Nevada Medicaid – Division of Health Care Financing and Policy

Functional Assessment for Personal Care Services (PCS)

Assessment Date: Time In: Time Out:

Recipient Name:		Recipient ID:		
DOB:	Age:	Height: ___ ′ _____ ″	Weight: lbs.	Gender: ☐ Male ☐ Female
Individuals legally responsible to provide medical support include spouses of recipients and parents of minor recipients including stepparents, foster parents and legal guardians.				
Name of Legally Responsible Individual (LRI):				
LRI's Relationship to Recipient: ☐ Self ☐ Parent ☐ Spouse ☐ Guardian ☐ Other, *specify*:				
Others in household and their relationship to recipient *(e.g., Mary Smith=sister, John Smith=uncle)*:				
Is the Personal Care Assistant (PCA) related to the recipient? ☐ Yes ☐ No *If yes,* specify PCA's relationship to recipient:				
PCA Name:		Does the PCA live in the recipient's home? ☐ Yes ☐ No		
Primary Source of Information: ☐ Recipient ☐ Other, *specify relationship to recipient*:				

Recipient and Household Routine:

Overview of Recipient's Health Status, Expectations, Needs and Goals:

Structural/Physical Barriers *(Check all that restrict independent mobility.)*

☐ None ☐ Stairs inside home which must be used for daily living ☐ Stairs inside home, optional use (e.g., laundry)
☐ Stairs leading from inside house to outside (only access) ☐ Narrow or obstructed doorways
☐ Other, *specify*:

Sensory Status *(Check all that apply.)*

Language

- ☐ 0 - Expresses complex ideas/needs clearly with no observable impairment.
- ☐ 1 - Minimal difficulty in expressing ideas/needs. May need extra time or minimal prompting. Speech is intelligible.
- ☐ 2 - Expresses simple ideas/needs with moderate difficulty.
- ☐ 3 - Has severe difficulty expressing basic ideas/needs and requires maximal assistance/guessing by listener.
- ☐ 4 - Recipient is responsive, but unable to express basic needs even with maximal prompting/assistance.
- ☐ 5 - Recipient is unresponsive. Unable to speak.
- ☐ 6 - Age appropriate.

Hearing and Auditory Comprehension of Language

- ☐ 0 - No observable impairment with or without corrective hearing aide, as applicable.
- ☐ 1 - With minimal difficulty, able to hear and understand most multi-step instructions.
- ☐ 2 - Has moderate difficulty hearing and understanding simple, one-step instructions. Needs frequent prompting assistance.
- ☐ 3 - Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations and/or additional time.
- ☐ 4 - Unable to hear and understand familiar words consistently.
- ☐ 5 - Not determined.

Vision (With Corrective Lenses as Applicable)

- ☐ 0 - Normal vision. Sees adequately including medication labels.
- ☐ 1 - Partially impaired. Cannot see newsprint or medication labels. Can see obstacles in path.
- ☐ 2 - Severely impaired. Cannot see obstacles. Cannot find way around without feeling or using cane. Cannot locate objects without hearing or touching.
- ☐ 3 - Completely blind. Compensates adequately.
- ☐ 4 - Completely blind. As yet, unable to compensate.

Mobility

- ☐ 1 - Ambulates unassisted.
- ☐ 2 - Modified mobility with or without assistive devices.
- ☐ 3 - Non-ambulatory, non-mobile.

Comments and Additional Information:

Recipient Name: Recipient ID:

Activities of Daily Living (ADLs)

Use the following sections to detail the recipient's functional ability and need. Authorize time only when the PCA will be performing the task. The times shown for each task are the maximums and should not routinely be authorized. PCAs are expected to employ multi-tasking techniques whenever possible. The amount of time for any particular task must be determined in consideration of:

- The amount of assistance the recipient will usually need;
- Availability of the LRI to assist with the task;
- Specific activities that need to be accomplished;
- Environmental or housing factors that may serve as a barrier to service delivery;
- Recipient's unique circumstances; and
- Recipient's lifestyle choices.

A. Bathing: Bathing or washing the recipient whether tub/shower/bed. Includes entering tub/shower, washing/rinsing body and hair, drying and applying lotion to the body.
Dressing: Changing from sleepwear to clothes and back. Includes application of prosthetics/orthotics.
Grooming: Combing/Brushing hair, shaving, brushing teeth, nail care.

