Nevada Medicaid: Functional Assessment Service Plan

Recipient Signature Page

1. Recipient information							
Last name:		First name:					
Recipient ID:		Date of birth:					
Translator required:	☐ Yes ☐ No	Language:					
Address:							
City:		State:	NV	Zip code:		Phone:	
☐ Male ☐ Female	HT:	Feet	Inches	WT:		Age:	

1. I have received a copy of the following documents:
   - Provider Responsibilities
   - Recipient Rights and Responsibilities
   - Program Criteria
2. I, my Legally Responsible Individual, or personal care representative participated in the assessment process, providing accurate information to the best of my/their ability.
3. The physical/occupational therapist arrived (enter date of the assessment, along with the start and end times of the assessment):
   - Date:
   - Begin time: ☐ a.m. ☐ p.m.
   - End time: ☐ a.m. ☐ p.m.

By signing below, I acknowledge the above information is correct. My signature does not indicate that I agree or disagree with the final outcome of the assessment.

Print Name (Recipient/LRI/PCR) _____ Signature _____ Date _____

Identify relationship of person signing this form:

☐ Self ☐ Legally Responsible Individual (LRI) ☐ Personal Care Representative (PCR)

☐ Other (please specify):

At Risk Recipient: ☐ YES ☐ NO

Date of Assessment:

2. Legally responsible individual (LRI) information (if applicable)			
LRI name:		Phone:	
Does LRI reside in the home with recipient?	☐ Yes ☐ No	Relationship to recipient:	

Identify the living arrangements of the LRI:

☐ Resides in the Home ☐ Disabled ☐ Works/Attends school (specify hours/days):

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3. Emergency contact information Complete this section if recipient has no LRI (such as: POA, family member, personal care representative).			
Contact Name: (*other than recipient*)		Phone:	
Relationship to Recipient:			

4. Daily routine (Describe recipient's usual daily routine)

5. Assessment information

Purpose of request:	Location:	Information obtained from:
☐ Initial ☐ Annual Reassessment ☐ Significant Change in Condition	☐ House ☐ Apartment ☐ Mobile Home ☐ Facility ☐ SLA (Supportive Living arrangement) ☐ Other:	☐ Recipient ☐ Other:

Name of personal care services (PCS) agency:	
Name of personal care aide (PCA):	
Others in household (if children, include ages of the children):	
Allergies (medications, foods, seasonal):	

6. Diagnosis affecting functional ability to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs). For example: affected limbs, affected gait, strength, endurance, etc.

Diagnosis	Diagnosis	Diagnosis

7. Medications

Medication/dosage/frequency	Medication/dosage/frequency

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8. Objective observations of functional ability including serious events over the past year

9. Functional deficits (check all that apply)

Mobility

Mobility/Range of motion:

Gait: ☐ Independent ☐ Independent with Device ☐ Mildly impaired ☐ Moderately impaired ☐ Severely impaired ☐ Non-ambulatory ☐ Bed bound ☐ Other/Comment:

Dominate Side: ☐ Right ☐ Left ☐ N/A

Right Arm: ☐ Full Use ☐ Mildly impaired ☐ Moderately impaired ☐ Severely impaired ☐ Other/Comment:

Left Arm: ☐ Full Use ☐ Mildly impaired ☐ Moderately impaired ☐ Severely impaired ☐ Other/Comment:

Right Leg: ☐ Full Use ☐ Mildly impaired ☐ Moderately impaired ☐ Severely impaired ☐ Other/Comment:

Left Leg: ☐ Full Use ☐ Mildly impaired ☐ Moderately impaired ☐ Severely impaired ☐ Other/Comment:

10. Sensory deficits (check all that apply)

Vision:

☐ Within normal limits without glasses ☐ Within normal limits with glasses ☐ Glasses ☐ Reading glasses

Vision Impaired:

Right Eye: ☐ Partially impaired ☐ Blind ☐ Other/Comment:

Left Eye: ☐ Partially impaired ☐ Blind ☐ Other/Comment:

Both Eyes: ☐ Partially impaired ☐ Blind ☐ Other/Comment:

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10. Sensory deficits (check all that apply)

Auditory:

☐ Within normal limits with or without hearing aids

Decreased hearing: ☐ Hearing aids ☐ Deaf

☐ Other/Comment:

