



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 DIVISION OF SENIOR AND DISABILITY SERVICES  
**NME HOME AND COMMUNITY BASED SERVICES REFERRAL/ASSESSMENT**

<b>DATE</b>					
PERSON BEING REFERRED (LAST, FIRST, MI)		DOB	DCN	RACE	SEX
ADDRESS (STREET, CITY, ZIP)			COUNTY	PHONE NUMBER(S)	
NAME OF PERSON MAKING REFERRAL		RELATIONSHIP		PHONE NUMBER(S)	
NAME OF REFERRING AGENCY			REASON FOR REFERRAL <input type="checkbox"/> In-home Services <input type="checkbox"/> RCF/ALF-Personal Care <input type="checkbox"/> Consumer-Directed Services <input type="checkbox"/> ADC <input type="checkbox"/> HDM		
<b>IS THE INDIVIDUAL RECEIVING HOME AND COMMUNITY BASED SERVICES</b> <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES EXPLAIN					
<b>MEDICAID STATUS</b>		<input type="checkbox"/> Active <input type="checkbox"/> Applied <input type="checkbox"/> Spenddown <input type="checkbox"/> Not Eligible <input type="checkbox"/> Potentially HCB Eligible			
<b>VISION/HEARING</b>		<input type="checkbox"/> Glasses <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Blind <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Deaf			
<b>LIVING ARRANGEMENTS AND MARITAL STATUS</b>					
OTHER PERSONS INVOLVED		ROLE	ADDRESS		PHONE
		Physician			
		Physician			
		Contact			
		Other (identify)			
<b>LIST ALL DIAGNOSES</b> (should correlate with meds., indicate if unstable, include name and date of physician verification)		<b>LIST (OR ATTACH A LIST OF) MEDICATION (RX and OTC) FOR DIAGNOSES</b> (should correlate with diagnoses, include dosage and frequency)			
<b>ASSESSED NEEDS</b>			<b>REQUIRED EXPLANATION –</b> include how need is/was being met, who is/was meeting the need, and why help is now needed. Attach additional pages if needed.		<b>LOC</b>
<b>MONITORING</b> <input type="checkbox"/> 0 (PRN medical check) <input type="checkbox"/> 3 (medical check 1 x mo; stable) <input type="checkbox"/> 6 (verified unstable medical condition) <input type="checkbox"/> 9 (intensive, continuous monitoring) <input type="checkbox"/> Sees physician? <input type="checkbox"/> Receives home health or hospice?			Include medical condition and frequency		
<b>MEDICATION</b> <input type="checkbox"/> 0 (No Rx Meds) <input type="checkbox"/> 3 (Rx Meds for stable condition) <input type="checkbox"/> 6 (Set-ups/supervision required) <input type="checkbox"/> 9 (Complex/ total assistance) <input type="checkbox"/> Medication management needs to be supervised? <input type="checkbox"/> Complex drug regime (i.e., multiple prescriptions with various dosages/time of administration or 9 or more prescribed meds.)			Indicate type of supervision needed and how often		
<b>TREATMENT</b> <input type="checkbox"/> 0 (none) <input type="checkbox"/> 3 (simple dressings, suppositories, <input type="checkbox"/> 6 (daily dressings – ulcers, cath. or ostomy care, PRN oxygen i.e., used within last 30 days) <input type="checkbox"/> 9 (dressing changes – more than 1 x dy., new/unregulated ostomy, cont. oxygen) <input type="checkbox"/> Bowel Program <input type="checkbox"/> Catheter <input type="checkbox"/> Ostomy <input type="checkbox"/> Oxygen			Include type of and frequency of treatment		
<b>RESTORATIVE</b> <input type="checkbox"/> 0 (No services) <input type="checkbox"/> 3 (maintain current level) <input type="checkbox"/> 6 (restore higher funct. level) <input type="checkbox"/> 9 (intense teaching/training services to restore to higher level) <input type="checkbox"/> Receives restorative (teaching/training) services?			Are services to maintain a current function, or restore the participant to a higher level of functioning		

