

Needs Assessment Tool Form Instructions

Needs Assessment Tool (NAT)

The previous tool known as the CMI (Care Management Instrument) has now been replaced by the NAT (Needs Assessment Tool).

The NAT is an assessment and its purpose is to gather information about the individual. The additional information included in the NAT (not contained in the LCD) is critical as it is used for implementing a care plan. The additional information includes: Eyes, Nose and Throat (ENT), Eyes, and Mouth in the Diagnoses section, Nutrition Issues, Risk Assessment, Suicide Screening, Addictive Behaviors, Informal Support involvement, Protective Service information, Physical Environment, Emergency information, and Financial information. The information contained in the NAT is used to determine a recipient's service needs, strengths, resources, preferences, and goals to develop a care plan.

Much of the information captured in the LCD (Level of Care Determination) will populate into the NAT using the SAMS copy feature (refer to SAMS Instructions). It is the responsibility of the care manager/service coordinator to ensure that all sections of the NAT are accurate and completed in the manner described in these instructions.

The Short Portable Mental Status Questionnaire has been replaced with the VAMC Saint Louis University Mental Status (SLUMS) Examination. The SLUMS has been placed before the medical condition section and must be completed. Placing the mental examination before the medical section enables the care manager to determine the cognitive ability of the individual to answer questions pertaining to medical diagnoses and functional ability.

Use of the NAT will improve consistency with documentation by decreasing text entries. Medical conditions now display drop down boxes for each type of diagnoses. The category of "Other" for selections of diagnoses not provided and a note section for expanded documentation in each section are available. In addition to determining if a medical diagnoses or condition affects the individual's ability to function, questions are included to assist the care manager determine who is managing care of the conditions and if additional care or assistance is needed.

The tool also has an algorithm to assist with a Functional Needs Score (FNS) score to be utilized when an agency implements a waiting list for programs. The tool will improve documentation and the results can be utilized by the Department for quality initiatives and general data collection regarding the individuals that are served.

Care Managers, Registered Nurses, and Supervisors must ensure that when logging into SAMS/OMNIA that they use their individually assigned user ID's and passwords. The signature in SAMS will indicate that the data recorded is complete and accurate.

Needs Assessment Tool Form Instructions

This is also important because SAMS/OMNIA will use the User ID to record an electronic signature for the Individual completing their correct portion of the assessment tool. The electronic signature replaces the need for hard copy signatures.

In order to fully assess a consumer's needs, a NAT should be completed in the consumer's home or other residential setting. It is understood that there are some situations (i.e. Nursing Home Transition) where a NAT may be initiated while a consumer is in a facility, but it is never to be considered fully completed until all areas addressed in the tool, including the home environment.

1. INTRODUCTION

1.A. INDIVIDUAL'S IDENTIFICATION

Question 1: Date of the face to face interview for Needs Assessment Tool (NAT):

Using the MM/DD/YYYY format, document the date that the Needs Assessment face to face interview was completed.

Question 2: Individual's Last Name:

Document the last name of the individual as it appears on his/her birth certificate or Social Security Card.

Question 3: Individual's First Name:

Document the first name of the individual as it appears on his/her birth certificate or Social Security Card.

Question 4: Individual's Middle Initial:

Document the individual's middle initial as it appears on his/her birth certificate or social security card.

Question 5: Individual's Name Suffix (If applicable):

Document the name suffix (e.g. Sr. or Jr.).

Question 6: Individual's Nickname/ Alias:

Document the individual's nickname or alias (e.g. Josephine, alias Jay).

***Question 7: Individual's Date of Birth (DOB):**

Using the MM/DD/YYYY format, document the individual's date of birth.

Needs Assessment Tool Form Instructions

***Question 8: Individual's Gender:**

Document if the individual is male or female.

***Question 9: Individual's Ethnicity: (Check only one.)**

Document the individual's ethnicity as described by the individual. Select only one response (box).

***Question 10: Individual's Race:**

Document the individual's race as described by the individual. Select only one response (box).

Question 11: Individual's Social Security Number (SSN):

Enter the individual's SSN. The individual must present their SSN to apply for services in the community or nursing facility.

Question 12a: Does the individual have a Medicaid number?

Answer No, Yes or Pending. If yes, enter the number in 1.A.12b.

Question 12b: Indicate Medicaid recipient number:

Enter the individual's Medicaid recipient number if applicable.

Question 13a: Does the individual have Medicare?

Answer No or Yes. If yes, enter the number in 1.A.13b.

Question 13b: Indicate Medicare recipient number:

Enter the individual's Medicare recipient number if applicable.

Question 14a: Does the individual have any other insurance?

Answer No, Yes or Don't Know. If yes, enter the number in 1.A.14.b.

Question 14b: Indicate other health insurance information:

Document the name of the individual's other health insurance if applicable.

1.B. ASSESSMENT INFORMATION

Question 1: PSA number conducting assessment:

Needs Assessment Tool Form Instructions

Document the Agency PSA number.

Question 2: Indicate type of Needs Assessment Tool (NAT):

Document the type of assessment completed. Select only one response (box).

Question 3: Where was the individual interviewed?

Document the location where the individual was interviewed. Select only one response (box).

Question 4: Did the individual participate in the assessment?

Answer No or Yes. If No, Must complete 1.B.5 and why they did not participate in the notes.

Question 5: If anyone else participated during the time of the needs assessment please document the name and relationship in Notes:

Document all present at the interview. Select all response boxes that apply. List the name(s) and relationship(s) in the notes section.

1.C. POWER OF ATTORNEY (POA) / LEGAL GUARDIANSHIP
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Question 1a: Does the individual have a legal guardian?

Answer No or Yes. If No, Skip to 1.C.2a.

Question 1b: Was proof of legal guardianship provided?

Answer No or Yes.

Question 1c: Name of legal guardian:

Document the name of the legal guardian.

Question 1d: Complete address of legal guardian:

Document the complete address of the legal guardian.

Question 1e: Primary phone number of legal guardian:

Document the primary phone number of the legal guardian.

Question 1f: Secondary phone number of legal guardian:

Needs Assessment Tool Form Instructions

Document any other secondary phone number where the legal guardian may be reached (if applicable).

Question 1g: E-mail address of legal guardian:

Document the legal guardian's E-mail address.

Question 2a: Does the individual have a Power of Attorney (POA)?

Answer No or Yes. If No, Skip to 1.D.1a.

Question 2b: Proof of POA provided?

Answer No or Yes.

Question 2c: Type of POA:

Document the type of power of attorney. If not listed, select "Other" and document details in the notes section.

Question 2d: Name of POA:

Document the name of the power of attorney.

Question 2e: Complete address of POA:

Document the complete address of the power of attorney.

Question 2f: Primary phone number of POA:

Document the primary phone number of the power of attorney.

Question 2g: Secondary phone number of POA:

Document any other secondary phone number where the power of attorney may be reached (if applicable).

Question 2h: E-mail address of POA:

Document the E-mail address of the power of attorney.

1.D. INDIVIDUAL'S DEMOGRAPHICS

Question 1a: Is the individual homeless?

Select No or Yes. If No, Skip to 1.D.2.

Needs Assessment Tool Form Instructions

A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation.

Question 1b: Does the individual have a place to stay tonight?

Select No or Yes. Select one response (box). If No, document details in the notes section.

Question 1c: Does the individual have a place to stay long-term?

Select No or Yes. Select one response (box). If No, document details in the notes section.

Question 1d: Explain homeless situation:

Select appropriate response(s). If not listed, select "Other" and document details in the notes section.

***Question 2: Type of PERMANENT residence in which the individual resides:**

Document type of residence the individual lives in. Select only one response (box).

***Question 3: What is the individual's PERMANENT living arrangement? (Include in the "Lives Alone" category, individuals who live in an AL, DC, or PCH, pay rent and have NO ROOMMATE.):**

Document the appropriate primary living arrangement. If the individual lives in Assisted Living, Dom Care, or PCH, pays rent and has no roommate, select the "Lives Alone" box and indicate in the notes section the type of living arrangement.

***Question 4: Individual's marital status:**

Document the marital status of the individual. Select one response (box).

***Question 5a: Is the individual a Veteran?**

Select No, Yes or Unable to Determine. Select one response (box). If Unable to Determine, document details in the notes section.

Question 5b: Is the individual the spouse or child of a Veteran?

Select No, Yes or Unable to Determine. If Unable to Determine, document details in the notes section.

Question 5c: Is the individual receiving Veteran's benefits?

Select No, Yes or Unable to Determine. If Unable to Determine, document details in the notes section.

Needs Assessment Tool Form Instructions

***Question 6a: Does the individual require communication assistance?**

Select No, Yes, or Unable to Determine. Select one response (box). If No, Skip to 1.D.7a. If Unable to Determine, document details in the notes section.

Question 6b: What type of communication assistance is required?

Document the type of assistance that the individual requires for communication. If the individual is unable to communicate, the care manager should check the response (box) titled Unable to Communicate.

Use the Notes section to clarify type of language assistance such as: interpreter or Assistive Technology assistance (i.e. letter board).

Question 7a: Does the individual use sign language as their PRIMARY language?

Indicate No or Yes. Select one response (box). If No, Skip to 1.D.8.

Question 7b: What type of sign language is used?

Document the individual's type of sign language used. Select one response (box). If not listed, select "Other" and document details in the notes section.

***Question 8: What is the individual's PRIMARY language?**

Document the primary language understood and used by the individual. If not listed, select "Other" and document details in the notes section.

1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED

Question 1: Is the individual's postal/mailing address exactly the same as the residential address?

Indicate No or Yes. If No, Complete sections 1.E & 1.F. Ask the individual where do you get your mail? Indicate yes, if it is the same address where they are residing.

Question 2a: Residential County:

Select the name of the County the individual lives in.

Question 2b: Residential Street Address:

Indicate Street Address where the individual resides.

Question 2c: Residential Address Second Line (Apt or Room #, Building or Complex Name, etc.):

Needs Assessment Tool Form Instructions

Document the Apartment # or Room # and the name of the building or complex (if applicable) where the individual resides. Ex: Apt #3 Independence Court.

***Question 2d: Residential Municipality – REQUIRED (usually a Township or Boro where the individual votes, pays taxes):**

This is the Township or Borough where the individual votes and pays taxes.

Question 2e: Residential City/ Town:

Document the City/Town where the individual lives.

Question 2f: Residential State:

Document the State where the individual lives.

Question 2g: Residential Zip Code:

Document the Zip Code where the individual lives.

Question 3: Directions to the individual's home:

Document the Directions to the individual's home.

***Question 4: Does individual reside in a rural area?**

This question will automatically populate based on the municipality entered in Question 2d.

Question 5a: Primary Phone Number:

Document the PRIMARY phone number of the individual.

Question 5b: Mobile Phone Number:

Document the individual's Mobile Phone Number (if applicable).

Question 5c: Other Phone Number (Enter number where individual can be reached.):

Document any other ancillary phone number where an individual may be reached.

Question 5d: E-mail Address:

Document the individual's E-mail Address.

***Question 6: What was the outcome when the individual was offered a voter registration form? REQUIRED:**

Needs Assessment Tool Form Instructions

Select one response (box).