Pain (affecting ability to do ADLs/IADLs):

☐ Pain scale 0 to 10: ____ If >0 indicate location/type of pain:

☐ Other/Comment:

Touch/Sensation:

☐ Within normal limits

☐ Other/Comment:

11. Cognitive deficits (check all that apply)

Memory/Cognitive:

☐ Within normal limits ☐ Not oriented

Oriented to:

☐ Person ☐ Place ☐ Time ☐ Other/comment:

Short term memory loss: ☐ Mild ☐ Moderate ☐ Severe ☐ Other/Comment:

Object Recognition: ☐ Mild ☐ Moderate ☐ Severe ☐ Other/Comment:

Requires cueing:

☐ Able to follow detailed directions ☐ Able to follow simple directions

☐ Unable to follow simple directions

☐ Other/Comment:

Speech/Language:

☐ Within normal limits (able to express and understand) ☐ Slurred speech ☐ Non verbal

☐ Aphasia:

☐ Expressive (difficulty expressing words/sentences)

☐ Receptive (difficulty understanding words/sentences)

☐ Global (difficulty expressing and understanding words/sentences)

☐ Other/Comment:

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12. Endurance deficits - the ability to withstand activities (check all that apply)

☐ Within normal limits ☐ Shortness of breath ☐ Inability to stand > 10 minutes
☐ Fatigues with activity of > 10 minutes ☐ Other(describe):

13. Assistive devices and other services (check all that apply)

Equipment: H=Has U=Uses N=Needs

H	U	N		H	U	N	
☐	☐	☐	Lift/Hoyer	☐	☐	☐	Walker
☐	☐	☐	Commode	☐	☐	☐	Oxygen
☐	☐	☐	Bath/Shower Bench	☐	☐	☐	Lifeline
☐	☐	☐	Manual Chair	☐	☐	☐	Slide Board
☐	☐	☐	Incontinent Supplies	☐	☐	☐	Hospital Bed
☐	☐	☐	Raised Toilet Seat	☐	☐	☐	Diabetic Supplies
☐	☐	☐	Hand Held Shower	☐	☐	☐	Glucometer
☐	☐	☐	Nebulizer	☐	☐	☐	Power Chair
☐	☐	☐	Cane Crutches				
☐	☐	☐	Other:				
☐	☐	☐	Other:				
☐	☐	☐	Other				

Services: R=Receives N=Needs

R	N		R	N	
☐	☐	ADSD aging and disability services			
☐	☐	Disability waiver (WIN)			
☐	☐	Dental	☐	☐	Medical
☐	☐	Ocular	☐	☐	Audiology
☐	☐	Physical Therapy			
☐	☐	Occupational Therapy			
☐	☐	Home Health			
☐	☐	MHDS	☐	☐	ADHC
☐	☐	Companion	☐	☐	Respite
☐	☐	Homemaker			
☐	☐	Transportation			
☐	☐	Home Delivered Meals	☐	☐	Chore
☐	☐	Other			

Note: A box marked "N" does not guarantee Medicaid coverage for that item or service.

Services (check if currently receiving)

☐ ADHC
Attends__ days per week __ hours per day

☐ Work Program
Attends__ days per week __ hours per day

☐ School
Attends __days per week __hours per day

Comments:

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14. Activities of daily living		
Level of Assistance (see instructions document for detail)	Days per week	Score
Bathing/Dressing/Grooming: 0 = Independent 1 = Minimum assist 2 = Moderate assist 3 = Maximum assist Justify score:		
Toileting: 0 = Independent 1 = Minimum assist 2 = Moderate assist 3 = Maximum assist Justify score:		
Transferring: 0 = Independent 1 = Minimum assist 2 = Moderate assist 3 = Maximum assist Justify score:		
Mobility/Ambulation: 0 = Independent 1 = Minimum assist 2 = Moderate assist 3 = Maximum assist 4 = Independent in wheelchair Justify score:		
Eating: 0 = Independent 1 = Minimum assist 2 = Moderate assist 3 = Maximum assist 4 = Non-covered services such as specialized feeding techniques and/or tube feedings. Justify score:		

15. Instrumental activities of daily living (continued to next page)

Recipient must have deficits that preclude them from actively shopping, doing their laundry, completing light housekeeping tasks, or preparing meals and there is not an LRI available. Indicate if the recipient is functionally independent with IADLs or meets criteria as described below.

