Community-Based Care Recipient Assessment Report

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

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

Recipient's Name: _____ Date of Birth: _____

Medicaid ID #: _____ Start of Care: _____

Recipient's Current Address: _____ Agency Name: _____

_____ Provider ID #: _____

Recipient's Phone: ( ) _____ Recipient's SSN#: _____

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): _____

_____

Recipient Name: _____ Date of Assessment: _____

SUPPORT SYSTEM

Waiver services the recipient 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 _____ ☐ PERS _____
What Waiver service is the patient pay to be deducted? _____
Hours the aide provides care to the recipient: Total Weekly Hours: _____ Days Per Week:_____
Specific Hours the aide is in the recipient's home: _____
Other Medicaid/non-Medicaid funded services received: (example: services through the Veterans Administration)_____
_____
Who is the primary care giver(s): _____
Does the primary care giver (PCG) live with the recipient: ☐ Yes ☐ No Relationship to recipient: _____
Type of care the PCG provides to the recipient: _____
_____
How often does the PCG see the recipient? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____
Who other than the recipient is authorized to sign the aide records?_____
Is the recipient receiving PERS?: ☐ Yes ☐ No If applicable, is he/she receiving a Medication Monitor?: ☐ Yes ☐ No

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

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

CONSUMER-DIRECTED SPECIFIC:

Person directing/managing the care: _____ Relationship to recipient: _____
Person providing the care: _____ Relationship to recipient: _____
Is the recipient in need of PERS at all times to be maintained safely?: ☐ Yes ☐ No

AGENCY-DIRECTED SPECIFIC:

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

SERVICE FACILITATOR / RN SUPERVISION

Dates of RN supervisory / SF visits for the last 6 months: _____
*__Agency-directed only__: Did the recipient/caregiver agree to frequency of visits, and is it documented in the recipient'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? ☐ Yes ☐ No
Does the Service Plan reflect the needs of the recipient? ☐ 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 assigned to the case in the last 6 months: Regular Aides: _____ Sub-Aides: _____
Has the recipient 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 recipient 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 Present During Visit? ☐ Yes ☐ No Name of Aide: _____

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

Is Personal Care Aide Related to the Recipient? ☐ Yes ☐ No --- If yes, please indicate relationship:

Client/Caregiver Signature _____ **DATE:** _____

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

INSTRUCTIONS FOR COMPLETION OF THE DMAS-99

Agency-directed services must have use this form for all RN 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-direct, 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 call the Waiver Services Unit for assistance at (804) 786-1465.

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

It must include: the recipient's name, address, date of birth, phone number, 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 recipient'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 recipient and completing this section. If there is any doubt in the recipient's ability to perform a task, the RN should ask the recipient to demonstrate the completion of that task. Shaded areas indicate the recipient is independent in that function. "Independent" means that the recipient 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 recipient'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 recipient should be noted on this visit. Remember that the recipient may have developed another medical complication requiring the documentation of another diagnosis. MEDICATIONS: List the individual'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 recipient's condition has improved, declined, or remained stable. The RN 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 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 recipient'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 recipient 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.

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 recipient 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 that the recipient is receiving, which may include, but not be limited to, Meals on Wheels, companion services, Adult Day Health Care, and etc. WHO WILL BE RESPONSIBLE FOR SIGNING THE AIDE RECORDS- If the recipient is cognitively impaired, note who this includes, i.e., family, friends and/or significant other. If someone other than the recipient will be signing the aide record, that person should be instructed to sign his/her own name, not the recipient'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 recipient. IS THE RECIPIENT IN NEED OF SUPERVISION- If the supervision is provided solely by the recipient's caregivers, the Request for Supervision Form is *not* required. If, however, supervision hours are provided on the recipient's plan of care, the Request for Supervision Form (DMAS 100) must be on file in the recipient's record. If the recipient requires supervision at all times and the caregivers are not available at all times, has the recipient been informed about the Personal Emergency Response System (PERS), if it is a covered service in the waiver? The recipient must be assessed to determine there are no cognitive deficits in order for PERS to be used appropriately. If the recipient has PERS, the related questions in this section must be answered.

