FAX COMPLETED FORM TO:
716-887-7913
Attn: Personal Care Services (PCS)

BlueCross BlueShield of Western New York

PO Box 80 • Buffalo. New York 14240-0080

HOME ASSESSMENT ABSTRACT
(to be completed by RN)

1. REASON FOR PREPARATION
   - ☐ INITIAL EVALUATION FOR PERSONAL CARE
   - ☐ REASSESSMENT FROM _____ TO _____

GENERAL INSTRUCTIONS:

THIS FORM MUST BE COMPLETED FOR MEDICAID PATIENTS RECEIVING PERSONAL CARE SERVICES OR REQUESTING PERSONAL CARE SERVICES.

2. MEMBER NAME

RESIDENT ADDRESS APT NO.

CITY STATE ZIP TEL. NO.

ADDRESS WHERE PRESENTLY RESIDING TEL. NO.

DIRECTIONS TO CURRENT ADDRESS

COUNTY

NEXT OF KIN/GUARDIAN

STREET

CITY STATE ZIP

RELATION TEL NO.

OTHERS PRESENT AT INTERVIEW

NAME RELATIONSHIP

NAME RELATIONSHIP

3. CURRENT LOCATION OF PATIENT
   ☐ HOSPITAL ☐ HRF ☐ HOME

NAME OF FACILITY/ORGANIZATION

STREET

CITY STATE ZIP TEL. NO.

DATE ADMITTED PROJECTED DISCHARGE DATE

4. DIAGNOSIS / ICD9 CODE

5. NOTIFY IN EMERGENCY

NAME

CITY STATE ZIP

RELATION

MEMBER INFORMATION

6. DATE OF BIRTH _____ AGE _____

LANGUAGE(S) SPOKEN/UNDERSTANDS _____

SEX ☐ MALE ☐ FEMALE

MARITAL STATUS ☐ MARRIED ☐ SEPARATED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ UNKNOWN

LIVING ARRANGEMENTS:
- ☐ ONE FAMILY HOUSE
- ☐ HOTEL
- ☐ MULTI-FAMILY HOUSE
- ☐ APARTMENT
- ☐ FURNISHED ROOM
- ☐ BOARDING HOUSE
- ☐ SENIOR CITIZEN HOUSING
- ☐ IF WALK-UP FLIGHTS (# OF FLIGHTS ____)
- ☐ OTHER, SPECIFY _____

LIVES WITH: ☐ SPOUSE ☐ ALONE ☐ OTHER _____

5430-2.pub 03/12

Name _____ Date of Birth _____

Landlord's Name	Telephone No.
Address	

SERVICES AVAILABLE	FACILITIES	
☐ Laundry	☐ Refrigerator	☐ Washing Machine
☐ Linens	☐ Cooking Facilities	☐ Dryer
☐ Cleaning Services	☐ Sink	☐ Air Conditioner
☐ Meals (☐ B ☐ L ☐ D ☐ ALL)	Working Smoke Detector	☐ Yes ☐ No

OTHER (specify)

Is rent payment current? ☐ Yes ☐ No

7. **OTHERS IN HOME/HOUSEHOLD:** Indicate days/hours that these persons will provide care to patient. If none will assist, explain in narrative.

	NAME	Age	Relationship	Days/Hours at Home	Days /Hours will Assist
1.					
2.					
3.					
4.					

8. **SIGNIFICANT OTHERS OUTSIDE OF HOME:** Indicate days/hours that these persons will provide care to patient.

	Name	Address	Age	Relationship	Days/Hours Assisting
1.					
2.					
3.					
4.					
5.					

9. **COMMUNITY SUPPORT:** Indicate organization/persons serving patient at present or has provided a service in the past six (6) months.

	Organization	Type of Service	Presently Receiving	Contact Person	Tel No.
1.					
2.					
3.					
4.					
5.					

