Iowa Department of Human Services

Off-Year Assessment

Background Information

Member Name: _____ (First Name) _____ (MI) _____ (Last Name) SID: _____ DOB: _____ (MMDDYYYY) Service Type: ---

CM/SW Name: _____ (First Name) _____ (Last Name) Anniversary Date _____ (MMDDYYYY) Assessor: --- Assessment Date: _____ (MMDDYYYY)

Medical Conditions/Diagnoses

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

Risk Factors (YES-NO-UNKNOWN)

--- Is the member in need of a primary healthcare provider?
--- Is the member in need of a dentist?
--- Is the member in need of a specialist?
--- Has the member had problems not taking or not receiving medications on time?
--- Have there been issues with medications not being re-evaluated timely?
--- Has the member had significant medication changes in the past year?
--- In the past year, has the member gone to an emergency room? If yes, how many times? _____ If yes, explain in notes.

Notes: _____

Any risk factor marked 'Yes' must be addressed in the member's Crisis Intervention Plan

Activities of Daily Living (IMPROVED-DECREASED FUNCTION-STAYED SAME-NOT A CONCERN)

---	Eating	How have the changes in the member's condition impacted the member's service needs?		
---	Bathing	Additional types of services	Type:	
---	Dressing	Fewer types of services	Eliminate:	
---	Hygiene	Increased frequency	Increase:	to
---	Toileting	Decreased frequency	Decrease:	to
---	Mobility in home	Have there been any increases or decreases in the availability of the member's natural supports?		
---	Mobility out of home	Additional supports	Type:	
---	Positioning	Fewer supports	Eliminate:	
---	Transferring	Increased frequency	Increase:	to
---	Communicating	Decreased frequency	Decrease:	to

Are there areas member has expressed interest in and could benefit from services not currently in place? If yes, explain in notes.

Risk Factors (YES-NO-UNKNOWN)

--- Is the member at risk of choking or other problems when eating?

--- Is the member's health at risk due to poor nutrition (e.g., eating disorder, refusal to eat, inability to afford nutritious food, etc.)?

--- Would member's health be at risk if a paid provider or natural support person did not show up to provide scheduled services?

Notes:

Any risk factor marked 'Yes' must be addressed in the member's Crisis Intervention Plan

Instrumental Activities of Daily Living (not required for children) (IMPROVED-DECREASED FUNCTION-STAYED SAME-NOT A CONCERN)

--- Preparing meals
--- Shopping
--- Transportation
--- Managing medications
--- Housework
--- Managing money
--- Telephone use
--- Employment

How have the changes in the member's condition impacted the member's service needs? (Enter in notes)

Additional types of services — Type: _____

Fewer types of services — Eliminate: _____

Increased frequency — Increase: _____ to _____

Decreased frequency — Decrease: _____ to _____

Have there been any increases or decreases in the availability of the member's natural supports?

Additional supports — Type: _____

Fewer supports — Eliminate: _____

Increased frequency — Increase: _____ to _____

Decreased frequency — Decrease: _____ to _____

Risk Factors (YES-NO-UNKNOWN)

--- Is the member without means of communication in an emergency?

--- Is the member able to respond to emergencies independently?* *If member is never alone, check here for N/A: ☐

Notes:

Any risk factor marked 'Yes' must be addressed in the member's Crisis Intervention Plan

Cognitive Function and Memory/Learning (IMPROVED-DECREASED FUNCTION-STAYED SAME-NOT A CONCERN)

--- Cognitive function
--- Judgment/decision-making
--- Memory/learning
--- Behavior concerns

How have the changes in the member's condition impacted the member's service needs?

Additional types of services	Type:		
Fewer types of services	Eliminate:		
Increased frequency	Increase:	to	
Decreased frequency	Decrease:	to	

Have there been any increases or decreases in the availability of the member's natural supports?

Additional supports	Type:		
Fewer supports	Eliminate:		
Increased frequency	Increase:	to	
Decreased frequency	Decrease:	to	

Risk Factors (YES-NO-UNKNOWN)

--- Does the member need to be supervised at all times?

Notes:

Any risk factor marked 'Yes' must be addressed in the member's Crisis Intervention Plan

Behavior Concerns (IMPROVED-DECREASED FUNCTION-STAYED SAME-NOT A CONCERN)

--- Injurious
--- Destructive
--- Socially offensive
--- Other serious

How have the changes in the member's condition impacted the member's service needs?

Additional types of services — Type: _____

Fewer types of services — Eliminate: _____

Increased frequency — Increase: _____ to _____

Decreased frequency — Decrease: _____ to _____

Have there been any increases or decreases in the availability of the member's natural supports?

Additional supports — Type: _____

Fewer supports — Eliminate: _____

Increased frequency — Increase: _____ to _____

Decreased frequency — Decrease: _____ to _____

Risk Factors (YES-NO-UNKNOWN)

--- Has the member refused or spit out medications?
--- Has the member misused prescription or OTC medications (e.g., taken too many at once)?
--- Has the member ingested foreign objects or been diagnosed with PICA?
--- Has alcohol or substance use caused the member any problems?
--- Has the member left/attempted to leave home or other supervised activities without permission or when it would be unsafe to do so?
--- Is the member non-compliant with medical appointments or treatments?

Notes:

Any risk factor marked 'Yes' must be addressed in the member's Crisis Intervention Plan

Additional Information (IMPROVED-DECREASED FUNCTION-STAYED SAME-NOT A CONCERN)

If the member currently receives any skilled service, check all that apply below.

☐ PT ☐ OT ☐ ST Therapist frequency _____ Home exercise plan frequency _____

☐ Full thickness wound ☐ Daily wound care ☐ Medical oversight

☐ Daily tracheostomy/NG suctioning ☐ Ventilator/respirator >6/24 hours

☐ Daily intermittent catheterization ☐ Daily catheter irrigations ☐ Medical oversight

☐ IV drug therapy (put doctor order in notes)

Due to inadequate nutrition ☐ Tube feeding ☐ IV infusion (put doctor order in notes)

☐ Nephrostomy care (put doctor order in notes)

Has the need for these services changed? _____

Describe any other changes in member's condition(s) that may impact the member's service need. (Enter in notes)

Risk Factors (YES-NO-UNKNOWN)

--- Is there any evidence of neglect by a caregiver?

--- Is there any evidence of self-neglect?

Notes:

Any risk factor marked 'Yes' must be addressed in the member's Crisis Intervention Plan