Department of Medical Assistance Services
Technology Assisted Waiver

Provider RN Initial Home Assessment

Individual’s Name____________________________________

Nursing Agency’s Name_________________________________ Date of Supervisor’s Admission Visit ________________

Family Primary Caregiver’s Name________________________ Medicaid # ______________________

Primary Diagnoses

Document Brief Medical History

________________________________________________________________________________________________________________________________________________

TECHNOLOGY / NURSING NEEDS (Circle Answer)       Ventilator       CPAP       BIPAP – continuous       intermittent

Oxygen: continuous intermittent PRN

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

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

Oral Supplements: ____________________________ (Type, frequency, amount)

Specific Trach Care Orders: ________________________________ Trach Change: weekly >weekly

Trach Suctioning: QHR. Q1-4 hrs Q 4 hrs+

Other wound care dressings: ________________________________ Q 8 hrs or less >Q 8 hrs

(Specify type and location)

List Scheduled Medications:

Peritoneal dialysis (frequency and length):

Catheterization: Q 4 hrs Q 8 hrs Q 12 hrs QD PRN

Nebulizer Treatments: ____________________________ QID TID BID QD

Specialized monitor I/O (reason): ____________________________ frequency ____________________________

Other Skilled Home Health Visit Nursing provided? (specify):

HEALTH, SAFETY, WELFARE ISSUES IDENTIFIED? Yes ☐ No ☐ If Yes, Explain and notify DMAS

THERAPIES (name of provider, frequency, location):

FAMILY’S NURSING SHIFT PREFERENCES:

NURSES STAFFING CASE / SHIFTS COVERED:
Department of Medical Assistance Services  
Technology Assisted Waiver  
Provider RN Initial Home Assessment

Individual’s Name ________________________________________ Assessment Date ___________________________

HOME ASSESSMENT

Describe Family's Willingness and Ability to Care for the Individual (Indicate training received, note type and amount of care family is committed to provide and variations in family’s schedule)
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________

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

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

Home Physical Standards
(If inadequate, note needed changes)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Adequate</th>
<th>Inadequate</th>
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<tbody>
<tr>
<td>LARGE BATTERY LIGHT AT BEDSIDE</td>
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<tr>
<td>SMOKE ALARM / FIRE EXTINGUISHER</td>
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<tr>
<td>PLUMBING SUPPORTS WATER AND SEWAGE</td>
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<tr>
<td>ADEQUATE HEATING SYSTEM</td>
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<td>ADEQUATE COOLING SYSTEM</td>
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<tr>
<td>TELEPHONE SERVICE</td>
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</tbody>
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TECH WAIVER SERVICES

Check the Tech Waiver Services Requested by the Family / Caregiver or Applicant:
☐ Private Duty Nursing ☐ Respite Care ☐ Environmental Modifications
☐ Assistive Technology ☐ Transition Services
Department of Medical Assistance Services
Technology Assisted Waiver

Provider RN Initial Home Assessment

Individual’s Name __________________________________________Assessment Date _________________________

FAMILY INFORMATION

Primary Representative / Caregiver: _________________________________ Relationship to Individual __________________________

(If custody not held by primary representative, identify name, address and telephone # of custodian)

Current Employment of Primary Representatives / Caregivers

Name: _____________________________________________ Name _____________________________________________
Employer___________________________________________ Employer__________________________________________
Phone # of employer__________________________________ Phone # of employer_________________________________
Work hours __________________________________________ Work hours __________________________________________

Total Number of Individuals in Home______________________ Name of Primary Decision Maker ______________________

NAMES OF HOUSEHOLD MEMBERS AGE RELATIONSHIP TO TECH 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.)

___________________________________________________________________________________________________________

Additional Comments:

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

RN Supervisor’s Signature ________________________________________ Date Completed _________________________