
SECTION 9 ASSESSMENT

Learning Objectives

1. Identify who may complete a CAP/C assessment.
2. Identify when the assessment should be completed.
3. Properly complete a CAP/C assessment.

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TIMING OF ASSESSMENT

The CAP/C assessment is completed:

- After you have received telephone approval of the FL-2
- Prior to completing the plan of care

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LOCATION OF ASSESSMENT

- The assessment is normally done in the child's home.
- If the child is in a hospital or rehabilitation facility, most of the assessment can be done in the facility so that services can be set up by discharge.

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If the assessment is done in the facility:

1. Be sure that you are not duplicating the work of the discharge planner at the facility
2. Section 8 of the assessment, Home Environment, must still be completed at the child's home.
3. Confirm your assessment of the child within 30 days after discharge, and revise the Plan of Care as needed.

If the child is temporarily hospitalized at the time of a Continued Need Review (CNR), contact your Nurse Consultant for guidance.

COMPONENTS OF ASSESSMENT

Primary

- Interview of the child and family
- Observation of the child and family

Secondary

- Medical records as available
- Information from other provider agencies as applicable (i.e., a supply list from a DME company)

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WHO MAY ASSESS

A CAP/C Assessment may be done by:

- A Registered Nurse only
- a team consisting of a Registered Nurse and a Social Worker

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The Registered Nurse must meet the NC Office of State Personnel job specifications for Public Health Nurse I or II or higher.

The social worker must meet the NC Office of State Personnel job specifications for Social Worker I or II or higher.

Refer to http://ncosp.osp.state.nc.us/class_specs/webpages/aspecs.htm. for the above job specifications.

If the assessment is done by a team, the assessment team members may visit the client at the same time or individually.

If the CAP/C case management agency employs only social workers or RNs, it may contract for the other member of the team.

To avoid any conflict of interest, the nurse that conducts the assessment should not be the same nurse that regularly provides direct patient care to the client or a supervising nurse from that same agency.

THE ASSESSMENT FORM GENERAL INFORMATION

- Located at <http://www.ncdhhs.gov/dma/forms.html#prov>
- May be filled out on the computer, but can not be submitted electronically.

Please print out the completed form, obtain the appropriate signatures, and mail it.

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THE ASSESSMENT FORM - GENERAL INFORMATION, CONT'D.

- Please submit only ONE form per child.
Information from a nurse and a social worker should be entered onto the same form.
- Section 5 of the assessment MUST be done by an RN. All other sections may be completed by an RN or a Social Worker.

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ASSESSMENT FORM – GENERAL INFORMATION, CONT'D.

All of the information on the assessment form should match all of the information on the FL-2. **If something does not match, you must resolve the discrepancy.**

This is an important part of CAP/C's assurance to maintain the child's health, safety, and well-being. The physician, family, and assessors should all be 'on the same page'. It is also part of your case management role as a coordinator of the child's care and services.

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How you resolve the discrepancy is up to you. There is a form available at <http://www.ncdhhs.state.gov/dma/formsprov.html#capc> which you may complete and send to the physician to resolve the discrepancy. This form is optional. You may elect simply to call the physician on the phone, attend an appointment with the child, or use some other method to resolve the discrepancy. Your method and the results should be documented in your case management notes. The assessment form should state that the discrepancy was addressed and what the resolution was.

ASSESSMENT FORM - GENERAL INFORMATION, CONT'D.

- Any time there is an abnormal finding, there should be a comment describing the finding and what is being done about it.
- Any time you identify a need – for equipment, services, teaching, etc. - you must comment on how you plan to meet the need.

These are also important parts of CAP/C 's assurance of health, safety, and well-being.

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ASSESSMENT FORM - GENERAL INFORMATION, CONT'D.

- The child's name and Medicaid ID number will automatically appear at the top of every page once you type the information into Section 1.
- Depending on how much information you type into certain sections, the name and Medicaid ID number may move to the middle or the bottom of the page.

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ASSESSMENT FORM - GENERAL INFORMATION, CONT'D.

- Submit ALL pages of the assessment form, even if a blank page is generated in the middle of the form.
- Make sure the name and MID number are on every page, even blank pages.
- On blank pages, write “page left blank intentionally”.
- There is a sample completed form in Chapter 9 of the CAP/C Manual.

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ASSESSMENT FORM - GENERAL INFORMATION, CONT'D.

Check your work before it is submitted. Refer to the checklist located on the web at <http://www.ncdhhs.gov/dma/cc/capc.htm> under **CAP/C Manual Updates May 2007**. There is a checklist for initials, CNRs, and revisions. Comparing your assessment to this checklist will ensure the completeness and quality of your paperwork and speed the approval process.

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COMPLETING THE ASSESSMENT FORM TOP SECTION

CAP/C Assessment	Client:	MID:
Community Alternatives Program for Children (CAP/C) Assessment North Carolina Division of Medical Assistance		
CAP/C CASE MANAGEMENT AGENCY		
CASE MANAGER/TITLE	PHONE NUMBER	() -
CASE MANAGER E-MAIL	FAX NUMBER	() -
<input type="checkbox"/> INITIAL, Medicaid application date	deadline date	
<input type="checkbox"/> CNR, due date	<input type="checkbox"/> REVISION, effective date	

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Enter the name of the CAP/C Case Management agency. Enter the name and title of the client's CAP/C Case Manager. Enter the Case Manager's phone number and email address where he/she can be reached by the DMA Nurse Consultant for questions.

Initial: Medicaid application date, deadline date

Check this box if the child is not presently on CAP/C and is applying for services. The Medicaid application date is used in determining the CAP Effective Date. The deadline date is used to make sure that the child is approved for CAP/C prior to the application deadline. Your Nurse Consultant does not know these dates unless you provide them!

CNR, due date

Check this box if this plan of care was done as part of the annual Continued Need review. The CNR due date is always the 5th of the month following the date the ORIGINAL FL-2 was approved.

If the FL-2 was approved on June 16, the CNR is due July 5.

If the FL-2 was approved February 1, the CNR is due March 5.

The CNR date never changes, even if you get a new FL-2 or change the level of care.

Revision, effective date

Check this box if you are making a change to the assessment in between annual CNRs. This is the date that the change takes effect. It can be up to 30 days prior to the date the paperwork is RECEIVED by DMA.

COMPLETING THE ASSESSMENT FORM SECTION 1, IDENTIFICATION

1. IDENTIFICATION (May be completed by RN or Social Worker)			
Client's (Child's) Name (as it appears on Medicaid application/card)			
Street Address		Mailing Address	
City	NC	ZIP code	County
Caregiver(s)			
<small>(For work and cell numbers, please indicate which caregiver the number belongs to.)</small>			
Phone (home) () -	Phone (work) () -	Phone (cell) () -	
Street Address		Mailing Address	
City	NC	ZIP code	County
Is the caregiver the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, please specify			
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Age	Medicaid ID No
Race <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black (not Hispanic) <input type="checkbox"/> Hispanic <input type="checkbox"/> White (not Hispanic)			
Living Arrangement <input type="checkbox"/> with parent(s) <input type="checkbox"/> with other relatives <input type="checkbox"/> foster care <input type="checkbox"/> with others (private residence) <input type="checkbox"/> group home or other facility			
Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, please specify			

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Name: Enter the client's name as it appears on the Medicaid card or application.

Street Address: Enter the street/highway/road where the client lives.

Mail Address: If the client's mailing address is the same as the street address, enter Same. If the mail address is different, enter the mail address here.

Town/State/Zip/ County: Use these entries to complete the client's address. Please indicate the county by name, not number.

Caregiver(s): Enter the name(s), of the person(s) who is/are responsible for providing most of the client's direct care.

Phone: Enter the phone numbers of the caregivers. Indicate which caregiver the work or cell phone number is for. If the caregiver does not have a phone, show a phone number through which the caregiver may be contacted and indicate the owner of the phone in parentheses following the number.

Street Address: Enter the street/highway/road where the caregiver lives.

Mail Address: If the caregiver's mailing address is the same as the street address, enter Same. If the mail address is different, enter the mail address here.

Town/State/Zip/ County: Use these entries to complete the caregiver's address. Please indicate the county by name, not number.

COMPLETING THE ASSESSMENT FORM SECTION 1, IDENTIFICATION, CONT'D.

I. IDENTIFICATION (May be completed by RN or Social Worker)			
Client's (Child's) Name (as it appears on Medicaid application/card)			
Street Address		Mailing Address	
City	NC	ZIP code	County
Caregiver(s)			
<small>(For work and cell numbers, please indicate which caregiver the number belongs to.)</small>			
Phone (home) () - () - ()		Phone (work) () - () - ()	
Phone (cell) () - () - ()			
Street Address		Mailing Address	
City	NC	ZIP code	County
Is the caregiver the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, please specify			
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Age	Medicaid ID No
Race <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black (not Hispanic)			
<input type="checkbox"/> Hispanic <input type="checkbox"/> White (not Hispanic)			
Living Arrangement <input type="checkbox"/> with parent(s) <input type="checkbox"/> with other relatives <input type="checkbox"/> foster care			
<input type="checkbox"/> with others (private residence) <input type="checkbox"/> group home or other facility			
Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, please specify			

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Legal Guardian: Please indicate if the caregivers are the legal guardians. If not, indicate the name, contact information, and relationship of the person or agency responsible for consenting to the client's care.

