

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)

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

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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 \_\_\_\_\_