NOTE: The AAA is not responsible to provide voter registration to Nursing Facility residents. Under the Code of Federal Regulations (CFR) this is the responsibility of the staff at the nursing facility. It is not a problem if you elect to ask the question; however, if you do not ask the question document “NF” in the notes section.

1.F. INDIVIDUAL’S POSTAL/MAILING ADDRESS INFORMATION

The purpose of this section is to document the individual’s postal/ mailing address which may not be the same as their residential address.

Question 1a: Postal Street Address:

Document the Street Address of the individual’s residence.

Question 1b: Postal Address Line 2 (Optional):

Document the Apartment # or Room # and the name of the building or complex (if applicable). Ex: Apt #3 Independence Court.

Question 1c: Postal City/Town:

Document the City or Town where the individual resides.

Question 1d: Postal State:

Document the State where the individual resides.

Question 1e: Postal Zip Code:

Document the Postal Zip Code where the individual resides.

1.G. EMERGENCY CONTACT

Question 1: Name of Emergency Contact:

Document the name of the Emergency Contact for the individual.

Question 2: Relationship of Emergency Contact:

Document the Relationship of the Emergency Contact to the individual.

Question 3: Telephone Number of Emergency Contact:

Needs Assessment Tool Form Instructions

Document the Telephone Number of the Emergency Contact.

Question 4: Work Telephone Number of Emergency Contact:

Document the Work Telephone Number of the Emergency Contact.

2. USE OF MEDICAL SERVICES

2.A. HOSPITAL, NURSING FACILITY, ER, INPATIENT PSYCHIATRIC VISITS/STAYS

Admission categories exist that include inpatient admission or outpatient observation status. You are an inpatient when you are formally admitted to a hospital with a doctor's order. Outpatient observation is not considered a hospital admission. An outpatient receives emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor has not written an order to admit you to a hospital as an inpatient. In these cases, you are considered an outpatient even if you spend the night at the hospital.

Question 1: Has the individual stayed in the HOSPITAL in the LAST 12 MONTHS?

Select No, Yes, or Unable to Determine. If No, Skip to 2.A.3. If Yes, Complete 2.A.2. If Unable to Determine, document details in the notes section. Stayed means admitted to the hospital.

Question 2: The approximate number of times the individual has stayed overnight in the HOSPITAL in the LAST 12 MONTHS. Document Details in Notes:

Indicate the number of times the individual was admitted to a Hospital in last 12 months. Document the details in the notes section.

NOTE: Number of times does not mean days in the hospital, but number of times admitted to the hospital.

Question 3: The approximate number of times the individual has visited the ER in the LAST 12 MONTHS and was NOT admitted:

Indicate the number of times the individual visited the ER in the last 12 months and was not admitted. Document the details in the notes section.

Question 4: The approximate number of times the individual was admitted to a NURSING FACILITY in the LAST 12 MONTHS: Document Details in Notes.

Needs Assessment Tool Form Instructions

Indicate the number of times the individual stayed in the Nursing Facility in the last 12 months. Document the details in the notes section.

NOTE: Number of times does not mean days in the nursing facility, but number of times admitted to the nursing facility.

Question 5: The approximate number of times the individual was an inpatient in a PSYCHIATRIC Facility in the LAST 24 MONTHS: Document Details in Notes.

Indicate the number of times the individual has had inpatient Psychiatric Visits/Stays in the last 24 months. Document the details in the notes section.

NOTE: Number of times does means admissions to a Psychiatric facility.

Question 6: The number of times the individual has had outpatient surgery in the LAST 12 MONTHS:

Indicate the number of times the individual has had outpatient surgery in the last 12 months. If not listed, select "Other" and document details in the notes section.

2.B. PRIMARY PHYSICIAN INFORMATION

Question 1: Does the individual have a PRIMARY care physician?

Answer No or Yes. If No, describe in the notes section.

Question 2: PRIMARY Physician's Name:

Enter the Name of the Primary Physician in the space provided.

Question 3: PRIMARY Physician's Street Address:

Enter the Primary Physician's Street Address in the space provided.

Question 4: PRIMARY Physician's City or Town:

Enter the Primary Physician's City or Town in the space provided.

Question 5: PRIMARY Physician's State:

Enter the Primary Physician's State in the space provided.

Question 6: Primary Physician's Zip Code:

Needs Assessment Tool Form Instructions

Enter the Primary Physician's Zip Code in the space provided.

Question 7: PRIMARY Physician's Business Phone Number: (Requires 10 digits to transfer to SAMS, optional 1-5 digit extension.)

Enter the Primary Physician's 10-digit Telephone Number in the space provided. It is optional to enter a 1-5 digit extension.

Question 8: PRIMARY Physician's FAX Number:

Enter the Primary Physician's 10-digit Fax Number in the space provided.

Question 9: PRIMARY Physician's E-MAIL ADDRESS:

Enter the Primary Physician's E-Mail address in the space provided.

Question 10: Additional Physicians:

Enter names and contact information for any Additional Physicians the individual has in the space provided (if applicable). Utilize note section as needed.

Question 11: Does the Individual receive alternative medical care from a practitioner?

Answer No or Yes. Choose one response (box). If No, Skip to 3.A.1. If Yes, Complete 2.B.12.

Question 12: Select the type of alternative medical care-Document Details in Notes:

Indicate the type of alternative medical care that the individual is receiving. If not listed, select "Other" and document details in the notes section.

3. SAINT LOUIS UNIVERSITY MENTAL STATUS (SLUMS)

The Saint Louis University Mental Status Examination (SLUMS) was designed as an alternative screening test to the widely used Mini-Mental State Examination (MMSE). The idea was that the MMSE is not great at diagnosing people with very early Alzheimer's symptoms which are sometimes referred to as Mild Cognitive Impairment (MCI) or Mild Neurocognitive Disorder (MNCD). These impairments occur as people progress from normal aging to early Alzheimer's. This can be of significance as early detection can allow for treatment and symptom management to begin sooner. As with

Needs Assessment Tool Form Instructions

any Alzheimer's test, the SLUMS is a screening test and does not substitute for a full diagnostic work-up for Alzheimer's disease.

The SLUMS identifies the subtle symptoms of dementia and allows individuals to seek medical intervention early for the treatment of dementia. Early intervention may affect the disease process. The SLUMS consists of 11 items, and measures aspects of cognition that include, orientation, short-term memory, calculations, naming of animals, clock drawing, and recognition of geometric figures.

Scores range from 0 to 30, with scores of 27-30 considered normal in a person with a high school education. Scores between 21 and 26 suggest Mild Neurocognitive Disorder, and scores between 0 and 20 indicate dementia.

Prior to conducting the SLUMS Exam, the care manager needs to determine that the individual is alert and that they are fully awake and able to focus. This is determined by asking and documenting questions 3.A.1-4. The care manager would not do the exam if the individual presents with the following:

- Extremely Ill
- Falling asleep
- Blind
- Unable to write
- Drowsy/Confused/Distracted/Preoccupied

The care manager needs to be prepared for the exam by having the following materials available:

- Watch with a second hand
- Form with clock outline and geometric figures

Cognitive refers to brain processes such as thinking, attention, perception, learning, memory, reasoning, problem solving, decision making, and planning. Cognitive processes are distinguished from emotional processes (feelings) and behavioral processes (actions).

Orientation refers to the cognitive ability of an individual to know who they are, where they are, and what day and year it is. Assessment of orientation is an important part of any mental status examination, as it helps to evaluate the changes that a disease process may have brought about.

Cognitive symptoms refer to problems with the processes mentioned above in the cognition definition, such as thinking, memory, and learning.

Mild Neurocognitive Disorder (MNCD), these occur as people progress from normal aging to early Alzheimer's.

Needs Assessment Tool Form Instructions

Mild cognitive impairment (MCI) is the type of memory loss once considered normal that now may be seen as an early sign of disease.

3.A. SLUMS PREPARATION

Question 1: Determine if the individual is alert. Alert indicates that the individual is fully awake and able to focus.

Select the response that best indicates the individual's current level of alertness. Select one response (box).

Question 2: Do you have trouble with your memory?

Select No or Yes. Select one response (box).

NOTE: If the individual answers "no", you should be aware of the fact that many people with dementia will answer that question by indicating "no". That is due to the fact that a common symptom of persons with dementia is that they suffer from anosognosia (the literal translation is that "they do not know that they do not know"). Thus, if an individual says "no", one cannot conclude that they are free of cognitive impairment. Therefore, the SLUMs should be completed by all residents unless they refuse to answer the questions.

Question 3: May I ask you some questions about your memory?

Select No, Yes, or Other. If No or Other, document details in the notes section.

Question 4: Is the individual able to complete the SLUMS Exam?

Select No or Yes. If No, document details in the notes section.

If the individual refuses to take the test document in the notes section and proceed to Section 4.

3.B. SLUMS QUESTIONNAIRE

Question 1: What DAY of the week is it?

Document the results of the individual's response to the question: Correct answer response or incorrect answer.

NOTE: Remember that the answer is incorrect if the individual does not answer.

Needs Assessment Tool Form Instructions

Question 2: What is the YEAR?

Document the results of the individual's response to the question: Correct answer response or incorrect answer.

Question 3: What is the name of the STATE we are in?

Document the results of the individual's response to the question. Select one response (box) only.

Question 4: Please remember these five objects, I will ask you what they are later. Apple, Pen, Tie, House, Car:

Recite the five objects to the individual clearly and slowly. Ask the individual to repeat them back to you and tell them that you will ask them again later. The care manager may repeat the objects as many times as it takes for the individual to repeat them back correctly.

The response to this question is recorded in question #7.

Question 5a: You have \$100 and you got to the store and buy a dozen apples for \$3 and a tricycle for \$20. How much did you spend?

Document the results of the individual's response to the question: Correct answer response, incorrect answer or unanswered.

Question 5b: How much do you have left?

Document the results of the individual's response to the question: Correct answer response or incorrect answer or unanswered.

The care manager may repeat the question once and must not give any hints to the answer.

Question 6: Please name as many animals as you can in one minute:

Select the appropriate response. The care manager may accept names of animals only and not categories. Names of birds and fish are acceptable answers. Give the individual one minute to answer and be sure to time them.

Question 7: What were the five objects I asked you to remember? (1 point for each one correct.):

Select each response (box) that the individual answers correctly.

Needs Assessment Tool Form Instructions

Question 8: I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say four-two, you would say two-four.

Select each response (box) that the individual answers correctly. The care manager should state each number by its individual name. 87 is pronounced eight, seven; 649 is pronounced six, four, nine; 8537 is pronounced eight, five, three, seven.

Question 9: This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock:

This is the clock drawing. The care manager will need to utilize the form with clock face and geometric figures. The hour hand must be shorter than the minute hand and the minute hand must point at the 10 and the hour hand point at the 11.

Document the results of the individual's response to the question.

Question 10a: Please place an X in the triangle:

Document the results of the individual's response to the question.

The care manager will utilize the same form as the clock diagram or enlarge the diagrams on a separate sheet of paper to accommodate those with visual impairments.

Question 10b: Which of the figures is the largest?

The care manager asks the individual to place an X in the triangle. Then the care manager asks the individual "Which of the above figures is largest?"

