

# ADVANTAGE NURSING ASSESSMENT/MONITORING FORM

<b>Member Name:</b>		<b>Medicaid ID:</b>	
<b>DOB:</b>	<b>Phone:</b>	<b>Time in:</b>	<b>Time out:</b>
<b>Nurse completing document: (please print)</b>		<b>Agency:</b>	<b>Date:</b>
<b>Case Manager &amp; CM agency:</b>		<b>Date copy sent to CM:</b>	
<b>Visit Type</b>	<input type="checkbox"/> Initial nurse evaluation, IDT (complete pages 1, 2, & 3) <input type="checkbox"/> Reassessment, IDT (complete pages 1, 2, 3, & 4)		
	<input type="checkbox"/> 6 month evaluation (complete pages 1, 2, 3, & 4) <input type="checkbox"/> ASR supervision (complete pages 1, 2, & 4) <input type="checkbox"/> Skilled nurse visit (complete box below) (complete pages 1 & 2)		
Reason for SN visit (check all that apply): <input type="checkbox"/> fill med box <input type="checkbox"/> foot care <input type="checkbox"/> wound care <input type="checkbox"/> catheter change <input type="checkbox"/> lab draw <input type="checkbox"/> other:			
<b>Diagnoses:</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> COPD <input type="checkbox"/> Other			
<b>Visit to any of the following in the past 6 months? Check all that apply</b>			
<input type="checkbox"/> Hospital	<input type="checkbox"/> Emergency room	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Behavioral health facility
Date(s): _____	Date(s): _____	Date(s): _____	Date(s): _____
Comments: _____	Comments: _____	Comments: _____	Comments: _____
_____	_____	_____	_____
<b>Physicians / Health Practitioners</b>			
<b>Practitioner Name</b>	<b>Specialty</b>	<b>Date last seen</b>	<b>Phone</b>
<b>ASSESSMENT</b>			
<b>VS</b>	<b>BP:</b> /	<b>Pulse:</b>	<b>Respirations:</b>
			<b>Height:</b>
			<b>Weight:</b>
<b>Neurological:</b>			
<b>Mental/Behavioral Health:</b>			
<b>Integument:</b>			
<b>Cardio/Pulmonary:</b>			
<b>Nutrition:</b>			
<b>Elimination:</b>			
<b>Mobility:</b>			
<b>Sleep:</b>			
<b>Pain:</b>			
<b>Details specific to Member's current chronic health condition(s):</b>			



## Needs Assessment Summary

<b>Member Name:</b> _____				<b>Medicaid ID:</b> _____			
<b>Needs Assistance With</b>							
<b>*KEY</b>							
Who: S = Self P = PCA/PSA I = Informal O = Other Freq: How often is assistance needed?							
PCA/PSA hrs/wk: If PCA/PSA performs or assists w/ task, designate the amount of time needed in this column.							
<b>ADL's</b>				<b>IADL's</b>			
Task	Who*	Freq*	PCA/PSA hrs/wk*	Task	Who*	*Freq	PCA/PSA hrs/wk*
Dressing				Shopping/Errands			
Bathing				Cooking/M meal Prep			
Grooming				Housekeeping			
Toileting				Laundry			
Eating				Money Management			
Mobility/Transfer				Telephone			
Standby Assist				Heavy Chores			
				Medication Assist			
				Transportation			
<b>Respite</b>							<b>Hours/wk</b>
Respite provided by: _____							
Comments: _____							
<b>Advanced Supportive Restorative (ASR) or Advanced Personal Services Assistant (APSA) Tasks</b>							<b>Hours/wk</b>
<input type="checkbox"/> Transfers <input type="checkbox"/> Specialty Lift <input type="checkbox"/> Catheter Care <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Range of Motion <input type="checkbox"/> Bowel Program							
<input type="checkbox"/> Other: _____							
<b>Safety Concerns</b>							
<b>How long can Member be home alone?</b> <input type="checkbox"/> Unlimited <input type="checkbox"/> Short Periods <input type="checkbox"/> Requires 24/7 supervision							
(If "Unlimited" is not checked, please explain why in the comment box)							
<input type="checkbox"/> No concerns <input type="checkbox"/> Health status <input type="checkbox"/> Recent fall <input type="checkbox"/> Change in supports <input type="checkbox"/> Environment <input type="checkbox"/> Finances <input type="checkbox"/> Change in mental status							
<input type="checkbox"/> Unintentional weight loss <input type="checkbox"/> Equipment needs <input type="checkbox"/> Unmet supervision needs <input type="checkbox"/> Active APS case							
<input type="checkbox"/> Other: _____							
Comments: _____							
<b>Current Other Agency Involvement:</b>							
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name, service provided and contact information							
_____							
<b>Resources</b>							
<input type="checkbox"/> Medicare		<input type="checkbox"/> Veterans Benefits		<input type="checkbox"/> Private Pay		<input type="checkbox"/> Indian Health Services	
<input type="checkbox"/> Private Health Insurance: _____		<input type="checkbox"/> Vocational Rehabilitation		<input type="checkbox"/> Community Organization: _____		<input type="checkbox"/> Independent Living Center	
<input type="checkbox"/> State Plan		<input type="checkbox"/> Hospice: _____		<input type="checkbox"/> Other: _____			
Comments: _____							
<b>Recommendations</b>							
<input type="checkbox"/> Adult Day Health		<input type="checkbox"/> Respite		<input type="checkbox"/> Home Delivered Meals		<input type="checkbox"/> Hospice	
<input type="checkbox"/> 24 hr. Supervision		<input type="checkbox"/> Mental Health Referral		<input type="checkbox"/> Nutritional Supplements		<input type="checkbox"/> Skilled Nursing	
<input type="checkbox"/> ASR SN Monitoring		<input type="checkbox"/> Dietitian		<input type="checkbox"/> PERS		<input type="checkbox"/> Therapy <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> ST	
<input type="checkbox"/> Environmental Modification(s): (Describe) _____				<input type="checkbox"/> Other: _____			
Comments: _____							
<b>Equipment &amp;/or Supplies Needed:</b>							
_____							
<b>Signatures (If Member signs with a mark, two witnesses are required.)</b>							
Member or Legal Agent			Date	Witness			Date
Nurse completing document			Date	Witness			Date
Case Manager (only applicable to IDT meetings)			Date				

