PreAdmission Screening Tool

Developmentally Disabled/Physically Disabled 0 – 5 (Under Age 6)

Case Information			
AHCCCS ID		Medicare Part D	☐ Yes ☐ No
Person/App ID:			
Type of PAS	☐ Initial ☐ Reassessment ☐ Posthumous		
PSE Name			
PSE Phone			

I. INTAKE INFORMATION

Customer Information			
PAS Date		PAS Time	
Customer Name:			
Age	months		
Birthdate			
Gender	☐ Male ☐ Female		
Location at time of Assessment			
Telephone Number			

DD Status:	☐ Not DD ☐ Potential DD ☐ DD in NF ☐ DD

Prior Quarter:	Month 1:		Month 2:		Month 3:	

Authorized Representative	
Name	
Telephone Number	

Physical Measurements	
Height	Feet Inches
Weight	lbs. oz.
Birth Weight (DD 0-5)	lbs.
Gestational Age (DD 0-5)	

Additional Information

I. Intake Information

PreAdmission Screening
Developmentally Disabled/Physically Disabled
0 – 5 (Under Age 6)

Customer Name

Person ID

1.	Is customer currently hospitalized or in an intensive rehabilitation facility?	☐ YES	☐ NO
2.	If in an acute care facility, is discharge imminent (within 7 days)?	☐ YES	☐ NO
	Projected discharge date:		
3.	Ventilator Dependent?	☐ YES	☐ NO
4.	Number of Emergency Room visits in last 6 months(EPD)		
5.	Number of Hospitalizations in last 6 months(last year for DD 0-5)		
6.	Number of Falls in last 90 days(EPD)		

Personal Contacts					
Contact #1					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #2					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #3					
Name					
Relationship					
Address					
City		State		Zip Code	
Phone Number(s)					
Contact #4					
Name					
Relationship					
Address					

I. Intake Information

PreAdmission Screening
Developmentally Disabled/Physically Disabled
0 – 5 (Under Age 6)

Customer Name

Person ID

City		State		Zip Code	
Phone Number(s)					

Customer Name

Person ID

II. FUNCTIONAL ASSESSMENT
A. DEVELOPMENTAL DOMAIN

All the developmental questions must be answered for all children in this age group.

FOR AGES SIX MONTHS AND OLDER

1.	Does your child lift their head when lying on their back?	☐ Yes	☐ No
Comments:			

2.	When your child is on their tummy, does s/he straighten both arms and push their whole chest off the bed or floor?	☐ Yes	☐ No
Comments:			

3.	If you hold both hands just to balance your child, does s/he support their own weight while standing? (That is, can s/he bear weight?)	☐ Yes	☐ No
Comments:			

4.	Does your child reach for or grasp a toy?	☐ Yes	☐ No
Comments:			

5.	Does your child try to pick up a crumb or Cheerio by using their thumb and all their fingers in a raking motion, even if they aren't able to pick it up? (If they already pick up the crumb or Cheerio, check "yes" for this item.)	☐ Yes	☐ No
Comments:			

6.	Does your child make high-pitched squeals?	☐ Yes	☐ No
Comments:			

7.	Does your child show two or more emotions? (For example, laughs, cries, screams, etc.)	☐ Yes	☐ No
Comments:			

Customer Name Person ID

8.	Does your child act differently toward strangers than s/he does with you and other familiar people? (Reactions to strangers may include, for example, staring, frowning, withdrawing or crying.)	☐ Yes	☐ No
Comments:			

9.	Does your child stiffen and arch their back when picked up? REVERSE SCORING	☐ Yes	☐ No
Comments:			

Stop here if child is less than nine months!

