



**APPLICANT/CLIENT BACKGROUND INFORMATION** (Please print or Type)

<b>1. NAME</b> (PRINT Last, First, MI)	<b>2. BIRTHDATE</b>																								
<b>3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS</b>	<b>VIII. MOBILITY/AMBULATION</b> (check a maximum of 2 for a through d)																								
<b>I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):</b> PRIMARY: _____ _____ SECONDARY: _____ _____ _____	[0] a. Independently mobile with or without device. [1] b. Ambulates with or without device but unsteady/subject to falls. [2] c. Able to walk/be mobile with minimal assistance. [3] d. Able to walk/be mobile with one assist. [4] e. Able to walk/be mobile with more than one assist. [5] f. Unable to walk.																								
<b>II. COMATOSE</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes," go to <b>XIV.</b>	<b>IX. BOWEL FUNCTION/CONTINENCE</b>																								
<b>III. VISION/HEARING/SPEECH</b> [0] a. Individual has normal or minimal impairment (with/without corrective device) of: <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech [1] b. Individual has impairment (with/without corrective device) of: <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech [2] c. Individual has complete absence of: <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech	[0] a. Continent. [1] b. Continent with cues. [2] c. Incontinent (at least once daily). [3] d. Incontinent (more than once daily, # of times _____ ).																								
<b>IV. COMMUNICATION</b>	<b>X. BLADDER FUNCTION/CONTINENCE</b>																								
[0] a. Adequately communicates needs/wants. [1] b. Has difficulty communicating needs/wants. [2] c. Unable to communicate needs/wants.	[0] a. Continent. [1] b. Continent with cues. [2] c. Incontinent (at least once daily). [3] d. Incontinent (more than once daily, # of times _____ ).																								
<b>V. MENTAL BEHAVIOR</b> (circle all that apply)	<b>XI. BATHING</b>																								
[0] a. Oriented (mentally alert and aware of surroundings). [1] c. Disoriented (partially or intermittently; requires supervision). [2] d. Disoriented and/or disruptive. [3] f. Aggressive and/or abusive. [4] g. Wanders at <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Both, or in danger of self-inflicted harm or self-neglect.	[0] a. Independent bathing. [1] b. Unable to safely bathe without minimal assistance and supervision. [3] c. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).																								
<b>VI. FEEDING/MEAL PREPARATION</b>	<b>XII. DRESSING AND PERSONAL GROOMING</b>																								
[0] a. Independent with or without an assistive device. [1] b. Feeds self but needs help with meal preparation. [2] c. Needs supervision or assistance with feeding. [4] d. Is spoon/syringe/tub fed, does not participate.	[0] a. Appropriate and independent dressing, undressing and grooming. [1] b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes.) [2] c. Physical assistance needed on a regular basis. [3] d. Requires total help in dressing, undressing and grooming.																								
<b>VII. TRANSFERRING</b>	<b>XIII. TOTAL POINTS</b>																								
[0] a. Independent with or without a device. [2] b. Transfers with minimal/stand-by help of another person. [3] c. Transfers with supervision and physical assistance of another person. [4] d. Does not assist in transfer or is bedfast.	Total Points Indicated _____																								
<b>XV. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS</b>	<b>XIV. MEDICATIONS/TREATMENTS</b>																								
_____ _____ _____ _____ _____	<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;"></th> <th style="width:10%; text-align: center;">Requires Supervision</th> <th style="width:20%; text-align: center;">PRNs Only Actual</th> </tr> </thead> <tbody> <tr> <td style="font-size: small;">(List all Significant Medications, Dosage, Frequency and mode/ Freq. Attach Treatment sheet if more space is needed.)</td> <td></td> <td></td> </tr> <tr> <td style="text-align: right;">and/or monitoring</td> <td></td> <td></td> </tr> <tr> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> </tbody> </table>		Requires Supervision	PRNs Only Actual	(List all Significant Medications, Dosage, Frequency and mode/ Freq. Attach Treatment sheet if more space is needed.)			and/or monitoring			_____	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____
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<b>1. NAME</b> (PRINT Last, First, MI)			<b>2. BIRTHDATE</b>	
<b>XVI. SKILLED PROCEDURES</b> D=Indicate number of times per day    (Check L or N if appropriate)    L=Less than once per day    N=Not applicable/Never				
<b>D(#)</b>	<b>L</b>	<b>N</b>	<b>PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:</b>	
