

**Department of Medical Assistance Services
Division of Long Term Care**

TECHNOLOGY ASSISTED WAIVER SUPERVISORY MONTHLY SUMMARY

Agency: _____ Date of Supervisor visit: _____
Primary Caregiver: _____ Month of service reported: _____
Tech Waiver Participant: _____ Medicaid #: _____
Orders renewed date: _____ Primary Diagnosis: _____
Participant attends school with a TW nurse? Yes No Health, safety and welfare needs met? Yes No
(If no, see note in problem section below)
Nursing hours authorized/day: _____ Respite hours provided: _____ Total Respite hours used to date: _____

CLINICAL STATUS THIS MONTH (illnesses, MD order changes, scheduled procedures, etc.) _____

PROBLEMS / CHANGES NOTED WITH DME (too much, too little, improper usage, agency): _____

TECHNOLOGY / NURSING NEEDS: (Circle Answer) Ventilator CPAP BIPAP – continuous intermittent
Oxygen: continuous intermittent back up only Enteral feedings: continuous q2hrs. q3hrs. Q4hrs+
IV/Hyperal: continuous 8-16hrs. 4-7hrs. <4hrs. Oral Supplements: _____
(type, frequency, amount)
Trach Care: QD BID TID Trach Change: weekly <weekly Suctioning: qhr. Q1-4hrs. q4hrs+
Other dressings: _____ q8hrs or less >q8hrs
(Specify type and location)
Medication changes: _____

Peritoneal dialysis (frequency and length) _____
Catheterization: q4hrs q8hrs q12hrs QD PRN Special TX: _____ QID TID BID QD
Specialized monitor I/O (reason): _____ frequency _____
Other skilled nursing (specify): _____

Has any technology been discontinued for this participant? Yes No **(If yes, notify the DMAS Health Care Coordinator)**

HOSPITALIZATIONS / REASONS: _____

THERAPIES (name of provider, frequency, location, progress): _____

CURRENT MD PLAN OF TREATMENT IN THE HOME CHART? Yes No **COPY SENT TO DMAS?** Yes No

CAREGIVER /PARTICIPANT'S RESPONSE TO NURSING SERVICES: _____

DATE OF CONTACT WITH FAMILY / CAREGIVER: _____ During Home Visit and / or Via Phone

NURSES STAFFING CASE THIS MONTH: **(If no nursing for 30 days or more notify the DMAS Health Care Coordinator)**

PROBLEMS IDENTIFIED _____

PARTICIPANT'S / FAMILY'S / CAREGIVER'S SIGNATURE (If available) _____

RN SUPERVISOR'S SIGNATURE

AGENCY PHONE #

DATE