Document the results of the individual's response to the question.

Question 11: I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

Select each response (box) that the individual answers correctly.

The care manager should not repeat the story but read it slowly and make sure the individual is paying attention. The answer of Chicago as the state gets no credit but the care manager may prompt the individual once by repeating the question.

3.C. SLUMS RESULTS

Question 1: SLUMS Total Score – This will be an INDICATOR:

The score for this exam will be automatically calculated in the NAT.

Needs Assessment Tool Form Instructions

Question 2: Record the highest grade (1-12) the individual completed in school:

Document the highest grade (1-12) that the individual completed in school.

Question 3: Identify the highest educational degree that the individual obtained:

Select the correct response.

Question 4: Care manager's conclusion after completion of the individual's SLUMS Exam:

Select the response based on the SLUMS Score and the education level.

3.D. COGNITIVE FUNCTION

Question 1a: Does the individual exhibit any cognitive impairments?

Select No or Yes. If No, Skip to 4.A.1. If Yes, Complete 3.E.

Question 1b: Does this impairment interfere with the individual's ability to function daily?

Select No or Yes. If No, Skip to 4.A.1. If Yes, document details in the notes section.

Question 1c: Is the individual able to direct/ supervise his own care with the impairment?

Select No or Yes. If No, Complete 3.D.1d.

Question 1d: Does the individual have a representative who is able and willing to direct the individual's care because of the impairment?

Select No or Yes. If Yes, Complete 3.D.1e.

Question 1e: Document contact information (Name, Relationship, Phone Number, etc.) of the individual who is willing to supervise care. Additional space in Notes:

Document the appropriate contact information of the individual who is willing to supervise care. Utilize the notes section for additional information if needed.

4. DIAGNOSES

Needs Assessment Tool Form Instructions

The purpose of this section is to document six important questions:

- Individual's diagnoses or conditions specified in each question.
- Signs and symptoms specific to each medical diagnosis or condition.
- If the individual is being treated for the Medical conditions.
- Does the diagnoses affect the individual's ability to function?
- Who is managing care of the individual's conditions?
- Does the individual need additional assistance in managing the care of their medical condition?

Self-manage is defined as having the knowledge, awareness and capability to manage their care as it pertains to a diagnosis or disability. This would include treatments or any prescribed medical measures for the diagnosis as directed by the individual's physician.

All questions must be answered. There may be more than one diagnosis in each section. Select the correct boxes for each and document in notes section any additional information about the diagnosis. In the event that there are no selections listed for the diagnosis, select the "Other" box and document in the notes section.

NOTE: Utilize the boxes to document as much as possible as the tool has an algorithm embedded and the boxes trigger the algorithm not the notes.

You will see ascites as a diagnosis under numerous medical sections of this tool. The term may not be familiar.

Ascites is an abnormal accumulation of fluid in the abdomen which results from high pressure in the blood vessels of the liver (portal hypertension) and low levels of a protein called albumin. Diseases that can cause severe liver damage can lead to ascites. These include long-term hepatitis C or B infection and alcohol abuse over many years. People with certain cancers in the abdomen may develop ascites. These include cancer of the colon, ovaries, uterus, pancreas, and liver. Other conditions that can cause this problem include: Clots in the veins of the liver (portal vein thrombosis), Congestive Heart Failure, Pancreatitis, thickening and scarring of the sac like covering of the heart and kidney dialysis may also be associated with ascites.

4.A. RESPIRATORY

Question 1: Select all RESPIRATORY diagnoses:

Select the appropriate response(s) for all diagnoses. If None, Skip to 4.B.1. If not listed, select "Other" and document details in the notes section.

Question 2: Signs and symptoms of RESPIRATORY diagnoses:

Needs Assessment Tool Form Instructions

Select the appropriate response(s) for all signs and symptoms specific to Respiratory diagnoses. If current signs and symptoms are not listed, select “Other” and document details in the notes section.

Question 3: Current treatments for RESPIRATORY diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 4: Do the RESPIRATORY diagnoses affect the individual’s ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 5: Who manages care of the RESPIRATORY condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 6: Does the individual need additional assistance in managing the care of the RESPIRATORY condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

4.B. HEART /CIRCULATORY SYSTEMS

Question 1: Select all HEART/ CIRCULATORY systems diagnoses:

Select the appropriate response(s) for all diagnoses. If None, Skip to 4.C.1. If not listed, select “Other” and document details in the notes section.

Question 2: Signs and symptoms of HEART/ CIRCULATORY systems diagnoses:

Select the appropriate response(s) for all signs and symptoms specific to Heart/ Circulatory system diagnoses. If current signs and symptoms are not listed, select “Other” and document details in the notes section.

Question 3: Current treatments for HEART/ CIRCULATORY systems diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 4: Do the HEART/ CIRCULATORY systems diagnoses affect the individual’s ability to function?

Needs Assessment Tool Form Instructions

Answer No or Yes. If Yes, document details in the notes section.

Question 5: Who manages care of the HEART/ CIRCULATORY systems condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 6: Does the individual need additional assistance in managing the care of the HEART/ CIRCULATORY systems condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

4.C. GASTROINTESTINAL

Question 1: Select all GASTROINTESTINAL diagnoses:

Select the appropriate response(s) for all diagnoses. If None, Skip to 4.D.1. If not listed, select “Other” and document details in the notes section.

Question 2: Signs and symptoms of GASTROINTESTINAL diagnoses:

Select the appropriate response(s) for all signs and symptoms specific to Gastrointestinal diagnoses. If current signs and symptoms are not listed, select “Other” and document details in the notes section.

Question 3: Current treatments for GASTROINTESTINAL diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 4: Do the GASTROINTESTINAL diagnoses affect the individual’s ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 5: Who manages care of the GASTROINTESTINAL condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 6: Does the individual need additional assistance in managing the care of the GASTROINTESTINAL condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

4.D. MUSCULOSKELETAL

Question 1: MUSCULOSKELETAL diagnoses and/ or signs and symptoms of MUSCULOSKELETAL diagnoses:

Select the appropriate responses for all diagnoses and/or signs/symptoms specific to Musculoskeletal diagnoses. If None, Skip to 4.E.1. If not listed, select “Other” and document details in the notes section.

Question 2: Select all the current treatments for MUSCULOSKELETAL diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 3: Do the MUSCULOSKELETAL diagnoses affect the individual’s ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 4: Who manages care of the MUSCULOSKELETAL condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 5: Does the individual need additional assistance in managing the care of the MUSCULOSKELETAL condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

4.E. SKIN

Wound is defined as a break in the continuity of soft parts of body structures caused by violence or trauma to tissues. It may be a result of an accident or disease. Wounds are not staged.

Ulcer is defined as an open sore or lesion of the skin or mucous membrane accompanied by sloughing or inflamed necrotic tissue. Ulcers are usually caused by irritation as in the case of bedsores.

Needs Assessment Tool Form Instructions

Unstageable Ulcer is defined as a full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. The “base of the ulcer” is used to denote the inability to determine the depth.

Refer to RESOURCES at the end of these instructions for Ulcer Staging.

Question 1: Select all SKIN diagnoses:

Select the appropriate response(s) for all diagnoses. If None, Skip to 4.F.1. If not listed, select “Other” and document details in the notes section.

Question 2: Check ALL affected SKIN location(s):

Select all appropriate response(s). If not listed, select “Other” and document details in the notes section.

Question 3: Identify the highest known ULCER STAGE:

Select the appropriate response. The care manager may have to refer to a medical professional or the medical record for this information.

Question 4: Signs and symptoms of the SKIN diagnoses:

Select the appropriate response(s) for all signs and symptoms specific to Skin diagnoses. If current signs and symptoms are not listed, select “Other” and document details in the notes section.

Question 5: Current treatments for SKIN diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 6: Do the SKIN diagnoses affect the individual’s ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 7: Who manages care of the SKIN condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 8: Does the individual need additional assistance in managing the care of the SKIN condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

4.F. ENDOCRINE /METABOLIC SYSTEMS

Question 1: Select all ENDOCRINE/ METABOLIC systems diagnoses:

Select the appropriate response(s) for all diagnoses. If None, Skip to 4.G.1. If not listed, select “Other” and document details in the notes section.

Question 2: Signs and symptoms of ENDOCRINE/ METABOLIC systems diagnoses:

Select the appropriate response(s) for all signs and symptoms specific to Endocrine/ Metabolic diagnoses. If current signs and symptoms are not listed, select “Other” and document details in the notes section.

Question 3: Select all the current treatments for ENDOCRINE/ METABOLIC systems diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 4: Do the ENDOCRINE/ METABOLIC systems diagnoses affect the individual’s ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 5: Who manages care of the ENDOCRINE/ METABOLIC systems condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 6: Does the individual need additional assistance in managing the care of the ENDOCRINE/ METABOLIC systems condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

4.G. GENITOURINARY

Question 1: Select all GENITOURINARY diagnoses:

Select the appropriate response(s) for all diagnoses. If None, Skip to 4.H.1. If not listed, select “Other” and document details in the notes section.

Needs Assessment Tool Form Instructions

Urinary incontinence almost always results from an underlying treatable medical condition. If an individual is incontinent of urine do not assume that it is caused by a bladder disorder such as neurogenic bladder, overactive bladder or urinary retention. Incontinence has many causes. Try to find out the underlying diagnosis that is causing the incontinence.

Neurogenic bladder dysfunction, sometimes simply referred to as neurogenic bladder, is a dysfunction of the urinary bladder due to disease of the central nervous system or peripheral nerves involved in the control of micturation (urination). Neurogenic bladder usually causes difficulty or full inability to pass urine without use of a catheter or other method.

Question 2: Signs and symptoms of the GENITOURINARY diagnoses:

Select the appropriate response(s) for all signs and symptoms specific to Genitourinary diagnoses. If current signs and symptoms are not listed, select “Other” and document details in the notes section.

Question 3: Current treatments for GENITOURINARY diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Catheter is selected, Complete 4.G.4. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 4: If the individual has a catheter, indicate the type:

Select the appropriate response. If the type is not listed, select “Other” and document details in the notes section.

Question 5: Do the GENITOURINARY diagnoses affect the individual’s ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 6: Who manages care of the GENITOURINARY condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 7: Does the individual need additional assistance in managing the care of the GENITOURINARY condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

4.H. GYNECOLOGICAL

NOTE: This section is only required for females.

Question 1: Select all GYNECOLOGICAL diagnoses:

Select the appropriate response(s) for all diagnoses. If None, Skip to 4.I.1. If not listed, select “Other” and document details in the notes section.

Question 2: Signs and symptoms of GYNECOLOGICAL diagnoses:

Select the appropriate response(s) for all signs and symptoms specific to Gynecological diagnoses. If current signs and symptoms are not listed, select “Other” and document details in the notes section.

Question 3: Current treatments for GYNECOLOGICAL diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 4: Do the GYNECOLOGICAL diagnoses affect the individual’s ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 5: Who manages care of the GYNECOLOGICAL condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 6: Does the individual need additional assistance in managing the care of the GYNECOLOGICAL condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

4.I. INFECTIONS /IMMUNE SYSTEM

NOTE: In this section the Infection/Immune System has numerous disorders with varying signs and symptoms. Therefore, answer Question 3 by listing all current signs and symptoms of Infections /Immune system diagnoses.

