MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES

HOME AND COMMUNITY BASED SERVICES
GENERAL HEALTH EVALUATION & LEVEL OF CARE RECOMMENDATION

A: PARTICIPANT INFORMATION

PARTICIPANT (LAST, FIRST, MI)	DCN	DATE OF BIRTH	REGION

DATE

ADDRESS (STREET, CITY, ZIP)	COUNTY	PHONE NUMBER(S)

B: PROVIDER NURSE INFORMATION

NAME OF PROVIDER NURSE (LAST, FIRST, MI)	NAME OF PROVIDER	PROVIDER PHONE NUMBER

C: REASON FOR NURSE VISIT

☐ Participant General Health and Care Plan Evaluation (Semi-Annual Nurse Visit)
☐ Initial Assessment for Authorization of: ☐ Advanced Personal Care ☐ Respite Care
☐ Monthly Review for Advanced Care Plan Authorization of: ☐ Advanced Personal Care; ☐ Respite Care
☐ Six (6) Month Review for Advanced Care Plan Authorization of: ☐ Advanced Personal Care; ☐ Respite Care

☐ Significant Change	Explain:
☐ Request from DSDS or its designee	Explain:
☐ Other	Explain:

D: HEALTH CARE INFORMATION

PRIMARY HEALTH CARE PROVIDERS	ROLE	PHONE
	Physician	
	Physician	
	Clinic/Hospital	
	Other (identify)	

CURRENT DIAGNOSES/CONCERNS:

RECENT HOSPITALIZATIONS, SURGERIES, OR PROCEDURES:

ANY ADDITIONAL HEALTH INFORMATION:

E: ALLERGIES AND VITAL SIGNS

Allergies:

Temperature:	Heart Rate ☐Regular ☐Irregular	Respirations:
Blood Pressure:	Blood Glucose:	A1C:

F. CARDIOPULMONARY ASSESSMENT

☐ Coronary Artery Bypass	☐ Pitting Edema	☐ Pedal Pulse	☐ Compression Hose Class:
☐ Central Line	☐ Hypertension	☐ Chest Pains	☐ Pacemaker

G. INTEGUMENTARY ASSESSSMENT

☐ No Concerns ☐ Concerns: Indicate on body diagram & assessment chart any skin tears, abrasions, wounds, decubitus ulcers, etc.

H: LEVEL OF CARE (Refer to Policy 4.10 for additional guidance)	REQUIRED EXPLANATION
MONITORING ☐ 0 (PRN monitoring) ☐ 3 (minimal monitoring: at least 1 x month for a stable health condition) ☐ 6 (moderate monitoring for verified unstable health condition) ☐ 9 (maximum intensive monitoring by licensed personnel) ☐ Sees physician or mental health professional? ☐ Receives home health or hospice?	Include condition and frequency:
MEDICATION Number of meds taken in the last three days or on a regular schedule _____ ☐ 0 (no prescribed meds) ☐ 3 (prescribed meds for stable condition) ☐ 6 (prescribed med set-ups/supervision required for stable condition) ☐ 9 (multi prescribed meds with various dosages/times of administration or 9 or more prescribed meds. or total assistance required)	Indicate type of supervision needed and how often: Participant compliance of current regimen:

PARTICIPANT (LAST, FIRST, MI)	DCN	DATE OF BIRTH	DSDS REGION

TREATMENT ☐ 0 (none) ☐ 3 (simple dressings, suppositories, TED hose) ☐ 6 (daily dressings for ulcers, cath. or ostomy care, PRN oxygen) ☐ 9 (dressing changes more than 1 x day, new/unregulated ostomy, cont. oxygen) ☐ Bowel Program ☐ Catheter ☐ Ostomy ☐ Oxygen ☐ Nebulizer	Include type/frequency of treatment:
REHABILITATION ☐ 0 (none) ☐ 3 (1 x week) ☐ 6 (2-3 x week) ☐ 9 (4 or more x week) Receives physician-ordered therapy? ☐ PT ☐ OT ☐ ST ☐ Audiology	Indicate where services are provided and frequency:
RESTORATIVE ☐ 0 (no services) ☐ 3 (maintain current level) ☐ 6 (restore higher functioning level) ☐ 9 (intense teaching/training services to restore to higher functioning level)	Indicate type of training/teaching:
PERSONAL CARE ☐ 0 (none) ☐ 3 (min. assist needed, infrequent incontinence) ☐ 6 (moderate assist needed, frequent incontinence 2-3 x week) ☐ 9 (max. assist needed; continuous incontinence) ☐ Grooming ☐ Bathing/Equipment ☐ Toileting	Indicate the amount and degree of human assistance required:
DIETARY ☐ 0 (no assist) ☐ 3 (min. assist w/ cooking/eating, physician ordered calculated diet) ☐ 6 (mod assist by others, physician ordered diet for an unstable condition) ☐ 9 (max assist/tube feeding) ☐ Prescribed Calculated Diet ☐ Meal Preparation Needed ☐ Tube Feeding ☐ Home Delivered Meals	Indicate type of prescribed diet and/or amount of assistance needed:
MOBILITY ☐ 0 (no human assist) ☐ 3 (periodic human assist) ☐ 6 (direct human assist required for ambulation) ☐ 9 (immobile) ☐ Turning/Positioning ☐ Assistive Device	Indicate type/duration of human assistance and any assistive device needed:
BEHAVIORAL INFORMATION & MENTAL STATUS ☐ 0 (no assist needed) ☐ 3 (periodic human assist) ☐ 6 (moderate human assist) ☐ 9 (maximum human assist ☐ Wanders ☐ Supervised for Safety ☐ Guardian ☐ Withdrawn ☐ Developmental Disability ☐ Conservator ☐ Disoriented ☐ Depression ☐ Power of Attorney ☐ Memory Deficit ☐ Suspicious/Paranoid ☐ Payee ☐ Combative ☐ Delusions	Indicate type and amount of human assistance needed: Recent changes in behavior or dangerous behaviors:

I: CURRENT AUTHORIZATION REVIEW

Was the Care Plan Discussed with the Participant? ☐ Yes ☐ No

Authorized Services Adequately Meet the Needs of the Participant? ☐ Yes ☐ No Explain:

Does the Aide Have the Ability to Perform Tasks as Assigned? ☐ Yes ☐ No

Does the participant need a care plan change? ☐ Yes ☐ No Explain:

Recent change in informal help? ☐ Yes ☐ No Explain:

J: EMERGENCY BACK-UP PLAN

K. DIRECTIONS TO LOCATE, SAFETY CONCERNS IN THE HOME, OR ADDITIONAL COMMENTS

NURSE SIGNATURE	DATE
PARTICIPANT SIGNATURE	DATE
SUPERVISORY NURSE / PHYSICIAN SIGNATURE	DATE