Sex: Enter M or F.

Date of Birth: Enter month/day/year of birth.

Age: Enter the age of the patient on the date the CNR is due.

MID: Enter the client's Medicaid Identification Number.

Race: Check the box that describes the observed race of the client. This information is used only for gathering program data that request breakouts by race.

Living Arrangements: Check the box that applies to the person's living arrangement. Note that clients residing in group homes or facilities are not eligible for participation in CAP/C. Refer to section 1.2 of this manual for specific information regarding living arrangements.

Health Insurance: Check Yes or No and the name, policy number, phone number, and contact person of any health insurance policy the client may have. Indicate co pays, deductibles, and other pertinent coverage information. Since Medicaid is the payer of last resort, it is very important to identify all other third party resources. Share this information with the client's DSS income maintenance caseworker.

The DMA Nurse Consultant compares the information in this section to the Medicaid computer system, our own CAP/C computer system, previous assessments, and the remainder of the current assessment and plan of care. You may be asked to help correct discrepancies.

COMPLETING THE ASSESSMENT FORM SECTION 2, PRIOR APPROVAL

2. PRIOR APPROVAL OF LEVEL OF CARE (May be completed by RN or Social Worker)

Service Review No.	Approval Date	Level of Care
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Service Review Number

Enter the most recent prior approval number received from the fiscal agent, found in box 12 of the FL-2.

Note: The first four digits of the PA number indicate the year in which the approval was given. If you have a number that starts with a 7 or 8 rather than a year, it is outdated; please contact your Nurse Consultant for the correct number.

Approval Date

Enter the date of the most recent prior approval from the fiscal agent, found in box 13 of the FL-2.

This date determines the CNR date and is used in determining the CAP Effective Date.

Level of Care:

Enter the most recently approved level of care, from box 13 of the FL-2. Enter IC, SC (with aide), SC (with Nurse), or SC (Hospital level of care).

The Nurse Consultant compares the information in this section to the FL-2, to the Medicaid computer system, and to the CAP/C database.

COMPLETING THE ASSESSMENT FORM SECTION 3, PHYSICIAN

3. COORDINATING CARE PHYSICIAN (May be completed by RN or Social Worker)

Name	Name of Practice		
Street Address	Mailing Address		
City	NC	ZIP code	
Emergency Phone () -	Office Phone () -	Fax () -	

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Enter information about the physician who is primarily responsible for the care of the client. This is usually, but not necessarily, a pediatrician or family physician. It should be the physician who knows the child the best. This is the physician that DMA would contact, if necessary, for additional information about the client. It does not have to be the physician who signed the FL-2.

If the mailing address is the same as the street address, enter Same. If the mailing address is different, enter the mailing address here.

If the physician has no emergency phone, enter 911.

DMA checks this information against our CAP/C database.

COMPLETING THE ASSESSMENT FORM SECTION 4, EMERGENCY CONTACTS

4. EMERGENCY CONTACTS (May be completed by RN or Social Worker)

At least one emergency contact should be a non-household member. It does not need to be someone capable of providing medical care to the client.

+ <input type="checkbox"/>	
Name	Street Address
Relationship	Mailing Address
Phone (home) () - - - - -	City
(cell) () - - - - - (work) () - - - - -	Zip Code
	State
Name	Street Address
Relationship	Mailing Address
Phone (home) () - - - - -	City
(cell) () - - - - - (work) () - - - - -	Zip Code
	State

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At least one emergency contact must be listed.

At least one emergency contact must be someone out of the child's household.

The emergency contact does not need to be someone local.

The emergency contact should be the person/people that would know how to reach the caregivers if you couldn't. They are people that know the family and would help in an emergency, even if they were unable to provide medical care for the client.

If DSS has custody of the child, enter the appropriate person at DSS as the first contact.

COMPLETING THE ASSESSMENT FORM SECTION 5A, CURRENT DIAGNOSES

5. PHYSICAL HEALTH (Must be completed by RN)

A. CURRENT DIAGNOSES – Please indicate how the diagnosis affects the client's abilities or care.

DIAGNOSIS	ONSET DATE	OUTCOME/CURRENT EFFECT	ICD-9 (optional)
Does above agree with FL-2? <input type="checkbox"/> Yes <input type="checkbox"/> No. If not, please specify action taken: _____			
Are there compliance problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____			
Comments: _____			

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The list of diagnoses must EXACTLY match the list of diagnoses on the FL-2. Alternatively, the list may match the list on the CMS-485 if applicable. Please indicate on your assessment form if you are using the CMS-485 rather than the FL-2.

Any discrepancies among the diagnoses MUST be resolved. As a matter of health, safety, and well-being, the assessment (reflecting the family's view of the client), the FL-2 (reflecting the physician's view of the client), and the CMS-485 (reflecting the staffing agency's view of the client), should all be the same. Although you are not responsible for the content of the CMS-485 form, it is expected that you would notify the agency if discrepancies exist, and that you and the agency would share information between yourselves, so that the client can receive accurate and consistent care.

Onset date does not need to be specific; the year is sufficient.

You may choose to enter the ICD-9 code for each diagnosis. You will use these codes on the claim form (CMS-1500).

COMPLETING THE ASSESSMENT FORM SECTION 5A, CURRENT DIAGNOSES,

CONT'D.

5. PHYSICAL HEALTH (Must be completed by RN)			
A. CURRENT DIAGNOSES – Please indicate how the diagnosis affects the client's abilities or care.			
DIAGNOSIS	ONSET DATE	OUTCOME/CURRENT EFFECT	ICD-9 (optional)
Does above agree with FL-2? <input type="checkbox"/> Yes <input type="checkbox"/> No. If not, please specify action taken:			
Are there compliance problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:			
Comments:			

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The outcome/current effect should be detailed and patient specific.
The outcome/current effect must NOT be left blank.

	Diagnosis	Outcome/Current Effect
incorrect	gastroesophageal reflux	ongoing
incorrect	gastroesophageal reflux	guarded
correct	gastroesophageal reflux	thickened liquids, reflux precautions, medication
correct	gastroesophageal reflux	NPO, GT/Nissen

Indicate any compliance problems with the prescribed treatment(s). Identify reasons for the non-compliant behavior – such as lack of funds, pain, confusion, or a poor understanding of the reasons for the treatment. Indicate a plan of action for promoting compliance.

Use Comments for additional information if needed.

COMPLETING THE ASSESSMENT FORM SECTION 5B, MEDICAL HISTORY

B. MEDICAL HISTORY – List surgeries, hospitalizations, and major treatments that occurred within the last year or that still have an effect on the client.		
EVENT	DATE	OUTCOME/CURRENT EFFECT

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List surgeries, hospitalizations, emergency department visits, medical procedures and other events:

that happened within the last year

that happened earlier, but still have an effect on the client.

	Event	Date	Outcome/Current Effect
incorrect	MVA	2004	wrist fracture, casted and resolved without complications
correct	MVA	2004	cervical spinal injury, quadriplegic

COMPLETING THE ASSESSMENT FORM SECTION 5C, SERVICES

C. SERVICES			
CURRENT SERVICES	FREQUENCY	PROVIDER AGENCY	COMMENTS/ RECOMMENDED CHANGES
NEW SERVICES	FREQUENCY	PROVIDER AGENCY	COMMENTS/ REASON FOR NEW SERVICE

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Current Services: Record the home care services currently being provided. Indicate the frequency, the name of the provider agency, and any comments or recommended changes to the services, such as increases, decreases, or cessations. Comments may be left blank for a current service if there is no recommendation for change and no additional information.

New Services: List any additional services that are recommended. Indicate the recommended frequency and the possible provider agency. Comments may be left blank; however, it is advisable to indicate the reason for the recommendation.

INCORRECT

current services			
PT	1X/wk	PT agency	
new services			
PT	1X/wk	PT agency	

CORRECT

current services			
PT	1X/wk	PT agency	Increase to 2X/wk
new services			
N/A	N/A	N/A	N/A

COMPLETING THE ASSESSMENT FORM SECTION 5C, SERVICES, CONT'D.

SCHOOL-BASED SERVICES	
<input type="checkbox"/> Client is not school-age	
<input type="checkbox"/> Individualized Education Plan	<input type="checkbox"/> Individualized Health Plan Specify services provided: _____
Is client mainstreamed? <input type="checkbox"/> Yes, completely <input type="checkbox"/> Yes, for some classes <input type="checkbox"/> Not at all	
Does client require 1:1 care during school?	
<input type="checkbox"/> Yes, continuously <input type="checkbox"/> Yes, for specific tasks/times (specify) _____ <input type="checkbox"/> No	
If yes, from whom? <input type="checkbox"/> teacher <input type="checkbox"/> teacher's aide <input type="checkbox"/> other trained school personnel <input type="checkbox"/> school nurse	
<input type="checkbox"/> private duty nurse <input type="checkbox"/> nurse's aide <input type="checkbox"/> parent/primary caregiver	

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School-Based Services: Indicate if the client has an Individualized Education Plan (IEP) or an Individualized Health Plan (IHP). Specify what services are provided by this plan. Also indicate if the client has a 504, and what services are provided under the 504.

Indicate if the client is in special education classes for all or part of the day.