- ☐ **0 - Independent:** Does not need help or supervision of another person.
- ☐ **1 - Intermittent Supervision or Minimal Assistance:** Needs occasional reminders or instruction or needs assistance into and out of the tub/shower or washing difficult areas; does not need physical presence of another person at all times to dress, lay out clothes or fasten clothes; does not need physical presence of another person at all times to groom.
- ☐ **2a - Constant Supervision:** Needs another person constantly present during this activity for instruction or safety, but does not need physical help.
- ☐ **2b - Help of Another:** Needs physical help and presence of another person during the entire activity. Recipient is able to physically participate. Includes bed or chair bath.
- ☐ **3 - Dependent on Another:** Needs physical help from other person. Recipient is unable to physically participate.
- ☐ **N/A -** Not age appropriate.

Factors directly impacting level of function:
☐ Mobility deficit ☐ Cognitive/Behavior ☐ Endurance ☐ Sensory deficit ☐ Other

Frequency: Bathing/Dressing/Grooming is/are done _____ times per day.

Time of Day: ☐ AM ☐ Noon ☐ PM ☐ HS

Bathing/Dressing/Grooming
Maximum allowable is 60 minutes per day.

If different amounts of time are needed on different days, use spaces under Items 1 and 2 below to specify.

1. Minutes per day: _____
Days per week: _____
Total Minutes: 0

2. Minutes per day: _____
Days per week: _____
Total Minutes: 0

Minutes per week: 0

This task is completed with or without an assistive device by:
☐ Recipient ☐ Family/Spouse
☐ PCA ☐ Other, *specify*:

Comments:

Identify the specific tasks requiring assistance with bathing.

☐ Standby assistance
☐ Assisting in/out of tub/shower
☐ Assisting with back
☐ Sponge bathing and drying
☐ Bed bathing and drying
☐ Tub bathing and drying
☐ Cleaning up after the bath, shower
☐ Showering and drying
☐ Shampooing/Washing hair

Bathing Routine:

Identify the specific tasks requiring assistance with dressing.

☐ Dressing recipient, completely
☐ Dressing recipient, partially
☐ Standby assistance
☐ Undressing recipient, completely
☐ Undressing recipient, partially
☐ Laying out clothes
☐ House clothes
☐ Street attire

Dressing Routine:

Identify the specific tasks requiring assistance with grooming.

☐ Shaving face ☐ Electric ☐ Razor
☐ Caring for finger nails
☐ Applying nonprescription lotion to skin
☐ Drying hair
☐ Brushing teeth/Denture care
☐ Laying out supplies
☐ Washing hands and face
☐ Combing/Brushing hair
☐ Shaving legs and/or underarms
☐ Standby assistance
☐ Assisting with setting/rolling/braiding hair (does not include permanents, cutting or chemical processing)

Grooming Routine:

Recipient Name: Recipient ID:

B. Toileting: Bowel and bladder elimination, including use of toileting equipment such as commode, cleansing self after elimination and adjusting clothes.

- ☐ **0 - Independent:** Does not need help or supervision of another person (includes recipient who manages problems of dribbling or incontinence).
- ☐ **1 - Intermittent Supervision or Minimal Assistance:** Needs intermittent supervision or cueing or minor assistance, e.g., clothes adjustment or washing hands. No incontinence.
- ☐ **2 - Constant Supervision or Help of Another:** Usually continent of bowel and bladder, but needs and receives supervision and/or physical assistance with major parts or all parts of the task including bowel and/or bladder programs and appliances, e.g., colostomy, ileostomy, urinary catheter, bed pan, incontinent product used as precaution.
- ☐ **3 - Dependent on Another:** Incontinent of bowel and/or bladder, diapered constantly. Recipient is unable to participate.
- ☐ **N/A -** Not age appropriate.

Factors directly impacting level of function:

☐ Mobility deficit ☐ Cognitive/Behavior ☐ Endurance ☐ Sensory deficit ☐ Other

Frequency: Toileting is done ____ times per day.

Time of Day: ☐ AM ☐ Noon ☐ PM ☐ HS

Toileting
Maximum allowable is 30 minutes per day.