FOR AGES NINE MONTHS AND OLDER

10.	Does your child roll from their back to their tummy, getting both arms out from under them?	☐ Yes	☐ No
Comments:			

11.	When you stand your child next to furniture or the crib rail, does s/he stand, holding onto the furniture for support?	☐ Yes	☐ No
Comments:			

12.	Does your child creep or move on their stomach across the floor?	☐ Yes	☐ No
Comments:			

13.	Does your child sit supported (for example, in a chair with pillows, etc.) for at least 1 minute?	☐ Yes	☐ No
Comments:			

14.	When a loud noise occurs, does your child respond? (For example, act startled, cry or turn toward the sound.)	☐ Yes	☐ No
Comments:			

15.	If you call your child when you are out of their line-of-sight, does s/he look in the direction of your voice?	☐ Yes	☐ No
Comments:			

Customer Name Person ID

16.	Does your child make non-word sounds? (That is, babble or jabber.)	☐ Yes ☐ No
Comments:		

17.	Does your child look toward you (parent or caregiver) when hearing your (parent or caregiver's) voice?	☐ Yes ☐ No
Comments:		

18.	Does your child enjoy playing peek-a-boo/pat-a-cake?	☐ Yes ☐ No
Comments:		

19.	Does your child feed themselves a cracker or cookie?	☐ Yes ☐ No
Comments:		

Stop here if child is less than twelve months!

FOR AGES TWELVE MONTHS AND OLDER

20.	Does your child walk around the furniture while holding on with only one hand?	☐ Yes ☐ No
Comments:		

21.	Does your child crawl at least 5 feet on hands and knees, without stomach touching the floor?	☐ Yes ☐ No
Comments:		

22.	Does your child hold a bottle or cup?	☐ Yes ☐ No
Comments:		

23.	Does your child move an object from one hand to the other?	☐ Yes ☐ No
Comments:		

24.	Does your child pick up a small object with thumb and fingers?	☐ Yes ☐ No

Customer Name Person ID

Comments:	

25. Does your child coo or laugh or make other sounds of pleasure? ☐ Yes ☐ No	
Comments:	

26. Does your child reach for familiar person when person holds out arms to them? ☐ Yes ☐ No	
Comments:	

27. Does your child play with a doll or stuffed animal by hugging it? ☐ Yes ☐ No	
Comments:	

28. Does your child suck or chew on finger foods? (For example, crackers, cookies, toast, etc.) ☐ Yes ☐ No	
Comments:	

Stop here if child is less than eighteen months!

FOR AGES EIGHTEEN MONTHS AND OLDER

29. Does your child stand up in the middle of the room by themselves and take several steps forward? ☐ Yes ☐ No	
Comments:	

30. Does your child climb on furniture? ☐ Yes ☐ No	
Comments:	

31. Does your child turn the pages of a board, cloth or paper book by himself/herself? (S/he may turn more than one page at a time.) ☐ Yes ☐ No	
Comments:	

32. Without showing them how, does your child scribble back and forth when you give them a crayon (or pencil or pen)? ☐ Yes ☐ No	
Comments:	

Customer Name Person ID

33.	Does your child stack a small toy, block, cup, dish or other object on top of another one?	☐ Yes ☐ No
Comments:		

34.	Does your child respond to their name when you call?	☐ Yes ☐ No
Comments:		

35.	When playing with sounds, does your child make grunting, growling or deep-toned sounds? (Examples may include a car, a motor, a train, an animal.)	☐ Yes ☐ No
Comments:		

36.	Does your child say “Da-da” or “Ma-ma” or another name for parent or caregiver (including parent’s or caregiver’s first name or nickname)?	☐ Yes ☐ No
Comments:		

37.	When you ask your child to point to their nose, eyes, hair, feet, ears and so forth, does your child correctly point to at least one body part? (They can point to themselves, you or a doll.)	☐ Yes ☐ No
Comments:		

38.	If you point at a toy across the room, does your child look at it?	☐ Yes ☐ No
Comments:		

39.	Does your child ever use their index finger to point, to indicate interest in something?	☐ Yes ☐ No
Comments:		

40.	Does your child ever bring objects over to you?	☐ Yes ☐ No
Comments:		

41.	Does your child imitate you? For example, you make a face – will your child imitate it?	☐ Yes ☐ No

Comments:	

42. Does your child take an interest in other children? (Includes siblings.) ☐ Yes ☐ No	
Comments:	

43. Does your child eat solid foods? (For example, cooked vegetables, chopped meats, etc.) ☐ Yes ☐ No	
Comments:	

44. Does your child like being hugged or cuddled? ☐ Yes ☐ No	
Comments:	

Stop here if child is less than twenty-four months!