Question 1: Select all INFECTION /IMMUNE system diagnoses:

Needs Assessment Tool Form Instructions

Select the appropriate response(s) for all diagnoses. If None, Skip to 4.J.1. If not listed, select “Other” and document details in the notes section.

Question 2: If HIV or AIDS is indicated in 4.I.1., has the individual ever had lab results of CD4 count under 400?

Answer No, Yes or Unknown. Use the notes section for additional information if needed.

Question 3: List all the signs and symptoms of INFECTION /IMMUNE system conditions. Use Notes for additional text:

Document by listing all signs and symptoms specific to Infections /Immune system conditions. Use the notes section for additional information if needed.

Question 4: Current treatments for INFECTION /IMMUNE system diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 5: Do the INFECTIONS /IMMUNE system diagnoses affect the individual’s ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 6: Who manages care of the INFECTION /IMMUNE system condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 6: Does the individual need additional assistance in managing the care of the INFECTIONS/ IMMUNE system condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

4.J. CANCER

Question 1: Does the individual have any current CANCER diagnoses?

Answer No or Yes, If No, Skip to 4.K.1.

Question 2: If Yes, identify the STAGE of CANCER:

Needs Assessment Tool Form Instructions

Select correct box. The care manager may have to refer to the medical record or the individual's physician to obtain the correct stage of cancer.

Staging describes the extent or severity of a person's cancer. Knowing the stage of disease helps the doctor plan treatment and estimates the person's prognosis. Staging systems for cancer have evolved over time and continue to change as scientists learn more about cancer. The TNM staging system is based on the size and/or extent (reach) of the primary tumor (T), whether cancer cells have spread to nearby (regional) lymph nodes (N), and whether metastasis (M), or the spread of the cancer to other parts of the body, has occurred. Physical exams, imaging procedures, laboratory tests, pathology reports, and surgical reports provide information to determine the stage of a cancer.

Question 3: Select all current CANCER diagnoses:

Select the appropriate response(s) for all Cancer diagnoses. If not listed, select "Other" and document details in the notes section.

Question 4: Select all of the individual's signs and symptoms of the CANCER diagnoses:

Select the appropriate response(s) for all signs and symptoms specific to Cancer diagnoses. If current signs and symptoms are not listed, select "Other" and document details in the notes section.

Question 5: Current treatments for CANCER diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select "Other" and document details in the notes section.

Question 6: Do the CANCER diagnoses affect the individual's ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 7: Who manages care of the CANCER condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select "Other" and document in the notes section.

Question 8: Does the individual need additional assistance in managing the care of the CANCER condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

4.K. EARS, NOSE & THROAT (ENT)

Needs Assessment Tool Form Instructions

Question 1: Select all ENT diagnoses:

Select the appropriate response(s) for all diagnoses. If None, Skip to 4.L.1. If not listed, select “Other” and document details in the notes section.

Question 2: Signs and symptoms of the ENT diagnoses:

Select the appropriate response(s) for all signs and symptoms specific to ENT diagnoses. If current signs and symptoms are not listed, select “Other” and document details in the notes section.

Question 3: Current treatments for ENT diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 4: Do the ENT diagnoses affect the individual’s ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 5: Who manages care of the ENT condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 6: Does the individual need additional assistance in managing the care of the ENT condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

4.L. EYES

Question 1: What EYE diagnoses/ disorders have been confirmed and documented by health/ medical professionals?

Select the appropriate response(s) for all diagnoses/ disorders that have been confirmed and documented by health/ medical professionals. If None, Skip to 4.M.1. If not listed, select “Other Visual Impairments” and document details in the notes section.

Question 2: Signs and symptoms for EYE conditions and/ or diagnoses:

Needs Assessment Tool Form Instructions

Select the appropriate response(s) for all signs and symptoms specific to Eye conditions and/ or diagnoses. If current signs and symptoms are not listed, select “Other” and document details in the notes section.

Question 3: Current treatments for EYE conditions and/ or diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 4: Do the EYE diagnoses affect the individual’s ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 5: Who manages care of the EYE condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 6: Does the individual need additional assistance in managing the care of the EYE condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

4.M. MOUTH

Question 1: Select all MOUTH conditions and/ or diagnoses:

Select the appropriate response(s) for all diagnoses. If None, Skip to 5.A.1. If not listed, select “Other” and document details in the notes section.

Question 2: Current treatments for MOUTH conditions and/ or diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 3: Signs and symptoms of MOUTH conditions and/ or diagnoses:

Select the appropriate response(s) for all signs and symptoms specific to Mouth conditions and/or diagnoses. If current signs and symptoms are not listed, select “Other” and document details in the notes section.

Question 4: Do the MOUTH diagnoses affect the individual’s ability to function?

Answer No or Yes. . If Yes, document details in the notes section.

Needs Assessment Tool Form Instructions

Question 5: Who manages care of the MOUTH condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 6: Does the individual need additional assistance in managing the care of the MOUTH conditions and/ or diagnoses?

Answer No or Yes. If Yes, document details in the notes section.

5. NEUROLOGICAL (Mandatory completion of Section 8 if Neurological diagnosis)
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5.A. NEUROLOGICAL

Question 1: If there are NEUROLOGICAL diagnoses, select all types & completion of Section 8: Behaviors is MANDATORY.

Select the correct response(s). If None, Skip to 6.A.1. If not listed, select “Other” and document details in the notes section.

Question 2: What characteristics describe the individual’s COGNITIVE state?

Select the correct response(s). If not listed, select “Other” and document details in the notes section.

Question 3: Signs and symptoms of NEUROLOGICAL diagnoses:

Select the appropriate response(s) for all signs and symptoms specific to Neurological diagnoses. If current signs and symptoms are not listed, select “Other” and document details in the notes section.

Question 4: Current treatments for NEUROLOGICAL diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 5: Do the NEUROLOGICAL diagnoses affect the individual’s ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 6: Who manages care of the NEUROLOGICAL condition(s)?

Needs Assessment Tool Form Instructions

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select "Other" and document in the notes section.

Question 7: Does the individual need additional assistance in managing the care of the NEUROLOGICAL condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

6. INTELLECTUAL DEVELOPMENTAL DISABILITY (IDD) (MANDATORY completion of Section 8 if IDD diagnosis)

6.A. INTELLECTUAL DEVELOPMENTAL DISABILITY (IDD)

Question 1: Does the individual have a diagnosis of Intellectual Developmental Disability (IDD) from birth to 22nd birthday or known to the ID system?

Select the correct response. If No, Skip to 7.A.1. If Yes, Completion of Section 8 (Behaviors) is MANDATORY.

Question 2: Is the individual able to self-manage care of the IDD condition?

Select the correct response. If No or Unable to Determine, document details in the notes section.

Question 3: Does the IDD diagnosis affect the individual's ability to function?

Select the correct response. If Yes or Unable to Determine, document details in the notes section.

7. MENTAL HEALTH (MANDATORY completion of Section 8 if Psychiatric diagnosis)

7.A. PSYCHIATRIC

Determine whether or not the individual has any type of Psychological Disorders/Mental Illness. Mental illness is defined as a mental or bodily condition marked primarily by sufficient disorganization of personality, mind, and emotions to seriously impair the normal psychological functioning of the individual. The illness may result in a disruption in a person's thinking, feeling, moods and ability to relate to others.

Prompting questions: Have you ever seen a psychiatrist? Have you ever been told that you have any psychiatric problems? Did you receive treatment?

Needs Assessment Tool Form Instructions

Question 1: If there are PSYCHIATRIC diagnoses, select all types & completion of Section 8 (Behaviors) is MANDATORY.

Select the correct response(s) for all diagnoses. If None, Skip to 7.B.1. If not listed, select “Other” and document details in the notes section.

Question 2: Signs and symptoms of PSYCHIATRIC conditions:

Select the appropriate response(s) for all signs and symptoms specific to Psychiatric diagnoses. If current signs and symptoms are not listed, select “Other” and document details in the notes section.

Question 3: Current treatments for PSYCHIATRIC diagnoses:

Select appropriate response(s) for all treatments the individual is receiving. If Medications is selected, List in 9.D. If the treatment is not listed, select “Other” and document details in the notes section.

Question 4: Do the PSYCHIATRIC diagnoses affect the individual’s ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 5: Who manages care of the PSYCHIATRIC condition(s)?

Select appropriate response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 6: Does the individual need additional assistance in managing the care of the PSYCHOLOGICAL condition(s)?

Answer No or Yes. If Yes, document details in the notes section.

7.B. SUICIDE SCREENING

The incidence in suicide of older individuals is very high; therefore the questions in this section are extremely important to ask a consumer in order to determine a consumer’s risk for suicide. There are many reasons why a consumer may consider suicide and the answers to these questions can assist a care manager in making an appropriate referral for medical or psychiatric intervention.

Question 1: Have you thought about hurting yourself or taking your life in the PAST 30 DAYS?

Needs Assessment Tool Form Instructions

Select No, Yes or Individual Refused to Answer. If Yes, Complete an Aging Suicide Risk Assessment.

Question 2: When did you have these thoughts and do you have a plan to take your life?

Select No, Yes or Individual Refused to Answer. If Yes, document details in the notes section.

Question 3: Have you ever had a suicide attempt?

Select No, Yes or Individual Refused to Answer. If Yes, document details in the notes section.

8. BEHAVIORS - MANDATORY if Neurological, IDD or Psychiatric Diagnosis

8.A. BEHAVIORS

Question 1: Does the individual present with any BEHAVIORAL signs/symptoms? This Section is REQUIRED if a Neurologic, IDD or Psychiatric Diagnoses were noted in Section 5, 6 or 7.

Select No, Yes or Unable to Determine. If No, Skip to 8.B.1. If Yes, or Unable to Determine, Complete ALL of Section 8.

Question 2a: Does the individual exhibit PHYSICAL behavioral symptoms toward OTHERS?

Select the correct response. If No, Skip to 8.A.3a. If Yes, Complete 8.A.2b and 2c.

Question 2b: Specify ALL types of aggressive PHYSICAL behavior toward OTHERS: (If not listed, document in Notes.)

Select the correct response(s). If not listed, select "Other" and document details in the notes section.

Question 2c: Does the aggressive PHYSICAL behavior toward OTHERS interfere with the individual's ability to function daily?

Answer No or Yes. If No, document why the behavior does NOT interfere in the notes section. If yes, document how the behavior interferes in the notes section.

Question 3a: Does the individual exhibit aggressive PHYSICAL behavioral symptoms towards SELF?

Needs Assessment Tool Form Instructions

Answer No or Yes. If No, Skip to 8.A.4a. If Yes, Complete 8.A.3b and 3c.

Question 3b: Specify ALL types of aggressive PHYSICAL behavior towards SELF: (If not listed, document in Notes)

Select the correct response(s). If not listed, select “Other” and document details in the notes section.

Question 3c: Does the aggressive PHYSICAL behavior toward SELF interfere with the individual’s ability to function daily?