Indicate what special needs the client has during the school day and who meets the need (e.g., client needs help with intermittent catheterization once per day, done by trained teacher's aide.)

Also indicate here if the child attends preschool or daycare.

DMA compares the information in this section to the most recently approved plan of care (if applicable) and to the plan of care corresponding to the assessment. We check for duplication of services and make sure that all the services that could benefit the client are listed.

COMPLETING THE ASSESSMENT FORM SECTION 5D, MEDICATIONS

CAP/C Assessment		Client:		MID:
D. MEDICATIONS (Prescription and over the counter)				
NAME	DOSE	FREQUENCY	ROUTE	COMMENTS/PROBLEMS
Does above agree with FL-2? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, indicate action taken: _____				
Pharmacy	City	Phone () -		
Allergic Reactions (specify medication and type of reaction): _____				

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The list of medications must EXACTLY match the list of medications on the FL-2 Alternatively, the list may match the list on the CMS-485 if applicable. Please indicate on your assessment form if you are using the CMS-485 rather than the FL-2.

Any discrepancies among the medications MUST be resolved. As a matter of health, safety, and well-being, the assessment (reflecting the family’s view of the client), the FL-2 (reflecting the physician’s view of the client), and the CMS-485 (reflecting the staffing agency’s view of the client), should all be the same. Although you are not responsible for the content of the CMS-485 form, it is expected that you would notify the agency if discrepancies exist, and that you and the agency would share information between yourselves, so that the client can receive accurate and consistent care.

List all prescription and over – the- counter medications currently used by the client. Indicate the dosage, frequency, route and any comments, including compliance problems. Have the client/responsible party show each medication, explain its purpose, and state when and how it is taken. If there are compatibility problems (such as medications that interfere with each other or medications that duplicate each other), contact the physician.

Enter the name, location, and phone number of the pharmacy usually used by the client.

Describe any allergic reactions that the client has encountered with medications. Include the drug name and type of reaction. For example, the client developed a rash as a result of taking penicillin; enter, “Penicillin – Rash.” Enter NKDA if none known.

COMPLETING THE ASSESSMENT FORM SECTION 5E, NUTRITION

E. NUTRITION	
Height <input type="checkbox"/> objective <input type="checkbox"/> estimated	Weight <input type="checkbox"/> objective <input type="checkbox"/> estimated
Weight change past year amount +/- <input type="checkbox"/> objective <input type="checkbox"/> estimated	
Is weight change appropriate for client's age and medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If not, explain: _____	
Is MD aware? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Food Allergies (specify food and type of reaction): _____	
<input type="checkbox"/> Oral feeds, type/amount/frequency: _____	
<input type="checkbox"/> Enteral feeds, type/amount/frequency: _____	
<input type="checkbox"/> Parenteral feeds, type/amount/frequency: _____	
Does above agree with FL-2? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, indicate action taken: _____	
Are patient and/or caregiver compliant with diet? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, explain: _____	
Additional Comments: _____	

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HT/WT: Enter the client's height and weight. Indicate if it is an actual height and weight or one that was estimated. If the objective height or weight is several months old, please indicate the date. It is helpful to also indicate the client's percentiles on the growth curve.

Weight Change Past Year: Enter the amount and indicate if the change is abnormal or if it is expected for the child's normal growth and/or medical condition. If abnormal, indicate the possible reason for the change. All incidences of abnormal weight change or unplanned weight change should be referred to the physician and documented here. It is helpful to use the growth curve as a point of comparison, both to the client's previous growth and to normal age-appropriate growth.

Food Allergies: List any food allergies experienced by the client, including the type of reaction.

Type of Diet: Indicate the type of diet for the client. Be specific (e.g., Pediasure 120 cc with water flush 30 cc Q4H 5 times per day via GT.) The amount of formula requested on the cost summary should correlate with the amount of formula indicated here. (120 cc 5X/d = 600 cc/day X 30 days=180000 cc/mo ÷ 237 cc/can = 76 cans per month 76 cans per month should be on the cost summary.) If the number on the cost summary is different, the difference must be explained.

FL-2 discrepancy: Explain if the diet does not agree with diet indicated on the FL-2. The discrepancy must be resolved.

Compliance: Indicate if the client and/or caregiver understand and/or comply with the diet. Identify reasons for the lack of understanding or for the non-compliant behavior – such as lack of funds, pain, or lack of formal education regarding special diet. Indicate a plan of action for promoting understanding and compliance.

Comments: Use Comments for additional information if needed.

COMPLETING THE ASSESSMENT FORM SECTION 5F, SKIN

CAP/C Assessment	Client:	MID:
F. SKIN (Check as many items as apply)		
Skin condition:	<input type="checkbox"/> Good	<input type="checkbox"/> Pressure Areas
	<input type="checkbox"/> Decubitus	<input type="checkbox"/> Rash
	<input type="checkbox"/> Other	
Skin color:	<input type="checkbox"/> Good	<input type="checkbox"/> Jaundiced
	<input type="checkbox"/> Pale	<input type="checkbox"/> Cyanotic
	<input type="checkbox"/> Other	
Trach site:	<input type="checkbox"/> N/A	<input type="checkbox"/> Within Normal Limits
	<input type="checkbox"/> Signs/Symptoms infection	<input type="checkbox"/> Signs/Symptoms skin breakdown
	<input type="checkbox"/> Other	
GT site:	<input type="checkbox"/> N/A	<input type="checkbox"/> Within Normal Limits
	<input type="checkbox"/> Signs/Symptoms infection	<input type="checkbox"/> Signs/Symptoms skin breakdown
	<input type="checkbox"/> Other	
Other site:	<input type="checkbox"/> N/A	<input type="checkbox"/> Within Normal Limits
Specify:	<input type="checkbox"/> Signs/Symptoms infection	<input type="checkbox"/> Signs/Symptoms skin breakdown
	<input type="checkbox"/> Other	
Does above agree with FL-2? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, indicate action taken: _____		
Descriptions of abnormal findings and other comments: _____		

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Assess the overall skin condition and skin color of the client and check the appropriate box for each. If the client's skin condition and/or skin color is other than "good," check all boxes that apply and describe under Descriptions.

Assess any wounds or sites. Specifically include gastrostomy, tracheostomy, and IV sites. If the condition is other than "within normal limits," check all boxes that apply and describe under Descriptions.

Anything that is checked "other" or is not a normal finding should be described. A plan should be indicated for any abnormal finding (ex: the GT site is marked as other. Your comment would say: Redness and slight drainage around stoma. Cleaned twice daily with ½ strength hydrogen peroxide and carafate paste applied. Treatment started 3 days age, some improvement noted.)

Describe any discrepancies between the assessment and FL-2 (or CMS-485) information and indicate the action taken to resolve it.

COMPLETING THE ASSESSMENT FORM SECTION 5G, SENSORY AND COMMUNICATION

G. SENSORY AND COMMUNICATION		
SENSE	DEGREE OF IMPAIRMENT (see CAP/C manual for definitions of minimal, moderate, and severe)	EXPLANATION OF MODERATE OR SEVERE IMPAIRMENT/OTHER COMMENTS (List any assistive devices that are used or needed.)
VISION	<input type="checkbox"/> No/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
SPEECH	<input type="checkbox"/> No/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
HEARING	<input type="checkbox"/> No/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Overall Communication Impairment <input type="checkbox"/> No/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Primary Method of Communication (If none, please indicate how client's needs are met.)		
<input type="checkbox"/> Speech <input type="checkbox"/> Gestures <input type="checkbox"/> Writing <input type="checkbox"/> Communication Device <input type="checkbox"/> None:		
Does above agree with FL-2? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, indicate action taken:		
Descriptions of abnormal findings and other comments:		
Is an English-speaking interpreter needed? <input type="checkbox"/> Yes, specify language <input type="checkbox"/> No		

NC DMA 10/2009

Rate vision, hearing, and speech and the overall ability to communicate. Document your use of age appropriate assessment techniques to evaluate this section. If you are unable to evaluate due to the child's age or diagnoses, leave the rating blank and make that note under Explanation. Rate the ability with the individual using any assistive devices that are regularly used. If the rating is completed with an assistive device, note under Explanation. Also, enter other needed comments under Explanation.

Vision

No or Minimal Impairment: Infants track objects with their eyes. Child can identify small objects in picture books, discern small objects (such as pills) without difficulty, and handle similar tasks.

Moderate Impairment: Child can only discern large objects (e.g., see and identify people, furniture, and other large objects). Can see well enough to move about safely. Give details of this rating under Explanation.

Severe Impairment: Infants do not track objects. Child cannot identify large objects and/or tell light from dark. Give details of this rating under Explanation.

COMPLETING THE ASSESSMENT FORM
SECTION 5G, SENSORY AND COMMUNICATION,
CONT'D.