FOR AGES TWENTY-FOUR MONTHS AND OLDER

45. Does your child run? ☐ Yes ☐ No	
Comments:	

46. Does your child jump, with both feet leaving the floor at the same time? (That is, can s/he jump up?) ☐ Yes ☐ No	
Comments:	

47. Does your child flip light switches off and on? ☐ Yes ☐ No	
Comments:	

48. Does your child put a small object in a cup and dump it out? (You may show them how.) ☐ Yes ☐ No	
Comments:	

49. Does your child stack at least four small toys, blocks, cups, dishes or other objects on top of each other? ☐ Yes ☐ No	
Comments:	

Customer Name Person ID

50.	Does your child name at least three objects? (For example, bottle, dog, favorite toy, etc.)	☐ Yes ☐ No
Comments:		

51.	Does your child follow instructions with one action and one object? (For example, "Bring me the book"; "Close the door"; etc.)	☐ Yes ☐ No
Comments:		

52.	Does your child demonstrate understanding of the meaning of no, or word or gesture with the same meaning? (For example, stops current activity briefly.)	☐ Yes ☐ No
Comments:		

53.	Does your child copy the activities you do, such as wipe up a spill, sweep, shave or comb hair?	☐ Yes ☐ No
Comments:		

54.	Does your child play near another child, each doing different things?	☐ Yes ☐ No
Comments:		

55.	Does your child hold and drink from a cup or glass? (Includes "sippy" cups.)	☐ Yes ☐ No
Comments:		

56.	Does your child look at you when you talk to them?	☐ Yes ☐ No
Comments:		

Stop here if child is less than thirty months!

FOR AGES THIRTY MONTHS AND OLDER

57.	While standing, does your child throw a ball or toy?	☐ Yes ☐ No
Comments:		

Customer Name Person ID

58.	Does your child ask questions beginning with what or where? (For example, "What's that?"; "Where doggie go?"; etc.)	☐ Yes ☐ No
Comments:		

59.	Does your child call themselves "I" or "me" more often than their own name? (For example, "I do it" more than "Mary (John) do it".)	☐ Yes ☐ No
Comments:		

60.	Does your child take off clothing that opens in the front (for example, a coat or sweater)? (Does not have to unbutton or unzip the clothing.)	☐ Yes ☐ No
Comments:		

61.	Does your child use a spoon to feed themselves?	☐ Yes ☐ No
Comments:		

62.	Does your child sleep at least 8 hours in a 24-hour period?	☐ Yes ☐ No
Comments:		

63.	Does your child do things over and over and can't seem to stop? (Examples are rocking, hand flapping or spinning.) REVERSE SCORING	☐ Yes ☐ No
Comments:		

64.	Does your child destroy or damage things on purpose? REVERSE SCORING	☐ Yes ☐ No
Comments:		

65.	Does your child hurt themselves on purpose? REVERSE SCORING	☐ Yes ☐ No
Comments:		

Stop here if child is less than thirty-six months!

FOR AGES THIRTY-SIX MONTHS AND OLDER

66.	Does your child stand (balance) on one foot for about 1 second without holding onto	☐ Yes ☐ No

anything?	
Comments:	

67.	Does your child walk up stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) S/he may hold onto the railing or wall.	☐ Yes ☐ No
Comments:		

68.	Does your child turn the pages of a book one at a time?	☐ Yes ☐ No
Comments:		

69.	Does your child use simple words to describe things? (For example, dirty, pretty, big, loud, etc.)	☐ Yes ☐ No
Comments:		

70.	Does your child state their own first name or nickname?	☐ Yes ☐ No
Comments:		

71.	Does your child follow instructions with two actions or an action and two objects? (For example, “Bring me the crayons and the paper”; “Sit down and eat your lunch”; etc.)	☐ Yes ☐ No
Comments:		