Answer No or Yes. If No, document why the behavior does NOT interfere in the notes section. If yes, document how the behavior interferes in the notes section.

Question 4a: Does the individual exhibit aggressive VERBAL behavior symptoms toward OTHERS?

Answer No or Yes. If No, Skip to 8.A.5a. If Yes, Complete 8.A.4b and 4c.

Question 4b: Specify ALL types of aggressive VERBAL behavior towards OTHERS: (If not listed, document in Notes.)

Select the correct response(s). If not listed, select “Other” and document details in the notes section.

Question 4c: Does the aggressive VERBAL behavior toward OTHERS interfere with the individual’s ability to function daily?

Answer No or Yes. If No, document why the behavior does NOT interfere in the notes section. If yes, document how the behavior interferes in the notes section.

Question 5a: Does the individual exhibit any GENERAL aggressive VERBAL behavior symptoms not specifically directed toward self or others?

Answer No or Yes. If No, Skip to 8.A.6a. If Yes, Complete 8.A.5b and 5c.

Question 5b: Select ALL GENERAL aggressive VERBAL behaviors: (If not listed, document in Notes)

Select correct response(s). If not listed, select “Other” and document details in the notes section.

Question 5c: Does the GENERAL aggressive VERBAL behavior interfere with the individual’s ability to function daily?

Answer No or Yes. If No, document why the behavior does NOT interfere in the notes section. If yes, document how the behavior interferes in the notes section.

Needs Assessment Tool Form Instructions

Question 6a: Does the individual exhibit any OTHER behavioral symptoms?

Answer No or Yes. If No, Skip to 8.B.1. If Yes, Complete 8.A.6b and 6c.

Question 6b: Specify ALL OTHER types of behaviors reported: (If not listed, document in Notes).

Select correct response(s). If not listed, select "Other" and document details in the notes section.

Question 6c: Do the OTHER types of behaviors interfere with the individual's ability to function daily?

Answer No or Yes. If No, document why the behavior does NOT interfere in the notes section. If yes, document how the behavior interferes in the notes section.

8. B. ADDICTIVE BEHAVIORS

The following questions will assist a care manager in identifying if a consumer has a drug or alcohol problem and lead to conversation about treatment.

Question 1: Has anyone ever expressed concern about your use of alcohol or drugs?

Answer No or Yes. If No, Skip to Section 9.A.1. If Yes, Complete Section 8.B. and document details in the notes section.

Question 2: Do you find yourself missing work, family events, activities that you once participated in due to over use of a substance?

Answer No or Yes. If Yes, document details in the notes section.

Question 3: Is drinking or use of other substances making your home life unhappy?

Answer No or Yes. If Yes, document details in the notes section.

Question 4: Do you find yourself reaching for an alcoholic drink or other substance to get you through an event or interaction with certain people?

Answer No or Yes. If Yes, document details in the notes section.

Question 5: Do you drink or use other substances alone? (Do you live alone? Feel lonely?)

Answer No or Yes. If Yes, document details in the notes section.

Needs Assessment Tool Form Instructions

Question 6: Have you ever felt remorse (regret) after you've drank or used other substance?

Answer No or Yes. If Yes, document details in the notes section.

Question 7: Do you believe that your drinking or use of other substances is causing a financial burden or decline?

Answer No or Yes. If Yes, document details in the notes section.

Question 8: Do you find your ambition (effort to get up and do things each day) has declined since drinking or using other substances?

Answer No or Yes. If Yes, document details in the notes section.

Question 9: Do you find yourself replacing meals with either an alcoholic drink or another substance?

Answer No or Yes. If Yes, document details in the notes section.

Question 10: Does drinking or use of other substances cause you to have difficulty sleeping?

Answer No or Yes. If Yes, document details in the notes section.

Question 11: Do you drink to escape (getaway from) worries or troubles?

Answer No or Yes. If Yes, document details in the notes section.

Question 12: Do you find yourself more depressed since drinking or using other substances?

Answer No or Yes. If Yes, document details in the notes section.

Question 13: Are you having memory problems due to drinking or use of substances?

Answer No or Yes. If Yes, document details in the notes section.

Question 14: Have you spoken to your doctor about drinking or use of other substances?

Answer No or Yes. If Yes, document details in the notes section.

Question 15: Have you ever been treated in a hospital, rehabilitation center or by a doctor for drinking or other substance use?

Needs Assessment Tool Form Instructions

Answer No or Yes. If Yes, document details in the notes section.

9. OTHER MEDICAL INFORMATION

9.A. INFORMATION

Question 1: Has the Individual exhibited ELOPEMENT behavior in the LAST 6 MONTHS? If so, indicate the FREQUENCY:

Elopement definition: An individual who is cognitively, physically, mentally, emotionally, and/or chemically impaired; wanders away, walks away, runs away, escapes, or otherwise leaves their environment unsupervised or unnoticed.

Select the correct response. If other, document details of the elopement behavior in the notes section.

Question 2: Does the individual require supervision?

Answer No or Yes. If No, Skip to 9.A.4. If Yes, Complete 9.A.

Question 2a: How long can the individual be routinely left alone?

Select the correct response.

Question 3: Why does the individual require supervision?

Select the correct response(s). There may be more than one. If not listed, select "Other" and document details in the notes section.

Question 4: Can the individual evacuate their home in the event of a fire?

Answer No or Yes. If No, document details in the notes section.

9.B. FRAILTY SCORE

The term "Frail" is intended to identify those people at greatest risk of adverse outcomes including falls, worsening disability, institutionalization and death. Frailty is a term in common use among health care professionals. It is a term often used to label the condition of an older person who has health problems, has lost functional abilities and is likely to deteriorate further. It is thus a syndrome, describing a health state that could occur as the result of a number of underlying health conditions.

Needs Assessment Tool Form Instructions

Someone is frail if they meet 3 or more of 5 criteria: weight loss, exhaustion, weak grip strength, slow walking speed and low physical activity. The following simple test measures frailty. If the individual has 3 negative* responses to the following questions they meet the definition of frail which is an indicator that they could deteriorate further. [*negative responses are underlined]

Question 1: Are you tired?

Select correct response No or Yes.

Question 2: Can you walk up a flight of stairs?

Select correct response No or Yes.

Question 3: Can you walk a city block (250-350 feet)?

Select correct response No or Yes.

Question 4: Do you have more than 5 illnesses?

Select correct response No or Yes.

Question 5: Have you lost more than 5% of your weight in the last year?

Select correct response No or Yes.

Question 6: Individual shows symptoms of being frail?

Frailty score: 3 of 5 indicators=frail

Generated by algorithm will be a true of false response.

9.C. DEPRESSION /LIFE SATISFACTION

This depression screen has been recommended by PDA/DPW's Medical Director. When the individual has 3 or more negative* responses they have an indicator for depression. Depression incidences in older individuals have been known to have increased institutionalizations (Hospitalizations and Nursing Facility admissions). [*negative responses are underlined]

Question 1: Are you basically satisfied with your life?

Answer No or Yes.

Question 2: Do you often get bored?

Needs Assessment Tool Form Instructions

Answer No or Yes.

Question 3: Do you often feel hopeless?

Answer No or Yes.

Question 4: Do you prefer to stay at home rather than going out and doing new things?

Answer No or Yes.

Question 5: Do you ever have feelings of worthlessness?

Answer No or Yes.

Question 6: Individual shows symptoms of being depressed.

Depression/Life Satisfaction score: 3 of 5 indicators=possible depression
Generated by algorithm will be true or false response.

9.D. MEDICATION MANAGEMENT

The purpose of this section is to document the name of the medication prescribed, dose, type, route, and frequency. It also describes the individual's ability level to manage medication.

Over the Counter (OTC) Medications are recorded under Over the Counter (OTC) Medications unless the individual is in a facility then it is recorded under Prescribed Medications. When you are evaluating an individual in a facility evaluate the **ability** of the individual to administer medications not what is currently occurring in the facility. This is imperative if the person is interested in returning home in the near future.

Central venous catheter ("central line", "CVC", "central venous line" or "central venous access catheter") is a long thin flexible catheter placed into a large vein in the neck (internal jugular vein), chest (subclavian vein or auxiliary vein) or groin (femoral vein) that is used to give medicines, fluids, nutrients, or blood products over a long period of time, take frequent blood samples, to receive kidney dialysis for kidney failure, give long-term medicine treatment for pain, infection, or cancer, or to supply nutrition. A central venous catheter can be left in place far longer than an intravenous catheter (IV).

Question 1: Does the individual take any PRESCRIBED Medications?

Answer No or Yes. If No, Skip to 9.D.6.

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Question 2: Does the individual have a central venous line?

Answer No or Yes. If Yes, document the Type and Details in the notes section.

Question 3: List all PRESCRIBED medications taken by the individual:

The care manager must document:

- The Name of the medication
- The Dose of the medication ordered
- The Form (route of administration as coded)
- The Route of administration
- The Frequency of the medication taken

Question 4: Does the individual take all medications as prescribed?

Answer No or Yes. If No, document details in the notes section.

Question 5: Does the individual know what medication they take and why? Document Details in Notes:

Answer No, Yes, or Unable to Determine. Document details in the notes section.

Question 6: List all OVER THE COUNTER (OTC) medications taken by the individual:

The care manager must document:

- The Name of the medication
- The Dose of the medication ordered
- The Form (route of administration coded)
- The Route of administration
- The Frequency of the medication taken

Question 7: Does the Individual have any allergies or adverse reactions to any medications?

Answer No or Yes. If Yes, document details in the notes section.

Question 8: What is the individual's ability level to manage medication?

Select the correct response. If Independent, Skip to 9.D.11.

Question 9: If LIMITED ASSISTANCE, indicate all types needed for medication management:

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Select correct response(s). If not listed, select "Other" and document details in the notes section.

Question 10: Who assists the individual with medication administration?

Select the correct response. Document details for all responses in the notes section.

Question 11: Does the Individual use herbs or other remedies?

Answer No or Yes. If Yes, document the details in the notes section.

Question 12: Pharmacy Information (Name, Phone, etc.)

Document the individual's pharmacy information including name and phone number.

9.E. HEIGHT/WEIGHT

An individual's weight is an important factor for a care manager/service coordinator to know especially if the individual has lost 10 pounds or more in the past 6 months. This could possibly be indicative of an illness/eating disorder.

Utilize the BMI calculation to determine weight type.

<http://www.nhlbi.nih.gov/guidelines/obesity/BMI/bmicalc.htm>

Some prompting questions for weight loss or gain: Have you recently (last six months) lost or gained weight without any changes to your diet or exercise? Do you know why your weight has gone up or down?

Question 1: What is the individual's height?

Indicate the height of the individual.

Question 2: What is the individual's weight?

Indicate the individual's weight.

Question 3: Has the individual lost or gained at least 10 pounds or more in the past 6 months? Document Details in Notes:

Select the correct response. If No, Skip to 9.E.6. Document details in the notes section.

Question 4: Reason(s) for weight gain or loss:

Needs Assessment Tool Form Instructions

Select the correct response. If not listed, Select “Other” and document the reason in the notes section.

Question 5: Is physician aware of the weight change?

Answer No or Yes.

Question 6: What is the Individual’s weight type?

Select the correct response.