## PCA/ASR Supervisory Visit Report

<b>Member Name:</b> _____	<b>Medicaid ID:</b> _____
<b>Name(s) of current worker(s) and relationship to Member:</b> _____	
<b>PCA/ASR present at time of visit?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Amount of time allotted for PCA tasks:</b> _____	<b>Amount being delivered:</b> _____
<b>Amount of time allotted for ASR tasks:</b> _____	<b>Amount being delivered:</b> _____
<b>Assigned Task(s):</b>	
<input type="checkbox"/> Bed Bath <input type="checkbox"/> Hair Care <input type="checkbox"/> Dusting <input type="checkbox"/> Vacuuming <input type="checkbox"/> Clean Kitchen <input type="checkbox"/> Bed Making <input type="checkbox"/> Tub Bath <input type="checkbox"/> Skin Care <input type="checkbox"/> Sweeping <input type="checkbox"/> Meal Prep <input type="checkbox"/> Dishes <input type="checkbox"/> Laundry <input type="checkbox"/> Shower <input type="checkbox"/> Standby Assist <input type="checkbox"/> Mopping <input type="checkbox"/> Clean Bathroom <input type="checkbox"/> Trash Removal <input type="checkbox"/> Advanced Meal Prep <input type="checkbox"/> Shampoo <input type="checkbox"/> Errands <input type="checkbox"/> Other: _____	
<b>Advanced Supportive Restorative Task(s):</b>	
<input type="checkbox"/> Transfers <input type="checkbox"/> Specialty Lift <input type="checkbox"/> Catheter Care <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Range of Motion <input type="checkbox"/> Bowel Program <input type="checkbox"/> Other: _____	
Details of ASR task(s) performed: _____	
Are PCA/ASR's current skills adequate to perform tasks? <input type="checkbox"/> Yes <input type="checkbox"/> No (specify) _____	
<b>Questions for the Member &amp;/or Responsible Party</b>	
Are the above tasks performed to your satisfaction?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Comment: _____	
Does the aide stay the entire time allotted?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Comment: _____	
Are you contacted if the aide is unable to come at the scheduled time?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Comment: _____	
Do you feel respected by the aide?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Comment: _____	
Who do you contact if the aide does not show up? _____	
Does the agency offer to send a replacement aide?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Comment: _____	
Who fills in if a replacement aide is not available? _____	
Is the current plan meeting your needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment: _____	
_____	
_____	

<b>Nurse's Recommendations</b>			
<input type="checkbox"/> No Changes <input type="checkbox"/> Increase Services <input type="checkbox"/> Decrease Services			
<b>Justification:</b> _____			
<b>Signatures</b> (If Member signs with a mark, two witnesses are required.)			
Member or Legal Agent	Date	Witness	Date
Nurse completing document	Date	Witness	Date
Nurse Supervisor (if applicable)	Date	PCA/ASR if present	Date
2 <sup>nd</sup> PCA/ASR if present	Date		