G. SENSORY AND COMMUNICATION		
SENSE	DEGREE OF IMPAIRMENT (see CAP/C manual for definitions of minimal, moderate, and severe)	EXPLANATION OF MODERATE OR SEVERE IMPAIRMENT/OTHER COMMENTS (List any assistive devices that are used or needed.)
VISION	<input type="checkbox"/> No/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
SPEECH	<input type="checkbox"/> No/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
HEARING	<input type="checkbox"/> No/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Overall Communication Impairment <input type="checkbox"/> No/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Primary Method of Communication (If none, please indicate how client's needs are met.)		
<input type="checkbox"/> Speech <input type="checkbox"/> Gestures <input type="checkbox"/> Writing <input type="checkbox"/> Communication Device <input type="checkbox"/> None:		
Does above agree with FL-2? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, indicate action taken:		
Descriptions of abnormal findings and other comments:		
Is an English-speaking interpreter needed? <input type="checkbox"/> Yes, specify language <input type="checkbox"/> No		

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Speech

No or Minimal Impairment: Infants cry appropriately. Child can speak clearly and loudly enough to be understood by someone with normal hearing.

Moderate Impairment: Child's speech is slurred or occasionally garbled or soft, but can be understood by listening carefully. Give details of this rating under Explanation.

Severe Impairment: Cannot speak, or the speech cannot be understood by someone with normal hearing. Give details of this rating under Explanation.

Hearing

No or Minimal Impairment: Infants turn towards voices of parents. Child can hear and understand normal speech without difficulty or can hear with the volume slightly raised. Can hear and understand TV programs even if he/she has to raise the volume somewhat.

Moderate Impairment: Infants turn only toward loud sounds. Child can hear if speaker talks in a loud voice and/or speaks slowly. Has to have TV loud enough to hear and understand. Give details of this rating under Explanation.

Severe Impairment: Infants do not respond to any sounds. Child misses many words even when spoken to loudly and slowly, or has no hearing that is useful for communication. Give details of this rating under Explanation.

COMPLETING THE ASSESSMENT FORM
SECTION 5G, SENSORY AND COMMUNICATION,
CONT'D.

G. SENSORY AND COMMUNICATION		
SENSE	DEGREE OF IMPAIRMENT (see CAP/C manual for definitions of minimal, moderate, and severe)	EXPLANATION OF MODERATE OR SEVERE IMPAIRMENT/OTHER COMMENTS (List any assistive devices that are used or needed.)
VISION	<input type="checkbox"/> No/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
SPEECH	<input type="checkbox"/> No/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
HEARING	<input type="checkbox"/> No/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Overall Communication Impairment <input type="checkbox"/> No/Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Primary Method of Communication (If none, please indicate how client's needs are met.)		
<input type="checkbox"/> Speech <input type="checkbox"/> Gestures <input type="checkbox"/> Writing <input type="checkbox"/> Communication Device <input type="checkbox"/> None: _____		
Does above agree with FL-2? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, indicate action taken: _____		
Descriptions of abnormal findings and other comments: _____		
Is an English-speaking interpreter needed? <input type="checkbox"/> Yes, specify language _____ <input type="checkbox"/> No		

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Overall Communication Ability

No or Minimal Impairment: Can communicate with others with little or no difficulty. Can readily make self understood and can easily understand others. This includes the use of alternate methods of communication such as signing or message writing. Infants startle at sounds and cry appropriately

Moderate Impairment: Has some difficulty in understanding others and/or making self understood. If uses alternative methods of communication, is not skilled in their usage. Give details of this rating under Descriptions/Comments.

Severe Impairment: In most instances, either cannot understand others and/or cannot make self understood or can never communicate. Give details of this rating under Descriptions/Comments.

Primary Method of Communication: Indicate the primary method of communication. If the person uses several methods, check the ones used most often in everyday situations. If you indicate that there is no primary method of communication, you must address the resulting health/safety/well-being issue: If the client cannot communicate his/her needs, how are those needs met? Often, these needs are met by providing scheduled or anticipatory care.

Describe any discrepancies between the assessment and FL-2 information and indicate the action taken to resolve it.

Indicate if there is a language barrier requiring an interpreter, and what language is used.

COMPLETING THE ASSESSMENT FORM SECTION 5H, CONTINENCE

H. CONTINENCE	
Bladder:	
<input type="checkbox"/> Continent <input type="checkbox"/> Occasionally Incontinent (more than once per week) <input type="checkbox"/> Frequently Incontinent (more than once per day) <input type="checkbox"/> Totally Incontinent <input type="checkbox"/> N/A (cath/ostomy)	
Age-appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Catheterizations: <input type="checkbox"/> intermittent <input type="checkbox"/> indwelling Frequency (if applicable) _____	
Bowel:	
<input type="checkbox"/> Continent <input type="checkbox"/> Occasionally Incontinent (more than once per week) <input type="checkbox"/> Frequently Incontinent (more than once per day) <input type="checkbox"/> Totally Incontinent <input type="checkbox"/> N/A (ostomy)	
Age-appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bowel regimen: _____	
Diapers: type/amount per day _____	
Does above agree with FL-2? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, indicate action taken: _____	
Descriptions of abnormal findings and other comments: _____	

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Indicate whether the client is continent or has incontinence problems for both bladder and bowel. If Not Applicable is used, enter the type of catheter and/or ostomy, as appropriate, with the related information.

Indicate if the level of continence is appropriate for the child's age. If the client is of borderline age, consider the client's prognosis. For example, if a 2 1/2 year old is incontinent, but there is nothing to indicate that she cannot become toilet-trained, check age-appropriate. If you know based on the child's medical condition that she will never be toilet trained, check age-inappropriate.

If the child is on a bowel regimen, indicate what it is, and who is responsible for it.

If the child is catheterized, please note the frequency and who is responsible for it. If the client self – catheterizes, also indicate the frequency with which the caregiver needs to assist with or provide any catheterizations.

The number of diapers used per day should correlate with the cost summary if applicable. If you indicate on the assessment that the client uses 8 diapers/day, DMA expects to see 240 diapers per month on the cost summary (8 diapers/day X 30 days/month = 240 diapers/month). Up to 10 diapers per day is considered normal use. If you are indicating that the client needs more than that amount, please provide an explanation. (Note that diapers should not be on the cost summary for any client under age 3, as diapers at that age are a developmental need, not a medical need.)

Describe any discrepancies between the assessment and FL-2 information and indicate the action taken to resolve it.

Describe any abnormal findings and provide any additional information that may be pertinent.

COMPLETING THE ASSESSMENT FORM SECTION 5I, CARDIAC-RESPIRATORY

<input type="checkbox"/> CAP/C Assessment	Client: _____	MID: _____
I. CARDIAC-RESPIRATORY – Check all that apply. This section is based only on observation and caregiver report. The Case Manager is not required to auscultate the patient.		
Respirations: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Tachypneic <input type="checkbox"/> Bradypneic <input type="checkbox"/> Apneic <input type="checkbox"/> Unlabored <input type="checkbox"/> Dyspnea <input type="checkbox"/> Dyspnea with exertion <input type="checkbox"/> Upper airway congestion <input type="checkbox"/> Cough <input type="checkbox"/> Stridor <input type="checkbox"/> Wheezing <input type="checkbox"/> Retractions <input type="checkbox"/> Other		
<input type="checkbox"/> Trach: Type _____ Size _____ Actual frequency of suctioning _____		
Pulse oximetry: <input type="checkbox"/> continuous always <input type="checkbox"/> continuous at night <input type="checkbox"/> spot checks, frequency _____ <input type="checkbox"/> PRN		
Oxygen: Amount _____ Route _____ Actual frequency of use _____		
CPAP: <input type="checkbox"/> BIPAP <input type="checkbox"/> ventilator Actual frequency of use _____		
Endurance: <input type="checkbox"/> Within normal limits <input type="checkbox"/> Fatigues with exertion <input type="checkbox"/> Easily fatigued <input type="checkbox"/> Unable to participate in ADLs		
Descriptions of abnormal findings and other comments: _____		

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This section is based on observation and caregiver report. You are not required to auscultate the patient.

Thoroughly describe any abnormal findings (e.g., apneic spells approximately two times per night during sleep, duration approximately 10 seconds, resolves spontaneously when client awakens to apnea alarm.)

Check the applicable assistive or monitoring devices: trach, pulse oximeter, oxygen, BiPAP/CPAP, or ventilator) and frequency of their use. The frequency of use should be the ACTUAL use. A client may have an order for tracheal suctioning Q4H and PRN, but that client ACTUALLY gets suctioned hourly. Hourly suctioning is what needs to be indicated on the assessment. If PRN is indicated, describe the need: how often is it needed? is the need predictable? For instance: PRN oxygen usually administered only during acute respiratory illness, continuous 1 liter, for about 3 days, happens 3-4 times/year.

If fatigue is not due to cardiac or respiratory issues, please indicate reason in comments section.

COMPLETING THE ASSESSMENT FORM SECTION 5J, MUSCULOSKELETAL

J. MUSCULOSKELETAL – Check all that apply				
Ambulatory Status: <input type="checkbox"/> Independent <input type="checkbox"/> Person-assist <input type="checkbox"/> Device-assist, specify _____ <input type="checkbox"/> Non-ambulatory				
Appearance: <input type="checkbox"/> Within normal limits <input type="checkbox"/> Scoliosis <input type="checkbox"/> Contractures <input type="checkbox"/> Other				
<input type="checkbox"/> AFOs <input type="checkbox"/> TLSO <input type="checkbox"/> Other braces/devices, specify _____				
Tone: <input type="checkbox"/> Rigid <input type="checkbox"/> Normal <input type="checkbox"/> Flaccid Location _____				
<input type="checkbox"/> Rigid <input type="checkbox"/> Normal <input type="checkbox"/> Flaccid Location _____				
Strength:				
<input type="checkbox"/> Normal (active range of motion against full resistance)				
<input type="checkbox"/> Mild weakness (active range of motion against gravity alone or light resistance)				
<input type="checkbox"/> Moderate weakness (passive range of motion when gravity removed)				
<input type="checkbox"/> Paresis/severe weakness				
<input type="checkbox"/> Paralysis				
Descriptions of abnormal findings and other comments: _____				

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This section is based on observation and caregiver report.