To qualify for IADLs, the recipient must score a minimum of a Level 2 in two or more areas of ADLs.

Check boxes that apply:

- ☐ Recipient does not have a Level 2 in two or more ADL areas (from Section 14 above) = No IADLs
- ☐ Recipient is functionally independent in IADLs with or without modifications = No IADLs
- ☐ LRI is capable/available to complete IADLs = No IADLs
- ☐ Recipient has other resources to complete IADLs. Identify:

NOTE: If any one of the above four boxes are checked, SKIP TO SECTION 16.

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15. Instrumental activities of daily living (continued from previous page)

☐ PCA to assist or complete IADLs as the recipient has an ADL need in two or more areas at a level 2 or higher and impairments in one of the following that directly impact their ability to perform IADLs:

☐ Mobility deficits ☐ Cognitive deficits ☐ Endurance deficits ☐ Sensory deficits

In the table below, check specific tasks that the recipient requires assistance with to complete.

Level of Assistance (see instructions document for detail)	Days per week	Score
Light housekeeping: 0 = Criteria not met 1 = Level 1 criteria 2 = Level 2 criteria 3 = Level 3 criteria 4 = NA Justify score:	Weekly 1	
Laundry: 0 = Criteria not met 1 = Level 1 criteria 2 = Level 2 criteria 3 = Level 3 criteria 4 = Level 4 criteria 5 = NA Justify score:	Weekly 1	
Essential shopping: 0 = Criteria not met 1 = Level 1 criteria 2 = Level 2 criteria 3 = Level 3 criteria 4 = NA Justify score:	Weekly 1	
Meal preparation: 0 = Criteria not met 1 = Level 1 criteria 2 = Level 2 criteria 3 = Level 3 criteria 4 = Level 4 criteria 5 = NA 6 = Non-covered services Justify score:		

16. Mathematical grid:

NOTE: After values have been made in the 'Days per week' and 'Score' fields in the preceding tables, double-click the embedded Excel spreadsheet below. Enter those values into the appropriate cells of this spreadsheet. Calculations will be automatic after entry. After all values have been entered, click outside of the spreadsheet to close it.

Task	Score	Score = Minutes per day or week	Days per week	Total minutes per task	Hours per week
Bathing/Dressing/Grooming	0	0	0	0	
Toileting	0	0	0	0	
Transferring	0	0	0	0	
Mobility/Ambulation	0	0	0	0	
Eating	0	0	0	0	
Light housekeeping	0	0	1	0	
Laundry	0	0	1	0	
Essential shopping	0	0	1	0	
Meal preparation	0	0	0	0	
			Total Points	0	0.00

Recipient Name: Recipient ID:

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Based on my clinical assessment utilizing the Nevada Medicaid Services Manual (MSM) Chapters 2600, Intermediary Services Organization (ISO) and Chapter 3500, Personal Care Services Program and the Nevada Medicaid Functional Assessment Service Plan Tool, I find the recipient met the criteria for the above hours as indicated on this tool and that no additional hours are medically necessary. Mark Yes or No.

☐ YES ☐ NO

If YES, transfer the hours to Section 18.

If NO, complete Section 17 indicating which of the following tasks require additional time based on objective, clinical observations.

Comments:

17. Override:

Task	Total minutes per task	Additional time to be allowed	New total minutes	Days per week	Total minutes per task	Hours per week
Bathing/Dressing/Grooming	0		0	0	0	
Toileting	0		0	0	0	
Transferring	0		0	0	0	
Mobility/Ambulation	0		0	0	0	
Eating	0		0	0	0	
Light housekeeping	0		0	1	0	
Laundry	0		0	1	0	
Essential shopping	0		0	1	0	
Meal preparation	0		0	0	0	
				Total Points	0	0.00

18. Authorized service hours:

Authorized service hours	
Total hours per week	0.00
Total days per week	
Visits per day	☐ 1 or more ☐ 2 or more ☐ 3 or more

19. Assessor Signature, Title:

Sign and date here after the assessment has been completed:

Print Name _____ Signature _____ Date _____