72.	Does your child pretend objects are something else? (For example, does your child hold a cup to their ear, pretending it is a telephone? Does s/he put a box on their head, pretending it is a hat? Does s/he use a block or small toy to stir food?)	☐ Yes ☐ No
Comments:		

73.	Does your child know if s/he is a boy or a girl?	☐ Yes ☐ No
Comments:		

74.	Does your child pull up clothing with elastic waistbands? (For example, underwear or sweatpants)	☐ Yes ☐ No
Comments:		

Customer Name Person ID

75.	Does your child suck from a straw?	☐ Yes ☐ No
Comments:		

76.	Does your child cry, scream or have tantrums that last for 30 minutes or longer? REVERSE SCORING	☐ Yes ☐ No
Comments:		

77.	Does your child act physically aggressive? (For example, hits, kicks, bites, etc.) REVERSE SCORING	☐ Yes ☐ No
Comments:		

78.	Does your child have eating difficulties? (For example, eats too fast or too slowly, hoards food, overeats, refuses to eat, etc.) REVERSE SCORING	☐ Yes ☐ No
Comments:		

79.	Does your child sometimes stare at nothing or wander with no purpose? REVERSE SCORING	☐ Yes ☐ No
Comments:		

Stop here is child is less than forty-eight months!

FOR AGES FORTY-EIGHT MONTHS AND OLDER

80.	Does your child hop up and down on one foot?	☐ Yes ☐ No
Comments:		

81.	Does your child pedal a tricycle or other three-wheeled toy at least 6 feet?	☐ Yes ☐ No
Comments:		

82.	Does your child walk down stairs, using only one foot on each stair? (The left foot is on one step, and the right foot is on the next.) S/he may hold onto the railing or wall.	☐ Yes ☐ No
Comments:		

Customer Name Person ID

83.	Does your child wiggle their thumb, for example when using a TV remote or video game controller?	☐ Yes ☐ No
Comments:		

84.	Does your child unbutton one or more buttons, or unfasten one or more Velcro straps? Your child may use their own clothing or a doll's clothing.	☐ Yes ☐ No
Comments:		

85.	Does your child use in, on or under in phrases or sentences? (For example, "Ball go under chair"; "Put it on the table"; etc.)	☐ Yes ☐ No
Comments:		

86.	Does your child say their first and last name?	☐ Yes ☐ No
Comments:		

87.	Does your child follow instructions in "if-then" form? (For example, "If you want to play outside, then put your things away"; etc.)	☐ Yes ☐ No
Comments:		

88.	Does your child share toys or possessions when asked?	☐ Yes ☐ No
Comments:		

89.	Does your child tell you the names of two or more playmates, including brothers and sisters? (Ask this question without providing help by suggesting names of playmates or friends.)	☐ Yes ☐ No
Comments:		

90.	Does your child brush their teeth?	☐ Yes ☐ No
Comments:		

91.	Does your child urinate in a toilet or potty chair?	☐ Yes ☐ No
Comments:		

Customer Name Person ID

92.	Does your child defecate in a toilet or potty chair?	☐ Yes	☐ No
Comments:			

93.	Does your child put on clothing that opens in the front (for example a coat or sweater)? (Does not have to button or zip the clothing.)	☐ Yes	☐ No
Comments:			

Stop here if child is less than sixty months!

FOR AGES SIXTY MONTHS AND OLDER

94.	Does your child open doors by turning door knobs? (Includes doors that open/close with levers rather than traditional round knobs.)	☐ Yes	☐ No
Comments:			

95.	Does your child identify and name most common colors (that is, red, blue, green, yellow)?	☐ Yes	☐ No
Comments:			

96.	Does your child follow three-part instructions? (For example, “Brush your teeth, get dressed and make your bed”; etc.)	☐ Yes	☐ No
Comments:			

97.	Does your child take turns when asked while playing games or sports?	☐ Yes	☐ No
Comments:			

98.	Does your child play informal group games? (For example, hide-and-seek, tag, jump rope, catch, etc.)	☐ Yes	☐ No
Comments:			