Indicate the ambulatory status of the client. This should match the FL-2 form. More than one box may be checked, with comments. For instance, the client may need person-assist for short distances, but use a wheelchair for long distances. Indicate both.

Under appearance, describe any abnormal or 'other' findings (e.g., contractures of bilateral ankles treated with AFOs on 2H/off 2H while awake.)

Two sections are provided for tone, as there may be differences between upper body and lower body or between right side and left side.

Indicate the client's general strength.

COMPLETING THE ASSESSMENT FORM SECTION 5K, SUMMARY

K. PHYSICAL HEALTH ASSESSMENT SUMMARY AND COMMENTS – Give a clear picture of the client's needs during a typical 24 hour period.
Day: <input type="text"/>
Evening: <input type="text"/>
Night: <input type="text"/>

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Provide as clear a picture as possible of the child's medical needs on an ongoing basis during a typical 24-hour period. Include detailed information on the amount and frequency of medical attention required and who provides it. Discuss the use of any life-sustaining equipment, such as oxygen equipment or ventilators, and give details on the frequency and duration of use. Also describe any special procedures or treatments such as suctioning, and provide information on how often the procedures or treatments are performed and by whom. Expand on any other areas that need more detail.

This section may be completed either in a narrative format, or as a list of times and events.

This section should be consistent with the remainder of the assessment, the FL-2, the CMS-485, the plan of care, and the nurse/nurse aide notes. It correlates to the hours of in-home care that you request by justifying the actual hands-on continuous interventions that are occurring during the time the staff is there.

COMPLETING THE ASSESSMENT FORM SECTION 5L, PHYSICAL FUNCTION RATING

I. PHYSICAL FUNCTION

The previous areas of this assessment provide the basis for determining if there are impediments to self-care for physical reasons. Select a statement below to rate physical function.

- Physical/medical status is adequate; no in-home supervision needed.
- Physical/medical status is adequate; supervision required due to age of child
- Physical health impairment requiring supervision for specific tasks or at specific times
- Physical health impairment requiring 24 hour supervision.

Comments:

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Function in the context of this assessment refers to impediments to self-care due to physical or medical problems. Check the appropriate box.

Use Comments for additional information if needed.

COMPLETING THE ASSESSMENT FORM SECTION 6, ADLS

ACTIVITIES OF DAILY LIVING	PERFORMANCE CODE	HELP CODE	NEED MET?
Grooming	<input type="checkbox"/> independent <input type="checkbox"/> verbal prompting <input type="checkbox"/> minor hands-on help <input type="checkbox"/> totally dependent <input type="checkbox"/> activity does not occur	<input type="checkbox"/> household member <input type="checkbox"/> other family <input type="checkbox"/> neighbor/friend <input type="checkbox"/> agency <input type="checkbox"/> activity does not occur	<input type="checkbox"/> totally met now, but will need help <input type="checkbox"/> need not met <input type="checkbox"/> activity does not occur
Bathing	<input type="checkbox"/> independent <input type="checkbox"/> verbal prompting <input type="checkbox"/> minor hands-on help <input type="checkbox"/> totally dependent <input type="checkbox"/> activity does not occur	<input type="checkbox"/> household member <input type="checkbox"/> other family <input type="checkbox"/> neighbor/friend <input type="checkbox"/> agency <input type="checkbox"/> activity does not occur	<input type="checkbox"/> totally met now, but will need help <input type="checkbox"/> need not met <input type="checkbox"/> activity does not occur

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Use this part of the assessment to document the client's performance in activities of daily living (ADL's). Assess the client's ADL functioning through self-reporting by the client/responsible party; observation by the assessor, possibly using performance tests; and/or reports from hospital personnel and others involved in the client's care. The best technique is for the assessor to observe the client performing the specific activities in the home. When that is not possible, use self-report by the client/caregiver and reports from others involved in the client's care.

If there are any apparent differences between the person's performance and capability, give possible reasons for the differences under Additional Comments. **EXAMPLE:** Cindy has a performance rating of 'minor hands on help' needed for eating. She is capable of feeding herself; in other words, she is alert and oriented and has no physical impairment that would prevent her from feeding herself. You suspect, however, that Cindy's primary caregiver continues to provide more assistance than is actually needed. Document this under Additional Comments. Assess each ADL listed on the assessment form.

Grooming includes combing hair, brushing teeth, and similar tasks.

COMPLETING THE ASSESSMENT FORM

SECTION 6, ADLS, CONT'D.

Dressing	<input type="checkbox"/> independent <input type="checkbox"/> verbal prompting <input type="checkbox"/> minor hands-on help <input type="checkbox"/> totally dependent <input type="checkbox"/> activity does not occur	<input type="checkbox"/> household member <input type="checkbox"/> other family <input type="checkbox"/> neighbor/friend <input type="checkbox"/> agency <input type="checkbox"/> activity does not occur	<input type="checkbox"/> to tally <input type="checkbox"/> met now, but will need help <input type="checkbox"/> need not met <input type="checkbox"/> activity does not occur
Elimination	<input type="checkbox"/> independent <input type="checkbox"/> verbal prompting <input type="checkbox"/> minor hands-on help <input type="checkbox"/> totally dependent <input type="checkbox"/> activity does not occur	<input type="checkbox"/> household member <input type="checkbox"/> other family <input type="checkbox"/> neighbor/friend <input type="checkbox"/> agency <input type="checkbox"/> activity does not occur	<input type="checkbox"/> to tally <input type="checkbox"/> met now, but will need help <input type="checkbox"/> need not met <input type="checkbox"/> activity does not occur

NC DMA 10/2009

Performance Code

Check the appropriate box for each activity with the client using any assistive devices that he/she normally uses. Note the type of device used. If the client has a device, but does not use it, do not rate with the use of the device.

Independent: Can perform activity without help or supervision from someone else.

Only Verbal Prompting Needed: Can only perform activity when someone gives verbal or written supervision, guidance, or prompting. Use this code only if no hands-on assistance is needed. Describe the help needed under Additional Comments.

Minor Hands-On Help Needed: Can only perform activity when someone provides minor physical assistance, such as physically guiding the client or buttoning clothing. Describe the type and amount of help needed in Additional Comments.

Totally Dependent: Someone else must complete the task for the client. For example, a client must be totally dressed as opposed to needing only some help with buttoning clothing. Describe the type of help needed with ADLs under Additional Comments.

Activity Does Not Occur: Use this code for activities that are not applicable to the client. For example, use this code for Wheelchair Use if the client is ambulatory. Also use this code if the activity is not appropriate for the child's age.

Elimination includes toileting, incontinence care, catheterizations, and ostomy care.

COMPLETING THE ASSESSMENT FORM

SECTION 6, ADLS, CONT'D.

Transfer	<input type="checkbox"/> independent <input type="checkbox"/> verbal prompting <input type="checkbox"/> minor hands-on help <input type="checkbox"/> totally dependent <input type="checkbox"/> activity does not occur	<input type="checkbox"/> household member <input type="checkbox"/> other family <input type="checkbox"/> neighbor/friend <input type="checkbox"/> agency <input type="checkbox"/> activity does not occur	<input type="checkbox"/> totally <input type="checkbox"/> met now, but will need help <input type="checkbox"/> need not met <input type="checkbox"/> activity does not occur
Walking	<input type="checkbox"/> independent <input type="checkbox"/> verbal prompting <input type="checkbox"/> minor hands-on help <input type="checkbox"/> totally dependent <input type="checkbox"/> activity does not occur	<input type="checkbox"/> household member <input type="checkbox"/> other family <input type="checkbox"/> neighbor/friend <input type="checkbox"/> agency <input type="checkbox"/> activity does not occur	<input type="checkbox"/> totally <input type="checkbox"/> met now, but will need help <input type="checkbox"/> need not met <input type="checkbox"/> activity does not occur
Wheelchair use	<input type="checkbox"/> independent <input type="checkbox"/> verbal prompting <input type="checkbox"/> minor hands-on help <input type="checkbox"/> totally dependent <input type="checkbox"/> activity does not occur	<input type="checkbox"/> household member <input type="checkbox"/> other family <input type="checkbox"/> neighbor/friend <input type="checkbox"/> agency <input type="checkbox"/> activity does not occur	<input type="checkbox"/> totally <input type="checkbox"/> met now, but will need help <input type="checkbox"/> need not met <input type="checkbox"/> activity does not occur

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Help Code

If the client needs assistance with any of the activities, check the appropriate box to show who is providing help. Check as many boxes as needed. If the client performs the activity independently, or the activity does not occur, do not enter a Help Code

Household Members: Anyone who lives in the same household as the client.

Other Family: A family member who lives outside the household.

Neighbor/Friend: A neighbor or friend, not a family member, who lives outside the household.