___	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy care/suctioning in ventilator dependent person.	
___	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy care/suctioning in non-ventilator dependent person.	
___	<input type="checkbox"/>	<input type="checkbox"/>	Nasopharyngeal suctioning in persons with no tracheostomy.	
___	<input type="checkbox"/>	<input type="checkbox"/>	Total Parenteral Nutrition (TPN) Specify number of hours per day. _____	
___	<input type="checkbox"/>	<input type="checkbox"/>	Maintenance of peripheral/central IV lines.	
___	<input type="checkbox"/>	<input type="checkbox"/>	IV Therapy – Specify agent & frequency. _____	
___	<input type="checkbox"/>	<input type="checkbox"/>	Decubitus ulcers – Stage III and above.	
___	<input type="checkbox"/>	<input type="checkbox"/>	Decubitus ulcers – Less than Stage III; Wound care – Specify nature of ulcer/wound and care prescribed.	
___	<input type="checkbox"/>	<input type="checkbox"/>	Instillation of medications via indwelling urinary catheters – Specify agent.	
___	<input type="checkbox"/>	<input type="checkbox"/>	Intermittent urinary catheterization.	
___	<input type="checkbox"/>	<input type="checkbox"/>	IM/SQ Medications – Specify agent. _____	
___	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with administration of oral medications – Explain.	
___	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing difficulties and/or choking.	
___	<input type="checkbox"/>	<input type="checkbox"/>	Stable Gastrostomy/Nasogastric/Jejunostomy tub feedings; Enteral Pump? <input type="checkbox"/> Yes <input type="checkbox"/> No	
___	<input type="checkbox"/>	<input type="checkbox"/>	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration. Specify reason person at risk for aspiration.	
___	<input type="checkbox"/>	<input type="checkbox"/>	Initial phase of Oxygen therapy; Oxygen therapy requiring bronchodilators.	
___	<input type="checkbox"/>	<input type="checkbox"/>	Complicating problems of patients on renal dialysis, chemotherapy, radiation therapy, with orthopedic traction. Circle problem(s) and describe.	
___	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral problems related to neurological impairment. Describe.	
___	<input type="checkbox"/>	<input type="checkbox"/>	Other – Specify condition and describe nursing intervention.	
<input type="checkbox"/> Yes    Therapeutic Diet – Describe.				
<input type="checkbox"/> Yes    Restorative Therapy: PT/OT/Speech – Circle therapy and submit/attach evaluation and treatment plan.				
<b>XVII. SOCIAL SITUATION</b>				
A. Caregiving support system is willing to provide/continue to provide care with assistance. <input type="checkbox"/> Yes <input type="checkbox"/> No				
State assistance needed by Caregiver _____				
If YES, complete B & C.    If NO, go to D.				
B. Name _____ Relationship _____				
Address _____ Last, First, MI				
_____ Phone _____				
_____ Fax _____				
C. Person currently has a home and can return home <input type="checkbox"/> Yes <input type="checkbox"/> No    Residential setting can be considered as an alternative to facility. <input type="checkbox"/> Yes <input type="checkbox"/> No				
D. Patient is appropriate for <input type="checkbox"/> Care Home <input type="checkbox"/> Assisted Living <input type="checkbox"/> Hospice Residence				
Check all appropriate site(s) <input type="checkbox"/> Foster Care <input type="checkbox"/> Shelter <input type="checkbox"/> Other _____				
<b>XVIII. RECOMMENDATIONS/DISCHARGE PLANS</b>				
A. Requested LOC _____			D. Hospice Elected <input type="checkbox"/> Yes <input type="checkbox"/> No	
B. Requested Effective Date of Medicaid Coverage. _____			E. Appropriate for HCBS <input type="checkbox"/> Yes <input type="checkbox"/> No	
C. Effective Date of LOC _____				
<b>XIX. PHYSICIAN'S SIGNATURE</b> _____				DATE _____
Physician's Name _____ Please Print				
<b>Comments</b> _____				
_____				