

Completing the ADvantage Nursing Assessment/Monitoring Form

Use the instructions below to complete an ADvantage Nursing Assessment/Monitoring Form.

Member Name:		Medicaid ID:	
DOB:	Phone:	Time in:	Time out:
Nurse completing document: (please print)		Agency:	Date:
Case Manager & CM agency:		Date copy sent to CM:	
Visit Type	<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:		
Diagnoses:	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
	<input type="checkbox"/> Other	<input type="checkbox"/> Cancer	<input type="checkbox"/> COPD

Member Name: Enter the Member's last name, first name and middle initial.

Medicaid ID: Enter the Member's nine digit Medicaid identification number

DOB: Enter the Member's date of birth.

Phone: Enter the Member's telephone number.

Time in: Enter the time the assessment/IDT began.

Time out: Enter the time the assessment/IDT ended.

Nurse completing document: Print your name.

Provider: Enter the name of your agency.

Date: Enter the date of the assessment.

Case Manager & CM agency: Enter the name of the Case Manager and the name of the Case Management Agency.

Date copy sent to CM: Enter the date a copy of this document was sent to the Case Manager.

Visit Type: Check the type of visit. Please note that checking "Initial nurse evaluation, IDT" or "Reassessment, IDT" documents your participation in the IDT.

Reason for SN visit: Check all that apply.

Diagnoses: Check all major diagnosis that apply. If the Member's diagnosis's is not listed, please check "Other" and specify.

Visit to any of the following in the past 6 months? <i>Check all that apply</i>			
<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: _____
Physicians / Health Practitioners			
Practitioner Name	Specialty	Date last seen	Phone

Visit to any of the following in the past 6 months?: Check and give dates for all that apply *within the last six months*. Comments should include reason for admission, length of stay and treatment.

Physicians/Health Practitioners: Write name, specialty, date last seen and phone number of any physician or other health practitioner the Member visited in the past six months (this could include nurse practitioner, physician's assistant, PT, OT, dietician, etc.)

ASSESSMENT				
VS	BP: /	Pulse:	Respirations:	Height: Weight:
Neurological:				

VS: Check and record blood pressure, pulse, respirations, height and weight. If unable to obtain height and weight, record Member's estimation.

Neurological:

Neurological: Determine if the Member's status is within normal limits such as:

- *Is the Member awake, alert and oriented to person, place and time?*
- *Can the Member communicate thought processes?*
- *List any neurological conditions/symptoms and describe current treatment and its effectiveness, including any self-care strategies the Member is using.*

Mental/Behavioral Health:

Mental/Behavioral Health: Determine if the Member's status is within normal limits such as:

- *Does the Member express sense of well being, have normal affect and a general feeling of optimism?*
- *List any mental health conditions/symptoms and describe current treatment and its effectiveness, including any self-care strategies the Member is using.*

Integument:

Integument: Determine if the Member's status is within normal limits such as:

- *Is skin intact?*
- *Is skin warm, dry and elastic?*
- *Does the Member have any lesions, rashes, sores, ulcers or wounds?*
- *List any skin conditions/symptoms and describe location, status, current treatment and its effectiveness, including any self-care strategies the Member is using.*

Cardio/Pulmonary:

Cardio/Pulmonary: Determine if the Member's status is within normal limits such as:

- *Does the Member have chest pain, pedal edema or calf tenderness?*
- *Are the Member's blood pressure and pulse within normal limits?*
- *Is the Member's pulse regular?*
- *Are pedal pulses present?*
- *Is the Member's skin warm, dry and have good color?*
- *Are the Member's respirations regular and not labored?*
- *Does the Member have an acute or chronic cough?*
- *Are the Member's lungs clear?*
- *Has the Member had a pneumococcal vaccination and annual flu shot?*
- *List any conditions/symptoms and describe current treatment and its effectiveness, including any self-care strategies the Member is using.*

Nutrition:

Nutrition: Determine if the Member's status is within normal limits such as:

- *Has the Member had unintentional weight loss or gain of 10% or more in the last six months?*
- *Is the Member eating a special diet?*
- *Describe the Member's approximate daily intake of meats, fruits, vegetables, dairy, grains, fats and sugars.*
- *Describe any problems that make it difficult for the Member to eat.*
- *Does the Member have a medical condition that requires the support of special dietary or oral nutritional supplements?*
- *Is the Member currently using oral nutritional supplements?*
- *If so, what kind, how much and what is the medical condition that requires the supplements?*
- *List any abnormal conditions/symptoms and describe current treatment and its effectiveness, including any self-care strategies the Member is using.*

Elimination:

Elimination: Determine if the Member's status is within normal limits such as:

- *Is the Member's abdomen soft and not distended?*
- *Are bowel sounds normal?*
- *Are stools regular, soft and brown?*
- *Does the Member report constipation, diarrhea, nausea or vomiting?*
- *Does the Member report any bowel or bladder incontinence?*
- *Does the Member have an ostomy, catheter or need any supplies?*
- *List any abnormal conditions/symptoms and describe current treatment and its effectiveness, including any self-care strategies the Member is using.*

Mobility:

Mobility: Determine if the Member's status is within normal limits such as:

- *Is the Member ambulatory? With or without assistance?*
- *Does the Member have a steady gait and good balance?*
- *Does the Member have full range of motion in all extremities?*
- *List any abnormal conditions/symptoms and describe current treatment and its effectiveness, including any self-care strategies the Member is using.*

Sleep:

Sleep: Determine if the Member's sleep patterns are within normal limits such as:

- *Does the Member fall asleep easily and stay asleep for 7 – 9 hours?*
- *Does the Member awaken feeling refreshed?*
- *Can the Member complete desired activities throughout the day without excessive napping?*
- *List any abnormal conditions/symptoms and describe current treatment and its effectiveness, including any self-care strategies the Member is using.*

Pain:

Pain: Determine if the Member is experiencing pain.

- *Assess intensity for each pain site using a numerical or faces pain scale from 0 - 10.*
- *Describe current treatment and its effectiveness, including any self-care strategies the Member is using.*

Details specific to Member's current chronic health condition(s):

Details: This space is provided for additional comments regarding the Member's health conditions. If more space is needed, attach extra pages.

Equipment/Supplies Member is Currently Using: Cane Wheelchair Walker Glasses
 Shower Chair Hand Held Shower Grab Bars BSC Incontinent Supplies Hearing Aid
 Other:

Equipment/Supplies Member is Currently Using: Indicate what equipment the Member is using. If the item is not listed, check "Other" and describe. If Member needs equipment that he or she does not have, please write that information on page 3 in the "Recommendations" box.

Details of skilled care provided:

Details of skilled care provided: Describe any skilled care provided such as:

- *Technique used (sterile, aseptic, clean, etc.)*
- *Specific wound care*
- *Health education*

Member's response to care:

Member's response to care: Describe Member's response to skilled care provided, including

- *Receptiveness*
- *Comprehension of health education, if provided*
- *Comfort/pain level*
- *Anxiety*

Medications						
Name of Medication	Dose	Route	Frequency	Purpose	Date Filled	Physician

Medications: Enter the name, dose, frequency, purpose, date filled and physician (if applicable) for each prescription medication, over-the-counter drug or home remedy. Obtain the information directly from the containers when possible.

Allergies	Pharmacy Information
	Name: _____ Phone: _____
Medication Information	
Medication administered by: <input type="checkbox"/> Self <input type="checkbox"/> Family/friend/other (list name and relationship): _____	
Uses med planner: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, filled by: _____	

Allergies: List all allergies the Member has, including allergies to medication, food, animals or the environment.

Pharmacy Information: Write the name and phone number of the Member's pharmacy. If the Member uses more than one pharmacy, write in the white space above the signature lines or attach an extra page.