Agency: A formal service provider who gives assistance to the client. The term "agency" includes paid workers (whether paid as an individual contractor or provided by an agency or organization), and volunteer workers arranged by an agency or organization. Use this code regardless of whether the client has to pay for the service.

Activity Does Not Occur: Use this code for activities that are not applicable to the client. For example, use this code for Wheelchair Use if the client is ambulatory. Also use this code if the activity is not appropriate for the child's age.

Transfer applies to assistance in and out of bed, wheelchairs, etc.

COMPLETING THE ASSESSMENT FORM SECTION 6, ADLS, CONT'D.

Eating	<input type="checkbox"/> independent <input type="checkbox"/> verbal prompting <input type="checkbox"/> minor hands-on help <input type="checkbox"/> totally dependent <input type="checkbox"/> activity does not occur	<input type="checkbox"/> household member <input type="checkbox"/> other family <input type="checkbox"/> neighbor/friend <input type="checkbox"/> agency <input type="checkbox"/> activity does not occur	<input type="checkbox"/> totally <input type="checkbox"/> met now, but will need help <input type="checkbox"/> need not met <input type="checkbox"/> activity does not occur
Medication Administration	<input type="checkbox"/> independent <input type="checkbox"/> verbal prompting <input type="checkbox"/> minor hands-on help <input type="checkbox"/> totally dependent <input type="checkbox"/> activity does not occur	<input type="checkbox"/> household member <input type="checkbox"/> other family <input type="checkbox"/> neighbor/friend <input type="checkbox"/> agency <input type="checkbox"/> activity does not occur	<input type="checkbox"/> totally <input type="checkbox"/> met now, but will need help <input type="checkbox"/> need not met <input type="checkbox"/> activity does not occur

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Needs Met

Check one of the boxes for every ADL .

Totally Met: The need is met and will continue to be met. Also, use this if the client is independent in the activity.

Met Now, But Will Need Help: The client's need is met, but the help will diminish or cease in the near future. For example, the client's parent must return to work.

Need Not Met: There is no help or the help is insufficient to meet the client's need. Suggest the type of help needed under Additional Comments.

Activity Does Not Occur: Use this for activities that are not applicable to the client. For example, use this code for Wheelchair Use if the client is ambulatory. Also use this if the activity is not appropriate for the child's age.

As you complete this section, remember that CAP/C can only be approved to meet specific unmet needs of the child. Particularly with IC level children who often only qualify for CAP/C because of their ADL needs, carefully consider whether CAP/C would be replacing rather than supplementing the care provided by the parents.

Eating also applies to feeding, such as GT feeds.

COMPLETING THE ASSESSMENT FORM SECTION 6, ADLS, CONT'D.

Please list all assistive devices/DME used:
(Please indicate with a * which, if any, equipment is owned by the client. All other equipment should be indicated on the Plan of Care Cost Summary.)

What assistive devices/DME may be needed?
What is the plan for meeting these needs?

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You no longer need to list all of the DME/assistive devices used by the client here; they should be listed on the cost summary. This question will be removed next time the form is updated.

List any devices that may be needed. Explain the need and the plan for obtaining the equipment/meeting the need. Remember, as part of our assurance of health, safety, and well-being, you may not identify a need without identifying a plan for meeting that need.

COMPLETING THE ASSESSMENT FORM SECTION 7A, CLIENT'S CONCERNS

CAP/C Assessment

Client:

MID:

7. SOCIAL SUPPORT (May be completed by RN or Social Worker)

A. CLIENT'S CONCERNS

Does client show any concern about family/informal support and care at home?

Yes No Unable to communicate concerns

If yes, please describe: _____

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Check Yes or No to indicate whether the client shows any concern about family/informal support. If yes, using the client's own words, describe his/her concerns and what help he/she thinks is needed.

COMPLETING THE ASSESSMENT FORM SECTION 7B, FAMILY/HOUSEHOLD DYNAMICS

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B. FAMILY/HOUSEHOLD DYNAMICS

Briefly describe the apparent relationships and interactions between the client, household members, and immediate family members. This is primarily based on observations during the assessment interview. Note whether there appears to be a supportive relationship, hostility, or other factor that would contribute to or detract from care in the home.

Describe any concerns of the family regarding care. What help do they believe is needed?

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During the assessment process, note the apparent relationships and interactions between the client and household members. Briefly describe what is observed in terms of support, indifference, hostility, tension, or other factors that could influence the success of care in the home. In observing household members in their interactions with the child, look at the informal caregivers' motivation and capacity to learn special techniques to care for the child. Note whether they are interested in and receptive to teaching and guidance from professionals, such as nurses or therapists, who are involved in the child's care. Note changes in the composition of the household such as a recent divorce, a sibling leaving for college, or a disabled grandparent moving in. Note if there are other disabled children in the home. If the child is in foster care with the goal of reuniting with his/her parents, indicate the progress being made toward that goal.

Just as you noted the concerns of the client in the last section, note the concerns of the family here. Indicate what help they believe is needed. Remember, CAP/C exists to meet the specific unmet needs of the child. If nothing is needed, there is no reason to approve CAP/C. At a minimum, there must be a need for CAP/C services to continue.

COMPLETING THE ASSESSMENT FORM SECTION 7C, INFORMAL SUPPORT

C. ASSESSOR'S EVALUATION OF INFORMAL SUPPORT	
After considering all of the input from the client, family, and other significant individuals, the assessor needs to evaluate the status of informal support. If informal support is insufficient, explain.	
<input type="checkbox"/> Intact and could expand if needed	<input type="checkbox"/> Intact, but at limit
<input type="checkbox"/> Stressed, meeting with difficulty	<input type="checkbox"/> Inadequate
Comment <input type="text"/>	
Describe any concerns of the informal support persons regarding care. What help do they believe is needed? <input type="text"/>	

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After considering all of the input from the client, family, friends and other significant persons, evaluate the status of the informal support using the following definitions.

Intact and could expand if needed: There is solid support. The informal caregivers can and are willing to do more, and/or there are other untapped resources at their disposal. Note in Comments the additional help that may be available.

Intact, but at limit: There is solid support, but no additional support may be expected from the informal caregivers.

Stressed, meeting with difficulty: The informal support is struggling to meet the client's minimum needs. There is obvious stress in the situation. This includes situations in which the needs are currently being met, but it is doubtful if the support can continue to be provided due to the stress on the caregivers. Specify the areas of support most endangered and add any other explanation of this rating in Comments.

Inadequate: The informal support is not meeting the client's minimum needs. This would be used in a situation of abuse or neglect. Identify in Comments the areas in which support is needed, and refer the child to Child Protective Services as applicable.

COMPLETING THE ASSESSMENT FORM SECTION 7D, ADVANCE DIRECTIVES

D. ADVANCE DIRECTIVES

Does the client have any type of advance directive, such as a Do Not Resuscitate order? Yes No

Please describe:

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Indicate the code status of the client. Document it as ordered by the physician and written on the Plan of Care.

Document other pertinent information, such as religious beliefs, cultural practices, or family attitudes that affect medical care (e.g., the physician recommends a GT but the parents refuse, considering it too invasive).

If the client has a terminal diagnosis, indicate whether hospice services have been considered.

COMPLETING THE ASSESSMENT FORM SECTION 7E, SAFETY AND WELFARE

E. SAFETY AND WELFARE

Do any concerns exist regarding the child's safety or well-being? Yes No

If yes, please describe: _____

NC DMA 10/2009

Concerns regarding the client's safety and welfare can arise from any source, including concerns from the caregivers, other sources of informal support, or your own observations. Concerns can arise from medical, physical, or psycho-social issues that affect the client directly or indirectly. Include any history of involvement with Child Protective Services, if known. Include any history of household members with drug or alcohol abuse, if known. If issues are identified, document your plan for ensuring the child's safety and well-being.

COMPLETING THE ASSESSMENT FORM SECTION 8, HOME ENVIRONMENT

CAP/C Assessment	Client:	MID: <input type="text"/>
<p>8. HOME ENVIRONMENT (May be completed by RN or Social Worker)</p> <p>If client receives services in more than one primary residence (i.e. lives part-time with mother, part-time with father), this section must be completed for EACH residence.</p> <p>Rate each component of the home environment according to the following definitions:</p> <p><u>Adequate</u> for client's needs/safety. Not a threat to health, safety, and well-being.</p> <p><u>Minor problem</u> area for which improvement would benefit client, however is not a threat to client</p> <p><u>Inadequate</u> – doesn't provide for client's needs/ safety, must be resolved before well-being can be assured.</p>		
<p>Street Address: <input type="checkbox"/> same address as listed for client on page 1 <input type="checkbox"/> other, specified below</p>		
<p>Location</p> <p><input type="checkbox"/> city/town</p> <p><input type="checkbox"/> isolated</p> <p><input type="checkbox"/> rural</p> <p><input type="checkbox"/> other</p>	<p>Client's Living Area</p> <p><input type="checkbox"/> one floor/ground level</p> <p><input type="checkbox"/> one floor/upper level</p> <p><input type="checkbox"/> multiple levels</p> <p><input type="checkbox"/> other</p>	<p>Dwelling</p> <p><input type="checkbox"/> owned by caregivers</p> <p><input type="checkbox"/> owned by others</p> <p><input type="checkbox"/> rented by caregivers</p> <p><input type="checkbox"/> rented by others</p> <p><input type="checkbox"/> other</p>

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The home environment must support the client's health, safety, and well-being.