Minutes per day: _____

Days per week: _____

Total minutes per week: 0

This task is completed with or without an assistive device by:

☐ Recipient ☐ Family/Spouse
☐ PCA ☐ Other, *specify*:

Comments:

Identify the specific tasks requiring assistance with toileting.

- ☐ Changing diapers
- ☐ Assisting with use of urinal
- ☐ Assisting with toilet hygiene (includes use of toilet paper and washing hands)
- ☐ Applying nonprescription lotion to perineal or rectal area
- ☐ Stand-by assistance
- ☐ Assisting with feminine hygiene needs
- ☐ Changing colostomy bag/emptying catheter bag
- ☐ Assisting on or off bed pan
- ☐ Assisting with clothing during toileting
- ☐ Set up supplies and equipment (does not include preparing catheter equipment)

Toileting Routine:

C. Transfers and Positioning: The movement from one stationary position to another, e.g., to/from bed, chair, standing. Includes adjusting/changing recipient's position in bed/chair.

- ☐ **0 - Independent:** Requires no supervision or physical assistance to complete necessary transfers. May use equipment such as railings and trapeze.
- ☐ **1 - Intermittent Supervision or Minimal Assistance:** Needs and receives guidance only. Requires physical presence of another person during transfer, e.g., verbal cuing, guidance.
- ☐ **2 - Requires Help of Another:** Needs physical help and presence of another when transferring. Recipient is able to participate.
- ☐ **3 - Dependent on Another:** Needs physical help from other person or mechanical device to carry out this activity, e.g., Hoyer lift. Recipient is unable to physically participate.
- ☐ **N/A -** Not age appropriate.

Factors directly impacting level of function:

☐ Mobility deficit ☐ Cognitive/Behavior ☐ Endurance ☐ Sensory deficit ☐ Other

Frequency: Transfers and positioning are done ____ times per day.

Time of Day: ☐ AM ☐ Noon ☐ PM ☐ HS

Transfers and Positioning
Maximum allowable is 30 minutes per day. Not to exceed 10 minutes per transfer.

Minutes per day: _____

Days per week: _____

Total minutes per week: 0

This task is completed with or without an assistive device by:

☐ Recipient ☐ Family/Spouse
☐ PCA ☐ Other, *specify*:

Comments:

Identify the specific tasks requiring assistance with transfers and positioning.

- ☐ Non-ambulatory movement from one stationary position to another (transfer)
- ☐ Adjusting or changing recipient's position in bed or chair (positioning)
- ☐ Uses slide board or Hoyer lift

Transfers and positioning routine:

Recipient Name: Recipient ID:

D. Mobility/Ambulation: The process of moving between locations, e.g., bedroom to living room.

- ☐ **0 - Independent:** Ambulatory without a device.
- ☐ **1 - Requires Assistance of a Device Independently or with Intermittent Supervision:** Can use a device such as cane, walker, crutch or wheelchair without physical help of another person, but may require some supervision.
- ☐ **2 - Requires Limited Physical Assistance:** Needs help of another person to negotiate stairs or home ramp and/or to lock/unlock wheelchair brakes.
- ☐ **3 - Needs Constant Physical Help of Another Person:** Total dependence with propelling wheelchair. Includes persons who remain bedfast.
- ☐ **N/A** - Not age appropriate.

Factors directly impacting level of function:

☐ Mobility deficit ☐ Cognitive/Behavior ☐ Endurance ☐ Sensory deficit ☐ Other

Frequency: Mobility/Ambulation is done ____ times per day.

Time of Day: ☐ AM ☐ Noon ☐ PM ☐ HS

Mobility/Ambulation
Maximum allowable is 15 minutes per day.

Minutes per day: _____

Days per week: _____

Total minutes per week: 0

This task is completed with or without an assistive device by:

☐ Recipient ☐ Family/Spouse
☐ PCA ☐ Other, *specify*:

Comments:

Identify the specific tasks requiring assistance with mobility/ambulation.

☐ Assist with rising from a sitting to a standing position and/or position for use of walking apparatus
☐ Assist with putting on or removing leg braces and prostheses for ambulation
☐ Assisting with ambulation/using steps
☐ Standby assistance with ambulation
☐ Assistance with manual wheelchair ambulation

Mobility/Ambulation Routine:

E. Eating: The process of getting food into the digestive system. Meal preparation is excluded. Excludes special feeding techniques or G-tube feedings.