99.	Does your child put shoes on correct feet? (Does not need to tie laces.)	☐ Yes	☐ No
Comments:			

Customer Name Person ID

100.	Does your child wash their hands using soap and water? (May be reminded.)	☐ Yes ☐ No
Comments:		

101.	Does your child use the toilet by themselves? (S/he goes to the bathroom, sits on the toilet, wipes and flushes. May be reminded.)	☐ Yes ☐ No
Comments:		

Bladder accidents?	Number: Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Customer Name Person ID

III. MEDICAL ASSESSMENT
A. MEDICAL CONDITIONS

Neurological/Congenital/Developmental Conditions	Comments	Major Dx
1. Cerebral Palsy		
a. Diplegia		
b. Hemiplegia		
c. Quadriplegia		
d. Paraplegia		
e. Unspecified Cerebral Palsy		
2. Epilepsy/Seizure Disorder		
a. Generalized non-convulsive (absence, petit mal, minor, akinetic, atonic)		
b. Generalized convulsive (clonic, myoclonic, tonic, tonic-clonic, grand mal, major)		
c. Unspecified (complex partial, psychomotor, temporal lobe, simple partial, Jacksonian, epilepsia partialis continual)		
3. Intellectual/Cognitive Disability		
a. Mild Intellectual/Cognitive Disability		
b. Moderate Intellectual/Cognitive Disability		
c. Severe Intellectual/Cognitive Disability		
d. Profound Intellectual/Cognitive Disability		
e. Unspecified Intellectual/Cognitive Disability		

f. Borderline Intelligence		

Autism, PDD, Autistic-Like Behaviors	Comments	Major Dx
4. Autism		
a. Autism		
b. Pervasive Developmental Disorder		
c. Autistic-Like Behaviors		
5. Attention Deficit Disorder (ADD)		
a. ADD with Hyperactivity		
b. ADD without Hyperactivity		
6. Other Neurological / Congenital / Developmental Conditions		
a. Prematurity		
b. Fetal Alcohol Syndrome		
c. Developmental Delays		
d. Hydrocephaly		
e. Macrocephaly		
f. Microcephaly		
g. Meningitis		
h. Encephalopathy		
i. Spina Bifida		
j. Genetic Anomalies		
k. Down's Syndrome		
l. Congenital Anomalies		
m. Near Drowning		
n. Head Trauma		
o. Dementia (Organic Brain Syndrome)		

Other Medical Conditions	Comments	Major Dx

Customer Name Person ID

7. Hematologic		
a. Anemia		
b. HIV Positive		
c. AIDS		
d. Leukemia		
e. Hepatitis		
8. Cardiovascular		
a. CHF		
b. Hypertension		
c. Congenital Anomalies of Heart		
d. Cardiac Murmurs		
e. Rheumatic Heart Disease		
9. Musculoskeletal		
a. Arthritis		
b. Fracture		
c. Contracture		
d. Anomalies of Spine (Kyphoscoliosis, Scoliosis, Lordosis)		
e. Paralysis		
10. Respiratory		
a. Asthma		
b. Bronchitis		
c. Pneumonia		
d. Respiratory Distress Syndrome		
e. Bronchopulmonary Dysplasia		
f. Cystic Fibrosis		
g. Reactive Airway		

Disease		
h. Tracheomalacia		
i. Congenital Pulmonary Problems		
11. Genitourinary		
a. Urinary Tract Infection		
12. Gastrointestinal		
a. Constipation		
b. Ulcers		
c. Hernia		
d. Esophagitis		
e. Gastroesophageal Reflux		
13. EENT		
a. Blindness		
b. Cataract		
c. Hearing Deficit		
d. Ear Infection		
e. Disorders of Eye Movements (Exotropia, Strabismus, Nystagmus)		
f. Glaucoma		
14. Metabolic		
a. Hypothyroidism		
b. Hyperthyroidism		
c. Diabetes Mellitus		
d. Pituitary Problem		
15. Skin Conditions		
a. Decubitus		
b. Acne		
16. Psychiatric		

Customer Name | Person ID

a. Major Depression		
b. Bipolar Disorder		
c. Schizophrenia		
d. Behavioral Disorders		
e. Conduct Disorder		
f. Alcohol Abuse		
g. Drug Abuse		

Diagnosis

ICD-10	a.					
ICD-10	b.					
ICD-10	c.					
ICD-10	d.					
ICD-10	e.					

