HSCSN Utilization Management Department
Personal Care Aide (PCA) Assessment Form

Type of Assessment: Initial □ Re-Assessment □

Address: _____

_____

Will the PCA service be provided at this location? Yes _ No □

If no, where will service be provided? □School □ Residence (not primary)
Address: _____

_____

Primary Caregiver:
□ Enrollee □ Parent(s) □ Sibling □ Foster Parent □ Other: _____

Diagnosis and ICD-9-CM Codes - List each medical diagnosis and ICD-9-CM code. (Diagnosis to be obtained from the referral form)		
Diagnosis	**ICD-9-CM code**	**Comments**

Medications		
Current Medications	**Dose/Frequency/Route**	**Comments**

How are medications given? Check one below	
	Without Assistance
	Administered/Monitored by family member
	Administered/Monitored by professional nursing staff

FOR 18y and older only. Is the enrollee independent in the following activities?		
Independent Activities of Daily Living	**Yes**	**No**
Meal Preparation		
Using the phone		
Shopping		
Home Maintenance		

Directing Care Determination - Enrollees must be able to direct their own care or have a responsible party that provides the support needed to direct the PCA care.

Yes No □ Can enrollee identify their own needs?
Yes No □ Can enrollee direct and evaluate PCA task accomplishments?
Yes No □ Can enrollee provide and/or arrange for their health and safety?
Yes No □ Primary caregiver is required and present for assessment?
Name: _____

Individual(s) present for Evaluation:
□ Enrollee □ Parent(s) □ Sibling □ Foster Parent
□ Other: _____

Does the primary caregiver have a condition that impacts their ability to provide care for the enrollee being assessed (medical, physical, or mental health)? Yes □ No □
If yes, what is the impairment? (Caregiver to provide documentation)

_____

_____

_____

Are there any problems where you currently reside? Check all that apply			
	Yes	**No**	**Describe Problem**
Barriers to access			
Electrical hazards			
Fire Hazards/No smoke alarm			
Insufficient Heat/Air conditioning			
Insufficient hot water/water			
Poor toilet facilities			
Defective stove, refrigerator, freezer			
Defective washer/dryer			
Poor bathing facilities			
Structural problems			
Telephone not accessible			
Unsafe neighborhood			
Unsafe/poor lighting			
Unsanitary conditions			
Other:			

Special Medical Procedures: Does the enrollee receive any special nursing care?		
Site, Frequency, Duration	**Yes**	**No**
Bowel/Bladder Training		
Dialysis		
Dressing/Wound Care		
Respiratory Treatment		
Eye care		
Glucose/Blood Sugar Testing		
Oxygen		
Radiation/Chemotherapy		
Restraints (Physical/Chemical)		
ROM Exercise		
Trach Care/Suctioning		
Ventilator		
Other:		

Sensory Functions
Does the enrollee have problems with vision, hearing and/or speech?

	No Impairment	**Impairment**		**Complete Loss**
		Compensation	**No Compensation**	
Vision				
Hearing				
Speech				

Activities of Daily – A dependency in an ADL is defined as a daily need for one or both of the following:

1. Cuing and constant supervision to complete the task OR
2. Hands-on assistance to complete the task.

Activity	**Y**	**N**	**Description of assistance needed**	**O**	**R**
Dressing					
Grooming/Hygiene					
Bathing					

Eating					
Transfers					
Mobility					
Positioning					
Toileting					

O=Observed R=Reported

Behaviors	**Y**	**N**
Increased vulnerability due to **cognitive** deficits or socially inappropriate behavior; or **resistive** to care, verbal aggression; or physical **aggression** towards self, others; or destruction of property		
If **"Yes"**, describe the behavior(s) of the enrollee, including the frequency and the intervention(s) needed below. If **"Yes",** Behavioral Health Home Assessment should be considered.		

Indicate day(s) and time(s) services are required M- (6a-12n) A- (12n-6p) E- (6p-10p)

Day(s) required	□ **Sun**	□ **Mon**	□ **Tues**	□ **Wed**	□ **Thurs**	□ **Fri**	□ **Sat**
Time(s) required	**M___** **A ___** **E _ _**	**M___** **A ___** **E _ _**	**M___** **A ___** **E ___**	**M___** **A _ _** **E _ _**	**M___** **A ___** **E _ _**	**M___** **A ___** **E ___**	**M___** **A _ _** **E ___**

Were any social, medical, rehabilitative and/or home health needs identified during the assessment? Yes ___ No ___

If "Yes", describe ongoing social, medical, rehabilitative and/or home health needs:

1. Evidence of medical instability

2. Need for PCA services.
3. Need for home health skilled services (RN, physical therapy, and/or occupational therapy).
4. Need for other supportive services (social worker, mental health, legal, etc.)

Comments:

RN Evaluator Attestation

I have completed an independent assessment of the enrollee's needs. The information documented is an accurate interpretation of what I observed and/or was reported by the enrollee or responsible caregiver.

Name: _____
(Print) (Signature and Title)

Date Assessment Completed: _____

Home Health Agency: _____
Address: _____
Phone #/Fax #:_____

Form adapted from the Minnesota Department of Human Services, Personal Care Assistance (PCA) Assessment and Service Plan/Instructions and Guidelines (May 2009)