

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:

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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)

Adequate

Inadequate

LARGE BATTERY LIGHT AT BEDSIDE
SMOKE ALARM / FIRE EXTINGUISHER

PLUMBING SUPPORTS WATER AND SEWAGE
ADEQUATE HEATING SYSTEM

ADEQUATE COOLING SYSTEM
TELEPHONE SERVICE

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

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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: _____
Employer _____
Phone # of employer _____
Work hours _____

Name _____
Employer _____
Phone # of employer _____
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 _____