Name _____ Date of Birth _____

10. **MEMBER TRAITS**	Yes	No	?N/A	If you check No, ? or N/A, describe
Appears self directed and/or independent				
Seems to make appropriate decisions				
Can recall med routine/recent events				
Participates in planning/treatment program				
Seems to handle crises well				
Accepts diagnosis				
Motivated to remain at home				

11. **FAMILY TRAITS (Complete as appropriate):**	Yes	No	?	
Is motivated to keep patient home				If no, because
Is capable of providing care (physically & emotionally)				If no, because
Will keep patient home if not involved with care				Because
Will give care if support service given				How much
Requires instructions to provide care				In what – who will give

12. **HOME/PLACE WHERE CARE WILL BE PROVIDED:**	Yes	No	?	If problem, describe
Neighborhood secure/safe				
Housing adequate in terms of:				
Space				
Convenient toilet facilities (own or share)				
Heating adequate and safe				
Air conditioning				
Cooking facilities & refrigerator				
Meals ☐ B ☐ L ☐ D ☐ All				
Laundry facilities				
Sink/tub/shower/hot water				
Elevator				
Telephone accessible & usable				
Is patient mobile in house				
Any discernable hazards (please circle)				Leaky gas, poor wiring, unsafe floors, steps, other (specify)
Construction adequate				
Excess use of alcohol/drugs by patient/caretaker; smokes carelessly.				
Is patient's safety threatened if alone?				
Pets				

Name _____ Date of Birth _____

DESCRIBE OVERALL HOME CONDITIONS (cleanliness, physical condition, type of pets, etc.):

_____

_____

_____

13. **RECOVERY POTENTIAL ANTICIPATED** COMMENTS

Full recovery	☐	_____
Recovery with patient management residual	☐	_____
Limited recovery managed by other	☐	_____
Deterioration	☐	_____

MEMBER PROFILE

14. **PRESENTING PROBLEMS** – Why are home care services needed at this time?

- ☐ Change in medical status
- ☐ Change in financial status
- ☐ Change in social status/support systems

Explain changes that precipitated this need and how member managed prior to request:

_____

_____

_____

_____

Name _____ Date of Birth _____

15. **DESCRIBE THE MEMBER, IN ALL OF THE FOLLOWING AREAS, IN NARRATIVE FORM:**

1. APPEARANCE: _____

2. ALERTNESS/RESPONSIVENESS: _____

3. PERCEPTION OF CIRCUMSTANCES AND PREFERENCES/MOTIVATION: _____

4. ABILITY/DESIRE TO COMMUNICATE: _____

5. ABILITY TO MANAGE FINANCIAL AFFAIRS: _____

SERVICES

16. If member is currently attending or receiving services listed below, enter the Provider's name, address and telephone number. If member needs any listed services, check "Needs" column and enter date referred.

	Name	Address	Telephone No.	Needs	IF NEEDED	
					Date Referred	Date of Service
Senior Center						
Adult Day Care						
Meals on Wheels						
Hospice						
Transportation						
Recreation Program						

17. **PERSONAL CARE**

Is member being currently assisted by personal care worker? ☐ Yes ☐ No

If yes, indicate name of worker, name of agency, if any, address, telephone number, # of hours daily and # of days service is provided.

Name of Worker: _____ Name of Agency: _____

Telephone #: _____ Hours of Care: _____

Name _____ Date of Birth _____

18. **FOR THE PATIENT TO REMAIN AT HOME – SERVICES REQUIRED**

	SERVICE REQUIRED	YES	NO	WHO WILL PROVIDE TYPE/FREQ/DUR	AGENCY/FAMILY	AGENCY FREQUENCY
A.	Bathing					
	Dressing					
	Toileting					
	Admin Med.					
	Grooming					
	Spoon feeding					
	Exercise/activity/walking					
	Shopping (food/supplies)					
	Meal preparation					
	Diet Counseling					
	Light housekeeping					
	Personal laundry/household linens					
	Personal/financial errands					
	Other					
B.	Nursing					
	Physical Therapy					
	Home Health Aide					
	Speech Pathology					
	Occupational Therapy					
	Personal Care					
	Homemaking					
	Housekeeping					
	Clinic/Physician					
	Other 1.					
	Other 2.					
C.	Ramps outside/inside					
	Grab bars/hallways/bathroom					
	Commode/special bed/wheelchair					
	Cane/walker/crutches					
	Self-help device, specify					
	Dressing/cath. equipment, etc.					
	Bed protector/diapers					
	Other					
D.	Additional Services (Lab O^2, medication)					
	Telephone reassurance					
	Diversion/friendly visitor					
	Medical social service/counseling					
	Legal/protective services					
	Financial management/conservatorship					
	Transportation arrangements					
	Transportation attendant					
	Home delivered meals					
	Structural modification					
	Other					