Indicate the address of the home being assessed. If the client receives services in more than one primary residence, this section must be completed for EACH residence.

Location

City/Town: The client lives in a city, town, or the suburbs of either.

Rural Community: The client lives in a small rural community, including farm communities and other areas where several dwellings are near each other, possibly centered around a church or store.

Isolated: The client lives in an area with few dwellings. While a few dwellings may be near each other, there is a significant distance to other dwellings, stores, and the usual community services.

Other: Please specify

COMPLETING THE ASSESSMENT FORM SECTION 8, HOME ENVIRONMENT, CONT'D.

CAP/C Assessment	Client:	MID:
<input type="checkbox"/> 8. HOME ENVIRONMENT (May be completed by RN or Social Worker)		
<p>If client receives services in more than one primary residence (i.e. lives part-time with mother, part-time with father), this section must be completed for EACH residence. Rate each component of the home environment according to the following definitions: <u>Adequate</u> for client's needs/safety. Not a threat to health, safety, and well-being. <u>Minor problem</u> area for which improvement would benefit client, however is not a threat to client <u>Inadequate</u> – doesn't provide for client's needs/ safety, must be resolved before well-being can be assured.</p>		
Street Address: <input type="checkbox"/> same address as listed for client on page 1 <input type="checkbox"/> other, specified below		
Location <input type="checkbox"/> city/town <input type="checkbox"/> isolated <input type="checkbox"/> rural <input type="checkbox"/> other	Client's Living Area <input type="checkbox"/> one floor/ground level <input type="checkbox"/> one floor/upper level <input type="checkbox"/> multiple levels <input type="checkbox"/> other	Dwelling <input type="checkbox"/> owned by caregivers <input type="checkbox"/> owned by others <input type="checkbox"/> rented by caregivers <input type="checkbox"/> rented by others <input type="checkbox"/> other

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Check the box to indicate where the client lives in the dwelling. If 'other', please specify. Provide an explanation under 'Comments' of any apparent discrepancies (e.g., a client in a wheelchair lives on multiple levels; document that the family carries the patient up and down the stairs).

Check the box that describes the ownership of the dwelling. If 'other', please specify.

COMPLETING THE ASSESSMENT FORM SECTION 8, HOME ENVIRONMENT, CONT'D.

	ADEQUATE	MINOR PROBLEM	INADEQUATE
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In assessing each area, consider the client's abilities, conditions, needs, and support. View the home environment in relation to the client's ability to perform home care and self-care tasks safely. The client's mental and physical condition, as well as support, affects decisions in this area. Be sure that your ratings here correlate with the other areas of the assessment. Overall, the environment must support an acceptable level of safety, care, and independence for the client.

Identify apparent barriers to adequate care and threats to the client's health and safety. Base ratings on your observations and common sense. You may seek professional advice. Use the definitions below to rate each area:

Adequate: Not a threat to health, safety, and well-being. The area meets the client's needs and does not present a health or safety hazard, given the client's condition and support. Comments are not required.

Minor Problem: Area for which improvement would benefit client, however it is not a threat to client. The area does not threaten the client; however, a repair or correction could benefit the client. Describe the type of problem and planned solution under Comments.

Inadequate: Doesn't provide for client's needs/safety – must be resolved before well-being can be assured: This is a problem that must be resolved before a client may be approved for CAP. Describe the problem and indicate whether a solution is feasible under COMMENTS.

COMPLETING THE ASSESSMENT FORM

SECTION 8, HOME ENVIRONMENT, CONT'D.

Exterior Access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interior Access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleanliness of Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trash Disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Exterior Access: Can the client enter and exit the home safely, especially in an emergency? For immobile clients, is the access adequate for someone to get the client out of the home?

Interior Access: Does the client have safe access to all essential areas within the home? For example, can a wheelchair bound client get through all needed doorways? Are there areas contributing to frequent falls? Are there necessary safety rails or grab bars? Are there potentially dangerous items, such as throw rugs, that could hinder safe access?

Heating: Is the heating adequate to maintain the client's living area at a comfortable temperature? Does the source of heat appear safe and reliable? Do special precautions need to be taken in extreme weather, such as alertness to freezing lines or overheating of the appliance?

Cooling: Is there a method to adequately cool the client? Does it appear to be safe?

Cleanliness of Home: Is the client's living area relatively neat and clean? Are there piles of litter that could attract and/or hide pests? Is there clutter that could make it difficult for the client to walk? Are there obvious unsanitary conditions?

Trash Disposal: Is there a sanitary way to dispose of garbage and trash? Is it being used?

COMPLETING THE ASSESSMENT FORM SECTION 8, HOME ENVIRONMENT, CONT'D.

Clean Water Source	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body Waste Disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking Appliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refrigerator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Electrical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Clean Water Source: Is there an adequate, reliable source of clean water to use for bathing and cooking? Are there potential problems in very cold or dry weather that need to be recognized?

Hot Water: Is there a safe and reliable source of hot water, whatever the means obtained (boiling on stove, water heater, or other means)?

Body Waste Disposal: If there is indoor plumbing, are there indications that it is not functional? Is the method of disposal sanitary and accessible?

Laundry: Is there an adequate and sanitary method to clean clothes and bed linen?

Cooking Appliance: Is there a safe and adequate method to prepare food? Does the appliance present any particular hazards to the client?

Refrigerator: Is there a functioning refrigerator in the home? If not, is there another means of keeping foods as well as medications that may require refrigeration?

Lighting: Is there adequate lighting for the client and caregivers to function? Does it appear safe?

Other Electrical: Are there obvious signs of electrical hazards, such as bare wires? Does the wiring appear adequate to support any life sustaining equipment in the home? If life-sustaining equipment is in use, has the power company been notified?

COMPLETING THE ASSESSMENT FORM

SECTION 8, HOME ENVIRONMENT, CONT'D.

Structural Integrity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pest/Vermin Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: <input style="width: 50px;" type="text"/>			

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Structural integrity: Does the home appear to be in good repair? Are there holes in the roof or floors in the client's living area? Are there unsafe steps? Is the living area drafty? Does rain come in through the windows, roof or doorways? Can the floor support equipment used by the client, such as a heavy wheelchair? Are windows or doors broken?

Telephone: Is there a phone in the client's living area for his/her use? Is it accessible to the client's caregivers? If there is not a phone in the client's living area, is there one in the immediate area?

Pest/Vermin Control: Are there any signs of infestation of any types of pests or vermin rats, mice, snakes, bugs, or other creatures? Are past infestations under control? Are there active measures to control infestations that may be likely?

Fire Safety: Are there obvious fire hazards in the home, such as piles of newspapers, frayed electrical cords, faulty heating appliances, or unsafe storage of flammables? Are there smoke detectors? Are local fire officials aware of a bedfast or wheelchair bound client? Are there safe exits in the event of a fire?

Security: Are there obvious security hazards for the client? Are there functioning and seemingly adequate locks?

Additional Comments: Use this space, if needed, to expand on any comments.

COMPLETING THE ASSESSMENT FORM SECTION 9, ECONOMIC STATUS

CAP/C Assessment	Client: [REDACTED]	MID: [REDACTED]
9. ECONOMIC STATUS (May be completed by RN or Social Worker)		
A. Financial Manager		
Who manages the client's finances? <input type="checkbox"/> Parent <input type="checkbox"/> Other		
If not the parent, give name and address of person as well as any formal designation (such as guardian, trustee, power of attorney) below:		
Name [REDACTED]	Formal Designation [REDACTED]	
Address [REDACTED]		
B. Financial Management		
Is there any indication of mismanagement of the client's funds? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, give details of referral to appropriate agency: [REDACTED]		
C. Financial Need		
Are there items or services that the client does without each month due to lack of funds? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain: [REDACTED]		

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Financial Manager: Check the appropriate box to show who handles the client's/family's money. If the individual is other than the client's parent, give the name and address of the person. If this person has a formal designation, such as Power of Attorney or Guardian, note it in the space provided.

Financial Management: Indicate if there seems to be any mismanagement of funds by checking the appropriate box. If a Yes is entered, refer to the appropriate agency and note the detail of the referral here (who took the referral, what agency, and the date of the referral). Example: Utilities cut off because of non-payment of bills. Refer to agency or church to assist with payment, or refer to credit counseling agency to assist with making timely payments.

Financial Need: Indicate if the monthly expenses exceed the monthly income. If so, describe how the client's needs are met or unmet (e.g., the formula prescribed for the client is too expensive so the family waters it down or substitutes a cheaper formula). Describe your plan to met those needs.

COMPLETING THE ASSESSMENT FORM SECTION 10, MENTAL HEALTH

10. MENTAL HEALTH (May be completed by RN or Social Worker)

This part of the assessment looks at a variety of mental health areas that relate to the client's ability for self-care and behaviors that may affect the provision of care. Many of these areas are difficult to measure objectively. When ratings are requested, enter the one that best describes the client most of the time. Many of the ratings may come from observations of the client's actions/responses during the assessment. Note that this is not a formal mental health evaluation, though it may show the need for a formal evaluation or referral.