Medication Information: Check the box which indicates who administers the Member's medications. If it is someone other than the Member, enter the name and relationship of that person(s). Check the box that indicates if a med planner is used. If yes, enter the name and relationship of the person who fills the med planner.

Signatures (If Member signs with a mark, two witnesses are required.)			
Member or Legal Agent	Date	Witness	Date
Nurse completing document	Date	Witness	Date

Signatures: Ask the Member or legal agent to sign and date the document. If the Member signs with a mark, the signatures of two witnesses are required. You and the Case Manager also sign and date the document. Please note, the Member's signature is only required on the last page completed for the type visit performed.

Needs Assistance With								
*KEY								
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.								
ADL's				IADL's				
Task	Who*	Freq*	PCA/PSA hrs/wk*	Task	Who*	*Freq	PCA/PSA hrs/wk*	
Dressing				Shopping/Errands				
Bathing				Cooking/Meal Prep				
Grooming				Housekeeping				
Toileting				Laundry				
Eating				Money Management				
Mobility/Transfer				Telephone				
Standby Assist				Heavy Chores				
				Medication Assist				
				Transportation				

Needs Assessment Summary

Who*: Refer to the Key and for each ADL and IADL task, enter the corresponding letter(s) which identifies who accomplishes the task.

Freq*: Enter the frequency needed to meet the Member's needs.

ADL PCA/PSA hrs/wk*: Enter the total number of hours per week PCA/PSA assistance is needed to meet the Member's needs.

IADL PCA/PSA hrs/wk*: Enter the total number of hours per week PCA/PSA assistance is needed to meet the Member's needs.

Respite	Respite Hours/wk
Respite provided by: _____	
Comments: _____	
Advanced Supportive Restorative (ASR) or Advanced Personal Services Assistant (APSA) Tasks	Hours/wk

Respite

Respite provided by: If respite is being provided, enter the provider's name (formal and/or informal).

Respite Hours: Enter the number of hours and frequency of respite needed per week.

Comments: Add comments such as Member's response to the service, justification for the service, change in needs, etc.

Advanced Supportive Restorative (ASR) or Advanced Personal Services Assistant (APSA) Tasks	Hours/wk
<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: _____	

Advanced Supportive Restorative (ASR) or Advanced Personal Services Assistant (APSA) Tasks

Check Boxes: Check the ASR/APSA task(s) required to meet the Member's needs. If the task(s) is not listed, check "Other" and describe the task(s).

Hours/wk: Enter the number of hours per week needed for ASR/APSA services.

Safety Concerns
How long can Member be home alone? <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: _____

Safety Concerns

Can Member be home alone?: Check the box that best describes the Member's abilities. If anything other than "Unlimited" is checked, provide an explanation in the comment box.

Check Boxes: Check the box(es) that best describes any safety concerns you, the Member or other team members have. If there are concerns that are not listed, check "Other" and explain. If there are no safety concerns, check "No concerns".

Current Other Agency Involvement:
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name, service provided and contact information _____ _____

Current Other Agency Involvement:

Check Boxes: Check "Yes" if there is other agency involvement (such as Medicare Home Health, Hospice, Indian Health Services, VA, Mental Health Services, etc.) and describe service provided and contact information. Check "No" if there are no other agencies providing services to the Member.

Resources			
<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:			

Resources

Check Boxes: Check all resources available to the Member.

Comments: If a Member has access to a resource (such as VA or Indian Health Services), but does not use it, explain in the comments box. For example, does the Member want to use or have an interest in exploring the resource?

Recommendations			
<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:			
Equipment &/or Supplies Needed:			

Recommendations

Check Boxes: Check the box(es) to indicate service recommendations.

Comments: Use the comment box to add pertinent information about the recommendations, the Member's needs and/or any other information useful for service planning.

Equipment &/or Supplies Needed: Enter recommendations for equipment and supplies. Include quantity and payor source when applicable.