9.F. PAIN

This section will address if the individual is experiencing pain, the location of the pain, the level of pain, the frequency of pain, and whether or not the individual’s pain is impacting on their ability to function daily. NOTE: When it is determined numerous sites of pain exists document the most severe and expand documentation in the notes section for additional pain.

Question 1: Does the individual report PAIN?

Select the correct response. If No or Unable to Determine, Skip to 10.A.1a.

Question 2: Location(s) of PAIN site(s):

Select the correct box (boxes) for location of pain. There may be more than one box selected. If not listed, select “Other” and document details in the notes section.

Question 3: Indicate the level of PAIN the individual reports using a scale from 0-10: (0=no pain, 10=severe pain)

Select the correct box to indicate the level of pain the individual is experiencing. Choose only one response.

Question 4: Indicate the frequency the individual reports the PAIN:

Select the correct box to indicate how frequent the individual has pain and document in the notes section any additional information.

Question 5: Select all the current treatments for PAIN diagnoses:

Select the correct response(s). If Medications is selected, List in 9.D. If treatment is not listed, select “Other” and document details in the notes section.

Needs Assessment Tool Form Instructions

Question 6: Pain Management:

If the individual has no pain treatments select “No pain treatment”. Document after the individual has received treatment for pain relief by selecting the correct box and provide additional information in the notes section.

Question 7: Does PAIN affect the individual’s ability to function?

Answer No or Yes. If Yes, document details in the notes section.

Question 8: Who manages care of the PAIN condition(s)?

Select correct response(s) for who manages care of the condition. There may be more than one selection. If not listed, select “Other” and document in the notes section.

Question 9: Does the individual need additional assistance in managing the care of the PAIN?

Answer No or Yes. If Yes, document details in the notes section.

10. ACTIVITIES OF DAILY LIVING (ADLs)
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10.A. ADLs

The care manager must rate the individual’s ability to perform their ADLs and the ability to manage them with reasonable safety. There may be instances in which the individual has no opportunity to perform ADL tasks because they may already be in a facility, a hospital, or family members are assisting. Therefore, in order to accurately assess the individual’s ability to perform any ADLs, the care manager is required to review facility charts in addition to asking the individual and evaluating their abilities.

ADL’s include:

- Bathing
- Dressing
- Grooming
- Eating
- Transferring
- Toileting
- Bladder/Bowel Incontinence
- Walking

Walking was added to the ADL section because it is a tool to accurately measure the individual’s capability of performing ADL’s.

Independent - describes the ability to completely manage the ADL.

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Limited Assistance - describes an individual who may require some assistance with the ADL. Select the response in the drop down menu that best describes what assistance is being provided.

Guided Maneuvers is defined as an Individual who requires hands on assistance or requires weight-bearing support while performing ADL's.

Total Assistance – describes the inability of the individual to complete the ADL in full.

Utilize the notes section for documentation of any additional details.

Question 1a: BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.

Select the appropriate response. Check one box only. If Independent, Skip to 10.A.2a.

Question 1b: If Limited Assistance; indicate ALL types needed for BATHING:

Select the appropriate response(s). There may be more than one box selected. If "Other", document details in the notes section.

Question 1c: BATHING: Assistance currently provided by what INFORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 1d: BATHING: Assistance currently provided by what FORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 1e: How often is BATHING support available? Document Details in Notes:

Select the appropriate response. If "Other", document details in the notes section.

Question 1f: Type of BATHING? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 1g: Assistive devices/adaptive equipment used for BATHING? Document Details in Notes:

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Select the appropriate response(s). There may be more than one box selected.
If assistive device/adaptive equipment are used, document details in the notes section.

Question 1h: Does the individual need additional assistance in BATHING?

Answer No or Yes. If Yes, document details in the notes section.

Question 2a: DRESSING: Ability to remove clothes from a closet/drawer; application of clothing; including shoes/socks (regular/TEDS); orthotics; prostheses; removal/storage of items; managing fasteners; and to use any needed assistive devices.

Select the appropriate response. Check one box only. If Independent, Skip to 10.A.3a.

Question 2b: If Limited Assistance, indicate ALL types needed for DRESSING:

Select the appropriate response(s). There may be more than one box selected. If "Other", document details in the notes section.

Question 2c: DRESSING: Assistance currently provided by what INFORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected.
Document details for all responses in the notes section.

Question 2d: DRESSING: Assistance currently provided by what FORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected.
Document details for all responses in the notes section.

Question 2e: How often is DRESSING support available? Document Details in Notes:

Select the appropriate response. If "Other", document details in the notes section.

Question 2f: Assistive devices/adaptive equipment used for DRESSING? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected.
If assistive device/adaptive equipment are used, document details in the notes section.

Question 2g: Does the individual need additional assistance in DRESSING?

Answer No or Yes. If Yes, document details in the notes section.

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Question 3a: GROOMING/ PERSONAL HYGIENE: Ability to comb/brush hair; brush teeth; care for/inset dentures; shave; apply make-up (if worn); apply deodorant, etc.

Select the appropriate response. Check one box only. If Independent, Skip to 10.A.4a.

Question 3b: If Limited Assistance, indicate ALL types needed for GROOMING/ PERSONAL HYGIENE:

Select the appropriate response(s). There may be more than one box selected. If “Other”, document details in the notes section.

Question 3c: GROOMING/ PERSONAL HYGIENE: Assistance currently provided by what INFORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 3d: GROOMING/ PERSONAL HYGIENE: Assistance currently provided by what FORMAL supports?

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 3e: How often is GROOMING/ PERSONAL HYGIENE support available? Document Details in Notes:

Select the appropriate response. If “Other”, document details in the notes section.

Question 3f: Are assistive devices/ adaptive equipment used for GROOMING/ PERSONAL HYGIENE?

Select the appropriate response(s). There may be more than one box selected. If assistive device/adaptive equipment are used, document details in the notes section.

Question 3g: Does the individual need additional assistance in GROOMING/ PERSONAL HYGIENE?

Answer No or Yes. If Yes, document details in the notes section.

Question 4a: EATING: Ability to eat/ drink; cut, chew, swallow food; and to use any needed assistive devices:

Select the appropriate response. Check one box only. If Independent, Skip to 10.A.5a. If Does Not Eat is selected, Skip to 10.A.4c.

Question 4b: If Limited Assistance, indicate ALL types needed for EATING:

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Select the appropriate response(s). There may be more than one box selected. If “Other”, document details in the notes section.

Question 4c: If response to 10.A.4a is "4-Does not eat", indicate type of nutritional intake. Check ALL that apply:

Select the appropriate responses. There may be more than one box selected. If “Other”, document the details in the notes section.

Question 4d: EATING: Assistance currently provided by what INFORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 4e: EATING: Assistance currently provided by what FORMAL supports?

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 4f: How often is EATING support available? Document Details in Notes:

Select the appropriate response. If “Other”, document details in the notes section.

Question 4g: Assistive devices/adaptive equipment used for EATING? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. If assistive device/adaptive equipment are used, document details in the notes section.

Question 4h: Does the individual need additional assistance for managing EATING?

Answer No or Yes. If Yes, document details in the notes section.

Question 5a: TRANSFER: Ability to move between surfaces, including to/ from bed, chair, wheelchair, or to a standing position; onto or off a commode; and to manage/ use any needed assistive devices.

Select the appropriate response. Check one box only. If Independent, Skip to 10.A.6a.

Question 5b: If Limited Assistance, indicate ALL types needed for TRANSFER:

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Select the appropriate response(s). There may be more than one box selected. If “Other”, document details in the notes section.

Question 5c: TRANSFER: Assistance currently provided by what INFORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 5d: TRANSFER: Assistance currently provided by what FORMAL supports?

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 5e: How often is support available for TRANSFER ? Document Details in Notes:

Select the appropriate response. If “Other”, document details in the notes section.

Question 5f: Assistive devices/ adaptive equipment used for TRANSFER? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. If assistive device/adaptive equipment are used, document details in the notes section.

Question 5g: Does the individual need additional assistance in managing TRANSFERS?

Answer No or Yes. If Yes, document details in the notes section.

Question 6a: TOILETING: Ability to manage bowel and bladder elimination:

Select the appropriate response. Check one box only. If Independent, Skip to 10.A.7a.

Question 6b: If Limited Assistance, indicate ALL types needed for TOILETING:

Select the appropriate response(s). There may be more than one box selected. If “Other”, document details in the notes section.

Question 6c: TOILETING: Assistance currently provided by what INFORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Needs Assessment Tool Form Instructions

Question 6d: TOILETING: Assistance currently provided by what FORMAL supports?

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 6e: How often is support available for TOILETING? Document Details in Notes:

Select the appropriate response. If "Other", document details in the notes section.

Question 6f: Assistive devices/adaptive equipment used for TOILETING? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. If assistive device/adaptive equipment are used, document details in the notes section.

Question 6g: Does the individual need additional assistance in managing TOILETING?

Answer No or Yes. If Yes, document details in the notes section.

Question 7a: BLADDER CONTINENCE: Indicate the description that best describes the individual's BLADDER function:

Select the appropriate response. Check one (box) only.

Question 7b: Does the individual need additional assistance in managing BLADDER CONTINENCE?

Answer No or Yes. If Yes, document details in the notes section.

Question 7c: BOWEL CONTINENCE: Indicate the description that best describes the individual's BOWEL function:

Select the appropriate response. Check one (box) only.

Question 7d: Does the individual need additional assistance in managing BOWEL CONTINENCE?

Answer No or Yes. If Yes, document details in the notes section.

Question 7e: Does the individual use incontinency products?

Answer No or Yes. If Yes, document details in the notes section

Needs Assessment Tool Form Instructions

Question 8a: WALKING: Ability to safely walk to/from one area to another; manage/use any needed ambulation devices:

Select the appropriate response. Check one box only. If Independent, Skip to 11.A.1.

NOTE: If an individual uses a ambulation device and can walk without any assistance when using the device (i.e. a walker or cane) they are considered Independent.

Question 8b: If Limited Assistance, indicate ALL types needed for WALKING:

Select the appropriate response(s). There may be more than one box selected. If “Other”, document details in the notes section.

Question 8c: Does the individual need additional assistance in managing WALKING?

Answer No or Yes. If Yes, document details in the notes section.

11. MOBILITY

11.A. CONSUMER’S MOBILITY

The care manager is to choose the correct response box (boxes) for each question regarding mobility status that best describes the individual’s ability to perform each task.

Bedbound is defined as an individual who is bedridden and never leaves the bed. Even if they are able to be transferred from bed to chair with assistance (by an individual/s or with an assistive device) they are not considered bedbound.

Guided Maneuvers is defined as an Individual who requires hands on assistance or requires weight-bearing support while performing ADL’s.

The care manager can evaluate an individual’s mobility through observation and questioning. If the individual is willing, the care manager must ask for a demonstration of walking or wheeling ability across a room and back.

Question 1: BEDBOUND: Is the individual bedbound? Indicate in notes any comments or relevant information:

Select the correct response. If Yes, Skip to 12.A.1. Describe additional information in the notes section.