- ☐ **0 - Independent:** Feeds self without help of any kind. Includes drinking from a glass and cutting food with a knife.
- ☐ **1 - Needs and Receives Personal Supervision:** Reminders in eating or programming in eating.
- ☐ **2 - Requires Limited Physical Assistance and/or Constant Supervision:** Needs help of another person to cut meat, arrange food, butter bread, etc. at meal time.
- ☐ **3 - Needs Physical Help of Another Person:** Recipient can participate. Recipient may require assistance with application of orthotics or in using assistive feeding device.
- ☐ **4 - Needs and Receives Total Feeding From Another Person:** Includes spoon feeding.
- ☐ **N/A -** Not age appropriate.

Factors directly impacting level of function:

☐ Mobility deficit ☐ Cognitive/Behavior ☐ Endurance ☐ Sensory deficit ☐ Other

Frequency: Eating assistance is needed ____ times per day.

Time of Day: ☐ AM ☐ Noon ☐ PM ☐ HS

Eating
Maximum allowable is 45 minutes per day. Not to exceed 15 minutes per meal.

Minutes per day: _____

Days per week: _____

Total minutes per week: 0

This task is completed with or without an assistive device by:

☐ Recipient ☐ Family/Spouse
☐ PCA ☐ Other, *specify*:

Comments:

Identify the specific tasks requiring assistance with eating.

☐ Spoon feeding
☐ Bottle feeding
☐ Set-up of utensils or adaptive devices
☐ Assistance with eating or drinking utensils or adaptive devices
☐ Cutting up foods
☐ Standby assistance or encouragement

Eating Routine:

Assessor Name *(please print or type)*: _____

Assessor Signature **Date**

Recipient Name: Recipient ID:

Instrumental Activities of Daily Living (IADLs)

Recipient must have deficits that preclude them from actively shopping, doing their laundry, completing light housekeeping tasks or preparing meals and there is not a willing and capable caregiver available. Indicate if the recipient is functionally independent with IADLs (Box 1) or meets criteria as described in either Box 2A or 2B.

1. ☐ **Recipient is functionally independent in IADLs with or without modifications (or has alternative resource).**
Does not meet criteria for assistance with IADLs.

2A. ☐ **Recipient has extensive impairments (level 2 or higher) in the following ADLs.**
Check all areas that scored a level 2 or higher on this assessment.

☐ Bathing/Dressing/Grooming ☐ Toileting ☐ Transfers and Positioning ☐ Mobility/Ambulation ☐ Eating

Comments:

2B. Check all that apply and provide supporting information for each item checked.

☐ **1. Mobility deficits/impairments** of an extensive nature (level 2 or higher on the Functional Assessment) which require use of an assistive device and which directly impacts the recipient's ability to safely perform household tasks or meal preparation independently.
Example: The recipient has severe rheumatoid arthritis which prevents him/her from manipulating or accessing needed equipment.
Supporting Information:

☐ **2. Cognitive deficits** that directly impact the recipient's ability to safely perform household tasks or meal preparation independently.
Example: Recipient has severe short-term memory loss and needs constant cueing to follow through and complete the needed task.
Supporting Information:

☐ **3. Endurance deficits** that directly impact the recipient's ability to complete a task without experiencing substantial physical stressors.
Example: Recipient has advanced COPD and experiences shortness of breath with minimal exertion.
Supporting Information:

☐ **4. Sensory deficits** that directly impact the recipient's ability to safely perform household tasks or meal preparation independently.
Example: Recipient has vision loss and has not established compensatory skills to be safe and effective when alone in the community.
Supporting Information:

F. Light Housekeeping: Services are integral to personal care and might include changing the recipient's bed linens and cleaning areas used by the recipient.

☐ 0 - Performs light housekeeping without assistance.
☐ 1 - Performs light housekeeping without assistance, but may need reminding or supervision.
☐ 2 - Able to do light housekeeping, but requires physical assistance or cueing from another.
☐ 3 - Needs physical help and presence of another person. Recipient is able to physically participate.
☐ 4 - All light housekeeping must be done by others.
☐ N/A - Not age appropriate.
☐ N/A - Resides with LRI.