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Use this portion of the assessment form to document findings on the client's mental status that may affect his/her capacity for self-care and the provision of care by others. Document your observations during the interview, while drawing upon other reliable information that is available to you. Examples of such information are medical reports, psychological evaluations and reports from the child's parents or other individuals who are familiar with the child's mental health status.

COMPLETING THE ASSESSMENT FORM SECTION 10A, ORIENTATION

A. ORIENTATION	
Is the client alert?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Is the client oriented to person, as appropriate for age?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Is the client oriented to place, as appropriate for age?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Is the client oriented to time, as appropriate for age?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Describe activities the client engages in with family members, others, or self, and their reactions to these activities. (Favorite toys, videos, reading, sensory stimulation activities):	

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Check Yes, No, or Sometimes on the form to indicate the client's alertness and orientation to person, place, and time. Use developmentally appropriate assessment techniques. For example,

oriented to person: responds with smile to mother, cries when held by strangers

oriented to place: behavioral change/calming when outdoors, cries as soon as enters physician's office

oriented to time: sensitive to changes in routine, awake during the day/asleep during the night.

Describe some of the client's favorite activities to help clarify the patient's level of interaction and developmental status. The information indicated here should match the information indicated on the FL-2 form.

COMPLETING THE ASSESSMENT FORM SECTION 10B, EMOTIONAL STATE

CAP/C Assessment	Client:	MID:
B. EMOTIONAL STATE		
Assess the client's overall emotional state – the client's affect, satisfaction with life, and activity level using the statements below.		
<input type="checkbox"/> Contented, shows interest		
<input type="checkbox"/> Unhappy/depressed for short periods, interest in activity has waned		
<input type="checkbox"/> Feelings of helplessness and hopelessness, dissatisfied with life, declining participation in <u>ADLs</u>		
<input type="checkbox"/> Non-responsive/unable to determine		
Expand on abnormal findings: <input type="text"/>		

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Assess the client's affect and consider the appropriateness of the client's emotional state for the client's situation. Check the box that most nearly describes the client most of the time. Explain abnormal findings. If the client is on medication such as antidepressants, note the reason for it and the results here.

If there is inappropriate depression or grandiosity, unreasonable or inappropriate ideas, delusions, hallucinations, or suicidal indications, make a referral to the appropriate person (client's physician or mental health specialist). Document the details of the referral under Comments.

COMPETING THE ASSESSMENT FORM SECTION 10C, JUDGMENT

C. JUDGMENT
Assess the client's ability to discern unsafe/threatening situations, and respond to emergency situations.
Use the statements below to indicate the rating.
ROUTINE – Describe several routine situations that may occur (e.g.; stranger knocks at door, dressing appropriately for weather/situation, recognizing soiled/wet diaper)
EMERGENCY – Does client know how to access 911? Yes No

Age-appropriate decisions and problem solving
 Mild deficit; can handle simple issues, difficulty with more complex issues
 Moderate to severe deficit; difficulty with simple issues, can not make decisions or solve problems
 Non-responsive/unable to determine
Give details of deficits: _____

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Describe a variety of routine and emergency situations to the client during the course of the interview, and evaluate the client's responses. Many situations fit naturally into the interview process during discussions of other assessment areas.

Use the definitions below to rate each area. Explain mild deficit, moderate to severe deficit, and unable to determine under 'Comments'. Comments may also be used for additional information.

Age-appropriate decisions and problem solving: The client responds appropriately, for his/her developmental stage, to real life problems and situations.

Mild deficit-usually handles simple issues; not good with complex issues: Check this box to describe a client that appears to handle simple decisions that involve only one or a few steps, but has difficulty when several steps are needed. For example, a client may know to call someone when the power goes off, but might not think through all of the other actions needed, such as handling medicine that relies on power for refrigeration. Describe the limitations and any implications on care requirements.

Moderate to severe deficit-difficulty with simple issues-cannot make decisions or solve problems: The client's judgment limitations are such that he/she cannot reliably deal with simple issues. The client does not show a consistent ability to make sound decisions on basic, everyday issues. Note under Comments the implications for care – this may be a simple statement such as, "the client cannot be left alone."

Non-Responsive/Unable to Determine: Client's judgment cannot be determined as he/she is not responsive during the assessment. Also use this code if you are unable to assess because of the client's age. Note: Children that are non-responsive all the time would be rated as moderate-severe.

COMPLETING THE ASSESSMENT FORM SECTION 10D, BEHAVIOR

D. BEHAVIOR

Based on the assessor's observations and available information from reliable sources, rate the client's usual behavior toward persons outside the household/immediate family.

cooperative passive argumentative/suspicious/hostile verbally abusive
 physically abusive other

Explain abnormal findings:

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This item refers to the social behavior of the client, primarily with those outside of the home and outside of the immediate family. Because negative behavior may impede the ability to provide care in the home, it is important that it be noted. Base your evaluation on your observations as well as information from reliable sources. Check all of the boxes that apply. Give explanations of abnormal findings. Indicate and describe the effect of any psychiatric medications, including ADHD medications that are prescribed for the client.

COMPLETING THE ASSESSMENT FORM SECTION 10E, MENTAL FUNCTION RATING

E. MENTAL FUNCTION

The previous areas of this assessment provide the basis for determining if there are impediments to self-care for mental reasons. Select a statement below to rate mental function.

- Mental status is adequate; no in-home supervision needed.
- Mental status is adequate; supervision required due to age of child
- Mental health impairment requiring supervision for specific tasks or at specific times
- Mental health impairment requiring 24 hour supervision.
- Unable to determine

Comments:

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Function in the context of this assessment refers to impediments to self-care due to mental status. Check the appropriate box as described on the form.

COMPLETING THE ASSESSMENT FORM SECTION 10F, MENTAL HEALTH SUMMARY

CAP/C Assessment

Client:

MID: [REDACTED]

F. MENTAL HEALTH ASSESSMENT SUMMARY

Expand on any areas that need more detail. Describe the client's overall level of psychosocial development and how it influences the client's care. Include results of any formal developmental evaluations.

[REDACTED]

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Briefly summarize the client's mental status. Highlight any information that is significant to the development of the Plan of Care or to the feasibility of CAP/C participation. If the client has been diagnosed with mental retardation or developmental delays, note this information and discuss the degree or level of cognitive impairment if known. Describe any involvement with mental health professionals, including services such as Community Support Services, or status on the CAP-MR/DD waiting list.

COMPLETING THE ASSESSMENT FORM SECTION 11, ADDITIONAL INFORMATION

11. ADDITIONAL INFORMATION (May be completed by RN or Social Worker) – This section is optional.

Use the space below to expand on any of the previous sections in which you did not have enough room to include all information. Please refer to the section number and/or letter.

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Use this section to expand on any areas of the assessment in which you did not have enough room to include all information, or to provide additional pertinent information.

COMPLETING THE ASSESSMENT FORM SECTION 12, SIGNATURES

12. ASSESSMENT CERTIFICATION (To be completed by both assessors as appropriate)

The signature of each member of the assessment team below certifies that each person has been involved in the assessment and completed the specific areas that require that member's professional expertise. An individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and will be referred to the appropriate professional licensing agency for investigation. Along with the signature, enter the assessor's title and the name and phone number of the agency that the assessor represents.

REGISTERED NURSE

Name	Signature	
Agency	Phone	Date
Sections Completed: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> All		

SOCIAL WORKER

Name	Signature	
Agency	Phone	Date
Sections Completed: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11		

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The assessor's signatures certify that they have been involved in the assessment and completed those areas that require the individual's professional expertise as indicated on the form. The assessment should be signed and dated on the day it is completed by each assessor. Enter the name of the agency that employs the assessor, and the assessor's phone number. Indicate which sections of the form were completed by each assessor.

SUMMARY

- Be specific.
- Be detailed.
- Be individualized.
- If there is a discrepancy between the assessment and the FL-2, resolve it.
- If you check 'other', describe it.
- If you check an abnormal finding, describe it and what is being done about it.
- If you identify a need, identify a plan to meet the need.

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SUMMARY, CONT'D.

All of the information on the assessment form should be consistent with all of the information on the FL-2 form, the CMS-485 form, the Plan of Care form, and the nurse/nurse aide notes, and the different sections of the assessment form should be consistent with each other.

Any inconsistencies or discrepancies must be explained and resolved.

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REVIEW QUESTIONS

Please make sure you can answer the following questions before proceeding to the next section.

1. The information that is on the assessment should match the information that is found on the
 - A. _____,
 - B. _____,
 - C. _____, and
 - D. _____
 - E. and it should be consistent within _____.
2. True or False: “Severe” is an acceptable way of describing a diagnosis’ outcome/current effect.
3. True or False: An abnormal finding need not be described, as long as you have indicated that it is abnormal.
4. If you identify a need for a piece of equipment, you must identify _____.
5. True or False: If you check ‘other’ you must describe specifically what ‘other’ means.

REVIEW ANSWERS

1A. The FL-2

1B The CMS-485

1C The Plan of Care

1D. The nurse/nurse aide noted

1E. Itself

2. False. "Severe" is not specific, detailed, or individualized.

3. False. All abnormal findings should be described in a detailed, individualized, specific way.

4. The plan for meeting that need.

5. True.