Needs Assessment Tool Form Instructions

Question 2a: INDOOR MOBILITY: Ability of movement within INTERIOR environment:

Select the appropriate response. Check one box only. Describe additional information in the notes section. If Independent, Skip to 11.A.3a.

Question 2b: If Limited Assistance, indicate ALL types needed for INDOOR MOBILITY:

Select the appropriate response(s). There may be more than one box selected. If "Other ", document details in the notes section.

Question 2c: Assistive devices needed for INDOOR MOBILITY. Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. If assistive device(s) are used, document details in the notes section.

Question 2d: Does the individual need additional assistance in managing INDOOR MOBILITY?

Answer No or Yes. If Yes, document details in the notes section.

Question 3a: OUTDOOR MOBILITY: Ability of movement OUTSIDE living arrangement:

Select the appropriate response. Check one box only. Describe additional information in the notes section. If Independent, Skip to 11A.4a.

Question 3b: If Limited Assistance, indicate ALL types needed for OUTDOOR MOBILITY:

Select the appropriate response(s). There may be more than one box selected. If "Other ", document details in the notes section.

Question 3c: Assistive devices needed for OUTDOOR MOBILITY – Document Details in Notes.

Select the appropriate response(s). There may be more than one box selected. If assistive device(s) are used, document details in the notes section.

Question 3d: Does the individual need additional assistance in managing OUTDOOR MOBILITY?

Answer No or Yes. If Yes, document details in the notes section.

Needs Assessment Tool Form Instructions

Question 4a: STAIR MOBILITY: Movement safely up and down STEPS:

Select the appropriate response. Check one box only. Describe additional information in the notes section. If Independent, Skip to 11.A.5.

Question 4b: If Limited Assistance, indicate ALL types needed for STAIR MOBILITY:

Select the appropriate response(s). There may be more than one box selected. If “Other”, document details in the notes section.

Question 4c: Does the individual need additional assistance in managing STAIR MOBILITY?

Answer No or Yes. If Yes, document details in the notes section.

Question 5: What is the individual's weight bearing status?

Select the correct response. Describe additional information in the notes section.

Question 6: Select all that affect the individual's MOBILITY:

Select the correct response(s). There may be more than one box selected. If “Other”, document details in the notes section.

11.B. FALLS

The care manager must document if the individual is at risk of falling.

Factors that may render an individual at risk for falls include, but are not limited to, poor health or declining health, impaired balance, decreased strength and/or flexibility, decreased vision, and medications. This item requires the care manager to make a judgment, regarding the individual’s risk for falls, based on observations or information provided by the individual or significant others.

In the Notes section, document what functional deficit related to their diagnoses puts them at risk. Provide as much information as possible.

Document whether or not the individual has fallen recently. Recently is defined as within the last six months.

Prompting questions: Have you fallen during the past six months? How often? Where did you fall? What were you doing at the time? Did you faint or lose consciousness? Were you injured in the fall(s)? Could you get back up by yourself? Did a physician see

Needs Assessment Tool Form Instructions

you or did you go to the emergency room to be evaluated after your fall? Do you do anything special to prevent falls?

Question 1: Is the individual at risk of falling?

Select the correct response. Describe additional information in the notes section.

Question 2: Select the number of times the individual has fallen in the LAST 6 MONTHS:

Select the correct response. If None, Skip to 12.A.1.

Question 3: Reasons for falls – Document Details in Notes:

Select the correct response. If “Other”, document details in the notes section. If the individual has fallen utilize the notes section to provide details.

12. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

12.A. IADLs

IADLs include tasks which are not necessarily done every day, but are important to independent living. These tasks include preparing meals, doing housework, laundry, shopping, using transportation, managing money, using the telephone and doing home maintenance. The ability to perform IADL tasks can help a care manager determine the impact of physical and mental impairments, since performance of these tasks requires a combination of memory, judgment and physical ability.

There may be instances in which the individual has no opportunity to perform IADL tasks. For example, some individuals do not prepare meals because a spouse or other relative (who lives with them) routinely does this task. In the same way, individuals who are in an institution at the time of the assessment have no regular opportunity to cook, clean, do laundry or shop. Therefore; when administering the IADL questions, it is very important for the care manager to stress the ability of the individual to perform the task.

The care manager is to choose one response (box) for each IADL that best describes the individual’s ability to perform each task. Record the identity of helpers, if any, in the additional space provided.

Question 1: MEAL PREPARATION: Ability to plan/prepare meals, use of kitchen appliances, heat meals. List any needed adaptive equipment/ assistive devices in Notes:

Needs Assessment Tool Form Instructions

Select the appropriate response. Check one box only. If Independent, Skip to 12.A.2. Describe additional information in the notes section.

Question 1a: MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 1b: MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 1c: How often is support available for MEAL PREPARATION? Document Details in Notes:

Select the appropriate response. If "Other", document details in the notes section.

Question 2: HOUSEWORK: Ability to maintain living space, includes tasks such as dishwashing, making the bed, dusting, running the vacuum or sweeping an area. List any needed adaptive equipment/ assistive devices in Notes.

Select the appropriate response. Check one box only. If Independent, Skip to 12.A.3. Describe additional information in the notes section.

Question 2a: HOUSEWORK: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 2b: HOUSEWORK: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 2c: How often is support available for HOUSEWORK? Document Details in Notes

Select the appropriate response. If "Other", document details in the notes section.

Question 3: LAUNDRY: Ability to gather clothes, place clothes in washing machine, turn on appliance, remove clothes and place in dryer, or hand wash

Needs Assessment Tool Form Instructions

items and hang to dry. List any needed adaptive equipment/ assistive devices in Notes:

Select the appropriate response. Check one box only. If Independent, Skip to 12.A.4. Describe additional information in the notes section.

Question 3a: LAUNDRY: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 3b: LAUNDRY: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 3c: How often is support available for LAUNDRY? Document Details in Notes:

Select the appropriate response. If "Other", document details in the notes section.

Question 4: SHOPPING: Ability to go to the store and purchase needed items, including groceries and other items. List any needed adaptive equipment/ assistive devices in notes.

Select the appropriate response. Check one box only. If Independent, Skip to 12.A.5. Describe additional information in the notes section.

Question 4a: SHOPPING: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 4b: SHOPPING: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 4c: How often is support available for SHOPPING? Document Details in Notes:

Select the appropriate response. If "Other", document details in the notes section.

Needs Assessment Tool Form Instructions

Question 5: TRANSPORTATION: Ability to travel on public transportation or drive a car. List any needed adaptive equipment/ assistive devices in Notes:

Select the appropriate response. Check one box only. If Independent, Skip to 12.A.6. Describe additional information in the notes section.

Question 5a: TRANSPORTATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 5b: TRANSPORTATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 5c: How often is support available for TRANSPORTATION? Document Details in Notes:

Select the appropriate response. If "Other", document details in the notes section.

Question 6: MONEY MANAGEMENT: Ability to manage financial matters, writing checks, paying bills, going to the bank. List any needed adaptive equipment/ assistive devices in Notes:

Select the appropriate response. Check one box only. If Independent, Skip to 12.A.7. Describe additional information in the notes section.

Question 6a: MONEY MANAGEMENT: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 6b: MONEY MANAGEMENT: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 6c: How often is support available for MONEY MANAGEMENT? Document Details in Notes:

Select the appropriate response. If "Other", document details in the notes section.

Needs Assessment Tool Form Instructions

Question 7: TELEPHONE: Ability to obtain phone numbers, dial the telephone and communicate with person on the other end. List any needed adaptive equipment/ assistive devices in Notes:

Select the appropriate response. Check one box only. If Independent, Skip to 12.A.8. Describe additional information in the notes section.

Question 7a: TELEPHONE assistance is currently provided by what INFORMAL supports? Document Details in Notes

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 7b: TELEPHONE assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 7c: How often is support available for TELEPHONE? Document Details in Notes:

Select the appropriate response. Document details for all responses in the notes section.

Question 8: HOME MANAGEMENT: Ability to perform heavier household tasks such as taking out the trash, completing minor repairs around the living space, yard work and/or snow removal. List any needed adaptive equipment/ assistive devices in Notes:

Select the appropriate response. Check one box only. If Independent, Skip to 13.A.1. Describe additional information in the notes section.

Question 8a: HOME MANAGEMENT: Assistance is currently provided by what INFORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Question 8b: HOME MANAGEMENT: Assistance is currently provided by what FORMAL supports? Document Details in Notes:

Select the appropriate response(s). There may be more than one box selected. Document details for all responses in the notes section.

Needs Assessment Tool Form Instructions

Question 8c: How often is support available for HOME MANAGEMENT?

Document Details in Notes:

Select the appropriate response. If “Other”, document details in the notes section.

13. NUTRITION

13.A. DIETARY ISSUES

Question 1: Does the individual generally have a good appetite?

Select the correct response. If No or Other, document details in the notes section.

Question 2: Does the individual use a dietary supplement?

Select the correct response. If Yes, document details in the note section.

Question 3: Does the individual have any food allergies?

Select the correct response. If Yes, document details in the notes section.

Question 4: Does the individual have a special diet for medical reasons?

Select the correct response. If Yes, document details in the notes section.

Question 5: Does the individual have a special diet for religious/cultural reasons?

Select the correct response. If Yes, document details in the notes section

13.B. NUTRITIONAL RISK ASSESSMENT

Question 1: Has there been a change in lifelong eating habits because of health problems?

Select the correct response. If Yes, document details in the notes section.

Question 2: Does the individual eat fewer than 2 meals per day?

Select the correct response. If Yes, document details in the notes section.

Question 3: Does the individual eat fewer than 2 servings of dairy products (such as milk, yogurt, or cheese) every day?

Needs Assessment Tool Form Instructions

Select the correct response. If Yes, document details in the notes section.

Question 4: Does the individual eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day?

Select the correct response. If Yes, document details in the notes section.

Question 5: Does the individual have trouble eating due to problems with chewing/swallowing?

Select the correct response. If Yes, document details in notes section.

Question 6: Does the individual have enough money to buy food?

Select the correct response. If No, document details in the notes section.

Question 7: Does the individual eat alone most of the time?

Select the correct response. If Yes, document details in the notes section.

Question 8: Does the individual take 3 or more prescribed or over-the-counter (OTC) drugs per day?

Select the correct response. If Yes, document details in the notes section

Question 9: Nutritional Risk Score Indicator WILL go here:

Responses to Questions 1-8 will provide a total score. A score of 6 or more indicates nutritional risk.

14. INFORMAL SUPPORTS

14.A. INFORMAL HELPER(S) INFORMATION

The questions in this section will assist the care manager in determining the existence of a primary caregiver as defined in the Caregiver Support Program and if so identified, will lead to the completion of the Caregiver Assessment Tool (CAT) to further assess the caregiver's needs.

Question 1: Does the individual have any NON-PAID helpers that provide care or assistance on a regular basis?

Select the appropriate response, If No, Skip to 14.C.1. If Yes, Complete Section 14.

Needs Assessment Tool Form Instructions

Question 2: List names, phone numbers and email addresses of the non-paid helpers. Use the Note section if more room is needed:

Document the non-paid helpers name(s), phone number(s) and email addresses.

Question 3: Do any of the non-paid helpers reside in the individual's home?