Factors directly impacting level of function:
☐ Mobility deficit ☐ Cognitive/Behavior ☐ Endurance ☐ Sensory deficit ☐ Other

Identify the specific tasks requiring assistance with light housekeeping.
☐ Emptying and cleaning bedside commode ☐ Changing bed linens ☐ Making bed
☐ Carrying out trash, setting out trash for pick-up ☐ Cleaning floor of living areas used by recipient
☐ Dusting ☐ Cleaning stove-top, counters, washing dishes
☐ Cleaning bathroom, e.g., tub/shower, toilet, sink, floor

Light Housekeeping Routine:

Light Housekeeping
Maximum allowable is 60 minutes per week.

Total minutes per week: _____

This task is completed with or without an assistive device by:
☐ Recipient ☐ Family/Spouse
☐ PCA ☐ Other, *specify*:

Comments:

G. Laundry: Identify the recipient's ability to do any part of their laundry (*excludes ironing).*

- ☐ 0 - Can wash all personal items and linen without assistance.
- ☐ 1 - Does laundry without assistance, but may need reminding or supervision.
- ☐ 2 - Able to do laundry, but needs special physical assistance or cueing from another.
- ☐ 3 - Needs physical help and presence of another person during all of this activity to complete task. Recipient is able to physically participate.
- ☐ 4 - Personal laundry and linens must be done by others.
- ☐ N/A - Not age appropriate.
- ☐ N/A - Resides with LRI.

Factors directly impacting level of function:
☐ Mobility deficit ☐ Cognitive/Behavior ☐ Endurance ☐ Sensory deficit ☐ Other

Identify the specific tasks requiring assistance with laundry:
☐ Doing hand wash ☐ Gathering and sorting ☐ Folding and putting away clothes
☐ Loading and unloading machines in residence ☐ Using offsite laundromat machines
☐ Hanging clothes to dry

Laundry Routine:

Laundry

Maximum allowable is 60 minutes per week when washer/dryer is on site or 120 minutes per week when there is no washer/dryer on site and laundry must be taken to a laundromat.

Total minutes per week: _____

This task is completed with or without an assistive device by:
☐ Recipient ☐ Family/Spouse
☐ PCA ☐ Other, *specify*:

Comments:

H. Essential Shopping: Items required specifically for the health and maintenance of the recipient including groceries, prescribed drugs and other household items.

- ☐ 0 - Can shop without assistance.
- ☐ 1 - Shops without physical assistance, but may need reminding and/or help carrying bundles.
- ☐ 2 - Requires physical assistance of another. Recipient is able to participate.
- ☐ 3 - Totally dependent. Unable to participate in shopping at all.
- ☐ N/A - Not age appropriate.
- ☐ N/A - Resides with LRI.

Factors directly impacting level of function:
☐ Mobility deficit ☐ Cognitive/Behavior ☐ Endurance ☐ Sensory deficit ☐ Other

Identify the specific tasks requiring assistance with shopping.
☐ Preparing shopping list ☐ Picking up medication or DME
☐ Going to store and purchasing or picking up items ☐ Putting food away
☐ Assistance with carrying groceries into the home

Shopping Routine:

Essential Shopping

Maximum allowable is 60 minutes per week when distance to the nearest store is less than 20 miles one way; maximum allowable is 120 minutes per week when distance to the nearest store is greater than 20 miles one way.

Total minutes per week: _____

This task is completed with or without an assistive device by:
☐ Recipient ☐ Family/Spouse
☐ PCA ☐ Other, *specify*:

Comments:

I. Meal Preparation: Essential to meeting a recipient's health needs, which includes activities such as menu planning, storing, preparing and serving food and clean up.

- ☐ 0 - Takes care of all areas of food preparation and clean up.
- ☐ 1 - Heats and serves prepared meals/foods without physical assistance or prompting.
- ☐ 2 - Prepares cold foods or simple meals, e.g., sandwiches, oatmeal, toast. May require prompting.
- ☐ 3 - Requires physical assistance of another to prepare meal. Recipient can participate.
- ☐ 4 - Meals and snacks must be completely prepared and served to recipient.
- ☐ N/A - Not age appropriate.
- ☐ N/A - Resides with LRI.