	Category	Condition	Diagnosis
MAJOR DIAGNOSES			

Comments:	

Customer Name Person ID

B. MEDICATIONS/TREATMENTS
Include PRN medications/treatments received in last thirty (30) days and any other current medications/treatments. Include dosage, frequency, duration, route, and form for each medication.

MEDICATIONS / TREATMENTS / COMMENTS
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18.
19.
20.

Comments:	

Customer Name Person ID

C. SERVICES AND TREATMENTS
Mark appropriate answers. Provide explanation when "N" is marked.

1. Injections/IV	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Intravenous Infusion Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Intramuscular/Subcutaneous Injections	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

2. Medications/Monitoring	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Drug Regulation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Drug Administration	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

3. Dressings	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Decubitus Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Wound Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Non-Bladder/Bowel Ostomy Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

4. Feedings	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Parenteral Feedings/TPN	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Tube Feedings	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Customer Name Person ID

Comments:	

5. Bladder/Bowel	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Catheter Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Ostomy Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Bowel Dilatation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

(Select appropriate answers) Provide explanation when (N) is marked.

6. Respiratory	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Suctioning	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Oxygen	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. SVN	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Ventilator	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Trach Care	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Postural Drainage	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
g. Apnea Monitor	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

7. Therapies	Receives	Needs	Frequency of Service			
			Cont.	Daily	Wkly.	Monthly
a. Physical Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Occupational Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Speech Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Respiratory Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Alcohol/Drug Treatment	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Customer Name Person ID

f. Vocational Rehabilitation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
g. Individual/Group Therapy	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
h. Behavioral Modification Program	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

8. Rehabilitative Nursing	**Receives**	**Needs**	**Frequency of Service**			
			Cont.	**Daily**	**Wkly.**	**Monthly**
a. Teaching/Training Program	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Bowel/Bladder Retraining	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Turning & Positioning	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Range of Motion	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Other Rehab Nursing (specify)	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

9. Other	**Receives**	**Needs**	**Frequency of Service**			
			Cont.	**Daily**	**Wkly.**	**Monthly**
a. Peritoneal Dialysis	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
b. Hemodialysis	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
c. Chemotherapy/Radiation	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
d. Restraints	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
e. Fluid Intake/Output	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M
f. Other (specify)	☐ R	☐ N	☐ C	☐ D	☐ W	☐ M

Comments:	

Customer Name Person ID

D. MEDICAL STABILITY

1. Record the number of acute hospitalizations that occurred over the past year		
2. Currently requires direct care staff or caregiver **trained in special health care procedures** (e.g., ostomy care, positioning, adaptive devices, G-tube feedings, SVN, seizure precautions [if current seizure activity], diabetic monitoring)	☐ YES	☐ NO
3. Currently **requires special diet** planned by dietitian, nutritionist, or nurse (e.g., high fiber, low calorie, low sodium, pureed)	☐ YES	☐ NO

Comments:	

Customer Name Person ID

E. SENSORY FUNCTIONS
(Select appropriate answers)

Impairment	Unable to Assess/ No Impairment	Minimum Impairment	Moderate Impairment	Severe Impairment
1. Hearing Ability to perceive sounds	☐ 0	☐ 1	☐ 2	☐ 3
2. Vision Ability to perceive objects visually	☐ 0	☐ 1	☐ 2	☐ 3

Comments:	

Customer Name

Person ID

F. SUMMARY EVALUATION

PCP: and other informants names for Personal Contacts entries

ELIGIBILITY REVIEW REQUESTED?	☐ Yes ☐ No	DATE	

Signature	Title	Date
Signature and Title	Title	Date

Completion Time (minutes)		Travel Time (minutes)	