospitalizations and days the member/caregiver requested no service. Record the number of regular and substitute aides used. Describe service problems, member/caregiver dissatisfaction, and follow-up actions.

NOTES AND SIGNATURES: Use the notes section for important issues between visits. The member/caregiver and RN should sign, print name, and date the form clearly at conclusion of the visit. File the DMAS-99 in the member record within 2 weeks of the visit. If an aide was present, document the aide's full name and whether the aide was regular or substitute. Note: Paid Agency Aide is not permitted to sign as the caregiver, except LRI aides.

AGENCY-DIRECTED SUPERVISORY VISITS

For routine visits, the member's address, date of birth, assessment date, and phone number may be omitted if unchanged. If functional status has not changed, draw a line through the Functional Status section and write "No Change."

Complete Medical/Nursing Information on every routine visit. "No Change" may be used for unchanged diagnoses, but health status, nursing needs, physician visits, medication changes, hospitalizations, therapies, and special procedures must be updated when applicable. Review critical incidents, support system changes, aide documentation, plan of care accuracy, supervision needs, continuity, service gaps, complaints, and follow-up when applicable.

The RN/LPN must sign and date the visit. File the form in the member record within 2 weeks. Use notes to document important issues and attach pages as needed.

CONSUMER-DIRECTED SERVICES
INITIAL VISIT AND SIX-MONTH REASSESSMENT

MEMBER AND PROVIDER INFORMATION: Enter the member name, address, date of birth, phone number, Medicaid ID number, assessment date, provider agency name, and provider number.

FUNCTIONAL STATUS: Complete this section in detail. Check the box that best describes the member's level of help for each area. Use the LTSS Screening Manual Chapter 4.. If ability is unclear, the Services Facilitator should ask the member to demonstrate the task when appropriate. Note limited joints and who administers or monitors medications.

MEDICAL/NURSING INFORMATION: Complete each line. List diagnoses, medications, current health status, medical/nursing needs, therapies, special procedures, physician visits, and hospitalizations. Include changes such as medication updates, symptoms, weight changes, wounds, blood sugar concerns, respiratory issues, therapy services, home health services, and admission/discharge information.

CRITICAL INCIDENTS: Document any actual, alleged, or suspected event that creates significant risk or harm that occurred within the last 3 months. Include what happened, when it happened, and actions taken. Incidents may include abuse, neglect, exploitation, theft, serious injury, medical error, or a deviation from standards of care. Follow required reporting procedures when applicable.

SUPPORT SYSTEM: Document services, approved hours, days per week, other supports, the Employer of Record, who provides care, who directs care, and any changes to the plan of care or support system. The person directing care and the attendant cannot be the same person.

SERVICE FACILITATOR SUPERVISION: For six-month reassessments, list routine visit dates for the last six months. Document whether the attendant is following the plan of care. If not, explain why and describe any changes needed to meet the member's needs.

CONSISTENCY AND CONTINUITY: For six-month reassessments, record days of no service, excluding hospitalizations and days requested by the member/caregiver. Record how many attendants provided care. Describe any dissatisfaction with the attendant, Services Facilitator, facilitation agency, or hours, and document follow-up.

NOTES AND SIGNATURES: Use the notes section for important issues between visits. The member/caregiver and Services Facilitator should sign with full name, title, and date at the conclusion of the visit. File the DMAS-99 in the member record within 2 weeks. If an attendant was present, document the attendant's full name.

CONSUMER-DIRECTED ROUTINE SERVICES FACILITATOR VISITS

For routine visits, the member's address, date of birth, assessment date, and phone number may be omitted if unchanged. If functional status has not changed, draw a line through the Functional Status section and write "No Change."

Complete Medical/Nursing Information on every routine visit. "No Change" may be used for unchanged diagnoses, but current health status, medical/nursing needs, physician visits, medication changes, hospitalizations, therapies, and special procedures must be updated when applicable. After hospitalizations, address critical incident questions when required.

Document changes in hours, support system, other services, plan of care concerns, attendant performance, continuity issues, complaints, and follow-up when applicable.

The member/caregiver and the Services Facilitator should sign with full names and complete dates. File the form in the member record within 2 weeks. If an assistant/attendant was present, document the person's full name and whether the person was regular or substitute. Use notes for important issues and attach pages as needed.