Factors directly impacting level of function:
☐ Mobility deficit ☐ Cognitive/Behavior ☐ Endurance ☐ Sensory deficit ☐ Other

Identify the specific tasks requiring assistance with meal preparation:
☐ Cooking full meal ☐ Warming up prepared food (including Meals on Wheels)
☐ Planning meals ☐ Helping prepare meals ☐ Serving food
☐ Grinding and pureeing food ☐ Clean-up

Meal Preparation Routine:

Meal Preparation
Maximum allowable is 90 minutes per day not to exceed 30 minutes per meal.

Breakfast: _____
Lunch: _____
Dinner: _____

Minutes per day: 0
Days per week: _____
Total minutes per week: 0

This task is completed with or without an assistive device by:
☐ Recipient ☐ Family/Spouse
☐ PCA ☐ Other, *specify*:

Comments:

Recipient Name: Recipient ID:

Functional Assessment Summary

The table below is populated from information entered on pages 2-6 of this form. Divide "Total Minutes Per Week" by 60 as described below, then use this information to complete the "Authorized Service Hours" section on the Service Plan that follows.

		Minutes Per Week	Days Per Week
ADLs	Bathing/Dressing/Grooming	0	+ = 0
	Toileting	0	
	Transfers and Positioning	0	
	Mobility/Ambulation	0	
	Eating	0	
IADLs	Light Housekeeping		
	Laundry		
	Shopping		
	Meal Preparation	0	
Total Minutes Per Week:		0	

Divide "Total Minutes Per Week" by 60 and enter the quotient below.
Use decimals and round to the nearest ¼ hour (e.g., .25 hours = 15 minutes).

___0___ *Total Minutes Per Week ÷ 60 =* _____ *Total Hours Per Week*

Nevada Medicaid – Division of Health Care Financing and Policy

Service Plan for Personal Care Services (PCS)

Is this recipient at risk? ☐ Yes ☐ No Refer recipient to DHCFP? ☐ Yes ☐ No

Service Type: ☐ Initial ☐ Redetermination ☐ Update		
Recipient Name:	Recipient ID:	
DOB:	Age:	Gender: ☐ Male ☐ Female
Phone:	Address *(include city, state, zip)*:	
Name of Legally Responsible Individual (LRI):		
LRI's Relationship to Recipient: ☐ Self ☐ Parent ☐ Spouse ☐ Guardian ☐ Other, *specify*:		
Others in household and their relationship to recipient *(e.g., Mary Smith=sister, John Smith=uncle)*:		
Personal Care Assistant (PCA) relationship to recipient (if applicable)		
PCA Name:	Does the PCA live in the recipient's home? ☐ Yes ☐ No	
Housing: ☐ House ☐ Apartment ☐ Mobile Home ☐ Supervised Housing ☐ Other *(specify)*:		
Transportation: ☐ Private Vehicle ☐ Public Transportation ☐ Medicaid Transportation ☐ Other *(specify)*:		
Primary Health Care Professional:	Address:	Phone:
Hospital Preference:	Advance Directive: ☐ Yes ☐ No	Allergies:
Medicare Eligible? ☐ Yes ☐ No Medicare Number:	Name of Other Insurance:	Veteran? ☐ Yes ☐ No
Overview of Recipient's Health Status, Expectations, Needs and Goals:		

Health Problems: ☐ Arthritis ☐ BP ☐ Cancer ☐ Cardiac ☐ Communicable Disease ☐ Diabetes ☐ Kidney
☐ Intestinal ☐ Neurologic ☐ Neuromuscular ☐ Paralysis ☐ Prostate ☐ Pulmonary ☐ Skeletal ☐ Thyroid

Diet: ☐ General ☐ Diabetic ☐ Low Salt ☐ Other *(specify)*:

ICD-9 CODE	MEDICAL DIAGNOSES	MEDICATION, DOSE, FREQUENCY	MEDICATION, DOSE, FREQUENCY

Compliance with Medical Regimen: ☐ Good ☐ Poor

ASSISTIVE DEVICES: H = Has, U = Uses, N = Needs

H	U	N		H	U	N		H	U	N		H	U	N	
☐	☐	☐	Lift/Hoyer	☐	☐	☐	Slide Board	☐	☐	☐	Walker	☐	☐	☐	Other: ____
☐	☐	☐	Commode	☐	☐	☐	Power Chair	☐	☐	☐	Cane/Crutches	☐	☐	☐	Other: ____
☐	☐	☐	Bath/Shower Bench	☐	☐	☐	Manual Chair	☐	☐	☐	Hospital Bed	☐	☐	☐	Other: ____

COMMENTS:

Recipient Name:	Recipient ID:

PATIENT PROFILE/FUNCTIONAL LIMITATION: Check the appropriate boxes: I = Independent, A = Assist, D = Dependent. Enter comments as appropriate. Tasks preceded by an asterisk (*) do not have time authorized under the functional assessment.