Signatures (If Member signs with a mark, two witnesses are required.)			
Member or Legal Agent	Date	Witness	Date
Nurse completing document	Date	Witness	Date
Case Manager (only applicable to IDT meetings)	Date		

Signatures: Ask the Member or legal agent to sign and date the document. If the Member signs with a mark, the signatures of two witnesses are required. You and the Case Manager also sign and date the document. Please note, the Member's signature is only required on the last page completed for the type visit performed.

PCA/ASR Supervisory Visit Report

Note: If you are not conducting a supervisory visit, you will not need to submit this page with the remainder of the Nursing Assessment/Monitoring Form.

Name(s) of current worker(s) and relationship to Member:	
PCA/ASR present at time of visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Amount of time allotted for PCA tasks: _____	Amount being delivered: _____
Amount of time allotted for ASR tasks: _____	Amount being delivered: _____
Assigned Task(s): _____	

Name(s) of current worker(s) and Relationship to Member: Enter the name(s) of all current PCAs and/or ASRs workers and their relationship to the Member (daughter, son, spouse, guardian, etc). If the worker is not a guardian or family member, N/A after their name.

PCA/ASR present at the time of visit?: Check yes or no.

Amount of time allotted for PCA tasks: Enter the time allotted for PCA tasks. This amount should match the time authorized in the service plan.

Amount being delivered: Enter the amount of time used by the PCA to deliver services.

Amount of time allotted for ASR tasks: Enter the time allotted for ASR tasks. This amount should match the time authorized in the service plan.

Amount being delivered: Enter the amount of time used by the ASR to deliver services.

Assigned Task(s):					
<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: _____			
Advanced Supportive Restorative Task(s): _____					

Assigned Task(s):

Check Boxes: Check all that apply. If "Other" is checked, please describe the task.

Advanced Supportive Restorative Task(s):					
<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) _____					

Advanced Supportive Restorative Task(s):

Check Boxes: Check all that apply.

Details of ASR task(s) performed: Describe the ASR task(s) performed.

Are the PCA/ASR's skills adequate to perform the tasks?: If skills are adequate, check "Yes". If skills are not adequate, check "No" and specify which skill(s) are not adequate and make recommendations for resolving the inadequacies.

Questions for the Member &/or Responsible Party		
Are the above tasks performed to your satisfaction? Comment: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Sometimes
Does the aide stay the entire time allotted? Comment: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Sometimes
Are you contacted if the aide is unable to come at the scheduled time? Comment: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do you feel respected by the aide? Comment: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Sometimes
Who do you contact if the aide does not show up? _____		
Does the agency offer to send a replacement aide? Comment: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Sometimes
Who fills in if a replacement aide is not available? _____		
Is the current plan meeting your needs? Comment: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Questions for the Member &/or Responsible Party

- Ask the Member each of the questions and check the appropriate response.
- If “No” or “Sometimes” is checked, ask the Member to explain and record the comments.
- If the Member is unable to respond to these questions, the Member’s legal agent or other informal support may answer on behalf of the Member.
- If someone other than the Member answers the questions, indicate the person’s name and relationship to the Member on the comment line.

Nurse’s Recommendations
<input type="checkbox"/> No Changes <input type="checkbox"/> Increase Services <input type="checkbox"/> Decrease Services
Justification: _____

Nurse’s Recommendations

Check Boxes: Check the box that applies. If “Increase Services” or “Decrease Services” is checked, write justification in the space provided.

Signatures (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	PCAVASR if present	Date
2 nd PCAVASR if present	Date		

Signatures:

- Ask the Member or legal agent to sign and date the document. If the Member signs with a mark, the signatures of two witnesses are required. Please note, the Member’s signature is only required on the last page completed for the type visit performed.
- PCA(s) or ASR(s) who are in the home at the time of the assessment also sign.
- You also sign and date the document. If you are an LPN, the document must be co-signed by your Nurse Supervisor.