RN SUPERVISION: Dates of RN supervisory visits for the last six months must be completed on the six - month reassessment. The accuracy of the aide documentation must be noted with every routine supervisory visit and should directly correlate with whether the aide is following the recipient plan of care, or if not, documenting the reason for not following the plan of care. The Frequency of the supervisory visit that was agreed upon between the RN and the recipient must be documented. This frequency can be from 30 to 90 days, for recipients without a cognitive impairment as defined by DMAS policy. 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 recipient'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 recipient'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 recipient/caregiver requested to be without service or days the recipient 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 recipient or caregiver(s) has been dissatisfied with the aide, RN, 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 122.

The RN/Coordinator 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's signature when conducting utilization review. The DMAS-99 must be filed in the recipient'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 recipient'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 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 recipient'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 recipient 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 recipient 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.

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 recipient is receiving may include (but not be limited to) meals on wheels, companion services, Adult Day Health Care, and etc. If the recipient is cognitively impaired, who will be responsible for signing the aide records must be noted and may include family, friends and/or significant other. If the recipient is in need of supervision at all times but supervision is provided solely by the recipient's caregivers, the Request for Supervision Form is *not* required. If supervision hours are provided on the recipient's plan of care, the Request for Supervision Form (DMAS 100) must be on file in the recipient's record. If the recipient requires supervision at all times but caregivers are not available at all times, has the recipient been informed about PERS, if it is a covered service in the waiver? The recipient must be assessed to determine there are no cognitive deficits in order for PERS to be used appropriately. If the recipient has PERS, the related questions in this section must be answered.

RN 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 recipient 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 recipient'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 recipient's needs.

CONTINUITY & CONSISTENCY: If the recipient or caregiver(s) has been dissatisfied with the aide, RN, 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 122**.**

The RN/Coordinator 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's signature when conducting utilization review. The DMAS-99 must be filed in the recipient'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.

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

It must include: the recipient's name, address, date of birth, phone number, 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 recipient'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 recipient and completing this section. If there is any doubt in the recipient's ability to perform a task, the CDSF should ask the recipient to demonstrate the completion of that task. Shaded areas indicate the recipient is independent in that function. "Independent" means that the recipient 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 recipient'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 recipient should be noted on this visit. Remember that the recipient 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 recipient's condition has improved, declined, or remained stable. The CDSF 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 CDSF 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 recipient'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 recipient 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.

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 personal assistant providing the care. PERSON DIRECTING THE CARE – If the recipient has someone managing his/her POC, the person's full name. The person directing the care and the assistant cannot be the same person.

SERVICE FACILITATOR SUPERVISION: Dates of Facilitator's supervisory visits for the last six months must be completed on the six-month reassessment. Document if the assistant is following the recipient plan of care, or if not, documenting the reason for not following the plan of care. If the 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 recipient's needs, answer "NO", and explain, including how the plan of care will be changed to meet the recipient'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 recipient/caregiver requested to be without service or days the recipient was hospitalized. Note how many assistants have been assigned over the past six months as well as how many substitute assistants were utilized. If the recipient or caregiver(s) has been dissatisfied with the assistant, 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 122.

The 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 Facilitator's signature when conducting utilization review. The DMAS-99B must be filed in the recipient'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.

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 SUPERVISORY VISITS:

The recipient'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 recipient'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 recipient 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 recipient 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.

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 assistant is not following the plan of care and the reason(s) why. If the 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 recipient's needs, answer "NO", and explain, including how the plan of care will be changed to meet the recipient's needs if it needs to be.

CONTINUITY & CONSISTENCY: If the recipient or caregiver(s) has been dissatisfied with the assistant, service facilitator, facilitator 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 122**.**

The client/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 facilitator's signature when conducting utilization review. The DMAS-99B must be filed in the recipient'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.

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.