Task	I	A	D	Minutes per Day	Days per Week	Comments Task		Comments
Bathing/Dressing/Grooming	☐	☐	☐	-	-		*Telephone	
Toileting	☐	☐	☐				*Vision	
Transfers and Positioning	☐	☐	☐				*Hearing	
Mobility/Ambulation	☐	☐	☐				*Speech	
Eating	☐	☐	☐				*Orientation	
Light Housekeeping	☐	☐	☐		Min./Week		*Medication Reminder	
Laundry	☐	☐	☐		Min./Week		*Transportation	
Essential Shopping	☐	☐	☐		Min./Week			
Meal Preparation	☐	☐	☐	0				

OTHER NEEDS/REFERRALS FOR TREATMENT, THERAPIES, SOCIAL SERVICES AND INFORMAL SUPPORT SYSTEMS

Check the appropriate boxes: R = Receiving Service, N = Needs. *If needs are identified, notify the NMDO.*

R	N		R	N		R	N		R	N	
☐	☐	Respite	☐	☐	Chore Services	☐	☐	Meals on Wheels	☐	☐	Medical/Dental/Ocular
☐	☐	Hospice	☐	☐	CHIPS	☐	☐	Home Health	☐	☐	Legal Services/Guardian
☐	☐	Adult Day Care	☐	☐	Disability Waiver Program	☐	☐	Transportation	☐	☐	OT/PT/Speech
☐	☐	School Based Services	☐	☐	MHDS	☐	☐	DME/Supplies	☐	☐	Companion
☐	☐	At Risk Recipient	☐	☐	Other:	☐	☐	Other:	☐	☐	Other:

AUTHORIZED SERVICE HOURS

In the table below, identify the distribution of service hours.

1. Complete the "Length of Visit" columns first (from left to right), entering the duration of each visit in hours. Use decimals and round to the nearest ¼ hour. For example, .25 hours = 15 minutes, .50 hours = 30 minutes, .75 hours = 45 minutes, etc. The "Hours Per Day" column will automatically add the length of visit columns in that row.
2. Next, in the "Days of Service Per Week" column, enter the number of days per week that this service schedule will be provided. The "Total Hours Per Week" column automatically multiplies "Hours Per Day" by "Days of Service Per Week."
3. **Rows below must be completed from left to right for "Total Hours Per Week" to calculate properly.** If you go back and change the length of a visit or the days of service per week, delete the number in the "Total Hours Per Week" column and then press "Enter" on your keyboard to recalculate that column.

Length of AM Visit	Length of Mid-day Visit	Length of PM Visit	Length of HS Visit	Hours Per Day	Days of Service Per Week	Total Hours Per Week
				0		0
				0		0
				0		0
				0		0

Total Hours Per Week = 0 ← *Number to the left must equal _____ hours.*

COMMENTS:

Daily hours cannot be combined or reconfigured (i.e., 5 hours per day, 7 days per week (35 hours) cannot be changed to 7 hours per day, 5 days per week (35 hours). Unused hours cannot be carried over into the following week. If recipient's needs change, a new assessment must be requested. Authorization of service does not guarantee provider availability.

Recipient Name *(please print or type)*: _____ Assessor Name *(please print or type)*: _____

Recipient Signature	Date	Assessor Signature	Date

Service Plan Attachment

Use the following table if additional space is needed to list all recipient diagnoses and medications.

Recipient Name: ______________________________________ Recipient ID: ________________________

ICD-9 CODE	MEDICAL DIAGNOSES	MEDICATION, DOSE, FREQUENCY	MEDICATION, DOSE, FREQUENCY

Progress Notes

Use the following table to record progress notes as applicable.