19. **SUMMARY OF SERVICE REQUIREMENTS**

Indicate services required, schedule and charges (allowable charge in area)

Services	Provided by	Hrs./Days/Wk.	Date Effective	Est. Duration
Physician				
Nursing				
Home Health Aide				
Physical Therapist				
Speech Pathology				
Resp. Therapy				
Med. Soc. Work				
Nutritional				
Personal Care				
Homemaking				
Housekeeping				
Other (Specify)				
Medical Supplies/Medication 1.				
2.				
3.				
Medical Equipment/PERS 1.				
2.				
3.				
Home Delivered Meals				
Transportation				
Additional Services 1.				
2.				
			SUBTOTAL	
Structural Modification				
Other (Specify) 1.				
2.				

Name _____ Date of Birth _____

20. **Person who will relieve in case of emergency:**

Name	Address	Telephone	Relationship

21. Narrative: Use this space to describe aspects of the patient's care not adequately covered above.

Assessment completed by:

RN	Agency
Date Completed	Telephone No.
Date Completed	Telephone No.

Name _____ Date of Birth _____

Level: PCA I/HSKPR____ PCA II____				Task Sheet			
AM	PM		Comments	AM	PM	Tasks Level II	Comments
		Kitchen:				***Personal Care Bathing:***	
( )	( )	Wash Dishes/Sink		( )	( )	Shower	
( )	( )	Clean Counter Tops/Table		( )	( )	Tub Bath	
		Refrigerator:		( )	( )	Bed Bath	
( )	( )	Clean		( )	( )	Sponge Bath	
( )	( )	Oven/Microwave/Applianc		( )	( )	Transfer Tub/Shower	
( )	( )	Damp Wipe				***Skin Care:***	
		Bathroom:		( )	( )	Apply non-medicated	
( )	( )	Clean Sink				lotion/powder	
( )	( )	Clean Tub				***Grooming:***	
( )	( )	Clean Toilet		( )	( )	Shampoo and Dry	
		Bedroom:		( )	( )	Set and Comb	
( )	( )	Linen Change		( )	( )	Nails: File and Clean Only	
( )	( )	Bed Making		( )	( )	Shaving-Electric Razor Only	
		General:				***Oral Hygeine:***	
( )	( )	Sweep		( )	( )	Brush Teeth or Rinse Mouth	
( )	( )	Mop		( )	( )	Denture Care	
( )	( )	Vacuum				***Dressing Assist With:***	
( )	( )	Dust		( )	( )	Transfer:	
( )	( )	Empty Trash		( )	( )	Supervise/Assist	
		Laundry:		( )	( )	Total Assist	
( )	( )	Wash		( )	( )	Turn and Position	
( )	( )	Dry		( )	( )	Up in Chair	
( )	( )	Laundromat				***Ambulation:***	
		Other Duties:		( )	( )	Assist/Supervise	
( )	( )	Errands		( )	( )	WC/Cane/Walker/Outdoors	
( )	( )	List Needed Supplies				***Toileting:***	
( )	( )	Grocery Shopping		( )	( )	Change "Attends"	
				( )	( )	Empty & Clean Commode	
				( )	( )	Empty & Clean Pan/Urinal	
				( )	( )	Empty & Clean Drainage Bag	
Member's Name				( )	( )	Transfer/Assist	
						Meal Preparation Diet	
Address				( )	( )	Assist/Prepare	
				( )	( )	Breakfast	
Phone Number				( )	( )	Lunch/Snack	
				( )	( )	Dinner	
Primary Care Physician						***Feeding:***	
				( )	( )	Cut Food	
Days & Hours				( )	( )	Feed	