Select the appropriate response, If Yes, document details in the notes section.

Question 4: Select the relationships of the individual's non-paid helpers:

Select the appropriate response(s). If "Other", document details in the notes section.

14.B. CONCERNS ABOUT THE HELPING RELATIONSHIPS

Question 1: What concerns does the individual have about any of the non-paid helpers? Document Details in Notes:

Select the appropriate response(s). If "Other", document details in the notes section.

Question 2: Care Manager's observations or concerns about the non-paid helpers-Document Details in Notes:

Select the appropriate response(s). If "Other", document details in the notes section.

14. C. ADDITIONAL INFORMAL SUPPORTS

Question 1: Is the individual involved with any informal supports in the community that are or may be willing to provide help and support (i.e., church, social or community organizations)?

Indicate No or Yes. If No, Skip to 15.A.1. If Yes, Complete 14.C.2.

Question 2: Document the name of the community support(s), type of help and frequency of help that could be or is provided:

Document the name of the community support(s), type of help provided, and the frequency of help provided.

15. PROTECTIVE SERVICES (PS)

Needs Assessment Tool Form Instructions

15.A. PROTECTIVE SERVICES (PS) Questions 1-3 are MANDATORY

Question 1: Does the individual feel afraid in his/her current living situation?

Select the appropriate response. If Yes, Completion of Section 15 is required.

Question 2: Is the individual safe to stay in his/her home environment?

Select the appropriate response. If No, Completion of Section 15 is required.

Question 3: Does the individual need a safe place to stay?

Select the appropriate response. If Yes, Completion of Section 15 is required.

Question 4: Note any dangers - Document Details in Notes.

Select all responses that apply.

Question 5: Is a referral to protective services indicated?

Select the appropriate response. If Yes, document details in the notes section.

15.B. ACCESS TO SERVICES

This section will assist the care manager in identifying what barriers may exist that will impact on the development of a care plan for the consumer.

Question 1: Does the individual have an issue with access to needed services or supports?

Select the appropriate response. If Yes, document details in the notes the section.

Question 2: If the individual does not have access to the needed services or supports, what assistance is needed?

Document the information for the assistance needed.

16. PHYSICAL ENVIRONMENT

16.A. CURRENT DWELLING UNIT

Question 1: Does the individual own his/ her current residence?

Needs Assessment Tool Form Instructions

Select the appropriate response. If No, document details in the notes section.

Question 2: Is the individual able to remain in his/ her current residence?

Select the appropriate response. If No or Uncertain, document details in the notes section.

Question 3: What conditions of the home environment cause health and safety risks to the individual? Document in Notes what and where are the problems:

Select the appropriate response(s). If “Other”, document details in the notes section.

Question 4: What areas of the home environment impact accessibility? Document in notes, what and where problems exist:

Select the appropriate response(s). If “Other”, document details in the notes section.

17. EMERGENCY INFORMATION

17.A EMERGENCY INFORMATION

Question 1: What are the individual’s physical limitations that would prevent individual leaving the home alone in an emergency?

Select the appropriate response(s). If “Other”, document details in the notes section.

Question 2: Does the individual have any of the following special medical needs during a public emergency?

Select the appropriate response(s). If “Other”, document details in the notes section.

Question 3: Select ALL types of Emergency Response Systems (ERS) with which the individual is currently utilizing:

Select the appropriate response(s). If “Other”, document details in the notes section.

Question 4: Is the consumer enrolled in a community response program?

Select the appropriate response. If Yes, document details in the notes section.

A community response program would include a local fire department or other local emergency response team.

18. INDIVIDUAL/SPOUSE/HOUSEHOLD FINANCIAL DATA

18.A. CONSUMER'S INCOME

The Financial Assistance Eligibility for the Caregiver Support Program (CSP) will be determined by using the Cost Sharing Guide published annually by the Department of Aging. Total household income for the previous calendar year is required to determine Financial Assistance Eligibility for CSP. Consumer and co-habiting spouse income and asset information is required for OPTIONS cost share determination and should be the current year income amounts.

For each income category listed in the section, note whether the consumer received income in that category and the monthly amount.

Sometimes, individuals will be reluctant to divulge information about income and assets. You should assure them that the information is strictly confidential, and will be used to determine eligibility for various programs and services. In addition, consumers or proxies may not know exact amounts of income. If an estimate is given, be sure to indicate in the notes that this amount is an estimate.

If the individuals refuse to provide this information after the purpose is fully explained, the interviewer should record this in the notes section and continue with the assessment.

Asset information is requested to determine if individuals' resources can be utilized in lieu of state funds.

Question 1: Refused to provide financial information?

Select the appropriate response. The implementation of mandatory cost sharing requires the consumer to disclose what their income is for the year. If the consumer refuses to disclose this information, they will cost share at 100% or not receive any services. Indicate whether the consumer refuses to disclose the information.

Question 2: Does the individual have direct deposit?

This question will identify if a consumer who may be at financial risk due to a living situation or circumstances, and may need assistance to reduce that risk by enrollment in direct deposit.

Select the appropriate response. If Yes, document details in the notes section.

Question 3: Individual's monthly Social Security (SS) income:

Needs Assessment Tool Form Instructions

Record this amount.

Question 4: Individual's monthly Supplemental Social Security (SSI) income:

Record this amount.

Question 5: Individual's monthly retirement/pension income:

Record this amount.

Question 6: Individual's monthly interest/dividends income:

Record this amount.

Question 7: Individual's monthly public assistance:

Record this amount.

Question 8: Individual's monthly VA benefit income:

Record this amount.

Question 9: Individual's monthly Black Lung income: Do not consider this as income for CSP determination.

Record this amount. This figure is not to be used as income for CSP determination.

Question 10: Individual's monthly wage/salary/earnings income:

Record this amount.

Question 11: Individual's monthly rental income:

Record this amount.

Question 12: Individual's railroad retirement benefit income:

Record this amount.

Question 13: Individual's annuity, trust, estate income:

Record this amount.

Question 14: Reverse mortgage monthly income:

Record this amount.

Question 15: Individual's other monthly income – Document the source of income in Notes:

Needs Assessment Tool Form Instructions

Record this amount. Document details in notes regarding the source of income.

Question 16: Individuals Total Monthly Income

The total income will be automatically calculated in the NAT.

18.B. CONSUMER'S ASSETS

Question 1: Individual's primary savings account balance:

Record the amount.

Question 2: Individual's primary checking account balance:

Record the amount.

Question 3: Individual's certificates/other retirement accounts:

Record the amount.

Question 4: Individual's NON-residential real estate assets value:

Record the amount.

Question 5: Cash surrender value of the individual's primary life insurance policy:

Record the amount.

Question 6: Individual's stocks and bonds account balances:

Record the amount.

Question 7: Individual's other account(s) balance(s)-Document type of account(s) in Notes:

Record the amount and specify the types of accounts in the notes section.

Question 8: Individual's Total Assets

The total assets will be automatically calculated in the NAT.

18.C. SPOUSE'S INCOME (Residing with individual)

Needs Assessment Tool Form Instructions

Question 1: Monthly Social Security (SS) income of spouse RESIDING with the individual:

Record this amount.

Question 2: Monthly SSI of spouse RESIDING with the individual:

Record this amount.

Question 3: Monthly retirement/ pension income of spouse RESIDING with the individual:

Record this amount.

Question 4: Monthly interest/ dividend income of spouse RESIDING with the individual:

Record this amount.

Question 5: Monthly public assistance income of spouse RESIDING with the individual:

Record this amount.

Question 6: Monthly VA benefits income of spouse RESIDING with the individual:

Record this amount.

Question 7: Monthly Black Lung income of spouse RESIDING with the individual:

Record this amount. This figure is not to be used as income for CSP determination.

Question 8: Monthly wage/ salary/ earnings income of spouse RESIDING with the individual:

Record this amount.

Question 9: Monthly NON-residential rental income of spouse RESIDING with the individual:

Record this amount.

Question 10: Other Monthly income of spouse RESIDING with the individual- Document the source of income in notes:

Record this amount and in the notes section, record the source of this income.

18.D. HOUSEHOLD INCOME

Question 1: Financial Resources Score

Select the appropriate response. If “Other”, document details in the notes section.

18.E. BENEFIT PROGRAMS

Question 1: Check all benefits the individual is currently RECEIVING:

Select the appropriate response(s). If “Other”, document details in the notes section.

19. NEEDS ASSESSEMENT SUMMARY

19.A. LCD & NAT OUTCOME

Question 1: What is the most recent Level of Care Determination (LCD) for this individual?

Select the appropriate response. Check one box only.

NOTE: There will not necessarily be an LCD completed immediately preceding the completion of the NAT. Beyond the initial LCD, it is only necessary to complete a new LCD if there has been a change in condition and/or a change in the individual’s Level of Care Determination.

Question 2: Has the individual had a change in condition that warrants a new LOC determination?

Select the appropriate response. If Yes, document details the notes section.

Question 3: What referral is recommended based on the LCD & NAT:

Select the appropriate response. If “Other”, document details in notes section.

DPW programs include all MA Waivers and Act 150.

19.B. NEEDS ASSESSMENT OUTCOME AND AUTHENTICATION

Needs Assessment Tool Form Instructions

The section is required to be completed following the completion of the NAT. A NAT is not considered to be fully completed until the Supervisor has reviewed and completed Questions 5 and 6. A review of a NAT by an RN is not required, but should occur in situations where the RN's input may be needed in the development of the care plan or as determined appropriate by the care manager and/or supervisor. The signatures indicate that the individual has complete and accurate information documented.

Question 1: Name of Care Manager (CM)/ Service Coordinator (SC) completing this Needs Assessment Tool:

Document the care manager or service coordinator's first and last name.

Question 2: Date of Care Manager (CM)/ Service Coordinator (SC) Signature:

Using the MM/DD/YYYY format, document the date the care manager or service coordinator signed the NAT.

Question 3: Name of Registered Nurse reviewing the Needs Assessment Tool (if reviewed):

Document the name of the registered nurse who reviewed the NAT.

Question 4: Date of Registered Nurse review (if reviewed):

Using the MM/DD/YYYY format, document the date the registered nurse reviewed the NAT.

Question 5: Name of Supervisor reviewing this Needs Assessment Tool:

Document the name of the supervisor who reviewed and approved the NAT.

Question 6: Date Supervisor approved the Needs Assessment Tool:

Using the MM/DD/YYYY format, document the date the supervisor reviewed the NAT.

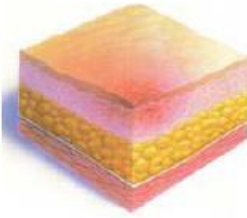
RESOURCES



Pressure Ulcer Staging

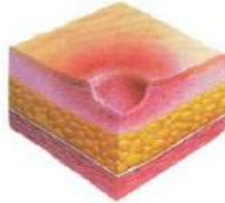
Stage I:

An observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.



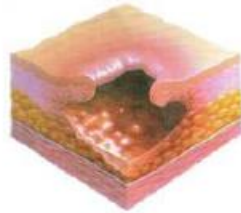
Stage II:

Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater.



Stage III:

Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.



Stage IV:

Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.



Eschar

Thick dry black necrotic tissue – Unstageable