Recipient Name: _____ Recipient ID: _____

DATE	TIME	NOTES

PERSONAL CARE AIDE SERVICES HOME CARE CRITERIA

1. I have ongoing Medicaid eligibility and personal care aide (PCA) services have been determined by Nevada Medicaid to be medically necessary;

2. My legally responsible adult(s) is/are unavailable or incapable of providing necessary care;

3. I am capable of making choices about activities of daily living or have a personal representative who assumes this responsibility;

4. I may require periodic professional medical and/or support services under professional supervision. These services are not required on a full-time basis;

5. I understand Medicaid personal care aide (PCA) services must be authorized in accordance with an approved service plan. The service plan prepared by the PCA case manager links personal care aide tasks to my unmet needs as determined by a Functional Assessment. I understand Medicaid authorization for payment of service(s) does not guarantee availability of Medicaid providers;

6. I understand personal care aide services must be medically necessary and meet Nevada Medicaid's utilization control procedures;

7. My legally responsible family members may not be reimbursed for providing care.

I understand the services I will receive must be within the above limits of Nevada Medicaid's Personal Care Aide Program.

In accordance with federal rules and regulations, the Nevada State Division of Health Care Financing and Policy and providers of Medicaid services do not discriminate unlawfully against recipients on the basis of race, color, national origin, sex, religion, age, disability or handicap (including AIDS or AIDS-related conditions). For further information or to file a complaint, please contact the Division of Health Care Financing and Policy civil rights coordinator at (775) 687-4776, or the Office of Civil Rights (OCR), Department of Health and Human Resources, 50 United Nations Plaza, San Francisco, CA 94102 at (415) 437-8310.

Recipient Name	Recipient/Personal Representative Signature	Date
Medicaid #	Service Worker Signature	Date

PERSONAL CARE AIDE SERVICES
RECIPIENT BILL OF RIGHTS

The Recipient's rights are to:

Receive considerate and respectful care at all times, and have property treated with respect;

- Participate in the development of the Service Plan and receive an explanation of services proposed. Receive a written list of alternative resources and referrals that may be available;
- Receive a copy of the service plan;
- Receive the name of the PCA case manager and the Nevada Medicaid district office supervisor's number to be contacted for complaints about caregiver, provider or DHCFP employees;
- Receive assurance that privacy and confidentiality about one's health, social, domestic and financial circumstances will be maintained pursuant to law;
- Know all communications and records will be treated confidentially;
- Expect all providers, within the limits set by the service plan and within program criteria, will respond in good faith to the recipient's reasonable requests for assistance;
- Receive information upon request on Nevada Medicaid's policies and procedures, including information on charges, reimbursements, and service plan determinations;
- Request a change of provider agency or ISO;
- Participate in the plan for discontinuation of service;
- Have access, upon request, to Medicaid payment history;
- Receive a written explanation of the hearing process;
- Request a hearing when a disagreeing with Nevada Medicaid's action to deny, terminate, reduce, or suspend services;
- Receive in writing the name and contact number of an official of Nevada Medicaid and the state ombudsman telephone number.

_____

Recipient/Personal Representative Signature Date

_____

Service Worker Signature Date

PERSONAL CARE AIDE (PCA) SERVICES
RECIPIENT RESPONSIBILITIES

The Recipient's responsibilities are to:

- Notify the provider and PCA case manager of changes in Medicaid eligibility.
- Notify the provider of current insurance information, including the name of other insurance coverage, such as Medicare.
- Notify the provider and PCA case manager of changes in medical status, service needs, address location (if you go on vacation or into a hospital or other facility) or in changes of status of legally responsible family member(s).
- Treat all staff appropriately.
- Sign the PCA delivery record to verify services were provided.
- Notify the provider when scheduled visits cannot be kept or services are no longer required.
- Notify the provider agency of missed visits by provider agency staff.
- Notify the provider agency of unusual occurrences, complaints regarding delivery of services, specific staff and/or requests for a change in caregivers.
- Supply the provider agency with a copy of advance directives.
- Establish a backup plan in the event a PCA is unable to work at the scheduled time.
- Not request your PCA work more than the hours authorized on your service plan.
- Not request your PCA work or clean for non-recipient family or household members.
- Not request your PCA provide services not on the service plan.
- Contact the district office PCA case manager to request a change of provider agency or ISO.

_____

Recipient/Personal Representative Signature Date

_____

Service Worker Signature Date