PERSON BEING REFERRED (LAST, FIRST, MI)	REFERRAL NUMBER (HCS USE ONLY)	LOC
<b>REHABILITATION</b> <input type="checkbox"/> 0 (none) <input type="checkbox"/> 3 (1 x wk) <input type="checkbox"/> 6 (2-3 x wk) <input type="checkbox"/> 9 (4 or more x wk) Receives physician-ordered therapy? <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> Audiology	Indicate where services are provided and frequency	
<b>PERSONAL CARE</b> <input type="checkbox"/> 0 (none) <input type="checkbox"/> 3 (min. assist need, infrequent incont. – 1 x wk or less) <input type="checkbox"/> 6 (moderate assist needed, frequent incont. – 2 to 3 x wk) <input type="checkbox"/> 9 (max. assist needed; continuous incont.) <input type="checkbox"/> Grooming <input type="checkbox"/> Bathing/Equipment <input type="checkbox"/> Toileting	Indicate the amount and degree of human assistance required	
<b>DIETARY</b> <input type="checkbox"/> 0 (no assist) <input type="checkbox"/> 3 (minimal assist w/ cooking/eating, special diet) <input type="checkbox"/> 6 (mod assist by others) <input type="checkbox"/> 9 (max assist/tube feeding) <input type="checkbox"/> Prescribed Calculated Diet <input type="checkbox"/> Meal Preparation Needed <input type="checkbox"/> Assist w/eating <input type="checkbox"/> Tube Feeding	Indicate type of prescribed diet and amount of assistance needed	
<b>MOBILITY</b> <input type="checkbox"/> 0 (no human assist) <input type="checkbox"/> 3 (periodic human assist) <input type="checkbox"/> 6 (direct human assist for ambulation) <input type="checkbox"/> 9 (immobile) <input type="checkbox"/> Human Assistance <input type="checkbox"/> Turning/Positioning <input type="checkbox"/> Assistive Device	Indicate type and duration of human assistance needed and any assistive device needed, architectural barriers	
<b>BEHAVIORAL INFORMATION &amp; MENTAL STATUS</b> <input type="checkbox"/> 0 (no assistance needed) <input type="checkbox"/> 3 (periodic human assist) <input type="checkbox"/> 6 (moderate human assist) <input type="checkbox"/> 9 (maximum human assist) <input type="checkbox"/> Wanders <input type="checkbox"/> MI/MR/DD <input type="checkbox"/> Combative <input type="checkbox"/> Withdrawn <input type="checkbox"/> Depression <input type="checkbox"/> Disoriented <input type="checkbox"/> Alert / Oriented <input type="checkbox"/> Thinks clearly <input type="checkbox"/> Dementia  <input type="checkbox"/> Lethargic <input type="checkbox"/> Memory deficits <input type="checkbox"/> Suspicious / Paranoid <input type="checkbox"/> Supervised for safety  <input type="checkbox"/> Able to make appropriate independent decisions <input type="checkbox"/> Guardian <input type="checkbox"/> Conservator <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Payee	Indicate type and amount of human assistance needed	<b>LOC TOTAL</b>
<b>Needs assistance with the following: (indicate what help is needed and who is currently helping)</b>		
<input type="checkbox"/> Laundry	<input type="checkbox"/> Gather/Take out trash	
<input type="checkbox"/> Vacuum/Dust	<input type="checkbox"/> Shopping Assistance	
<input type="checkbox"/> Clean Bathroom	<input type="checkbox"/> Transportation	
<input type="checkbox"/> Clean Kitchen	<input type="checkbox"/> Assist w/ Handling Money	
<input type="checkbox"/> Make/Change bed	<input type="checkbox"/> Assist w/Telephone	
<b>Safety/Emergency Plan</b>		
<input type="checkbox"/> History of violent behavior	Priority Risk: <input type="checkbox"/> 1 High <input type="checkbox"/> 2 Medium <input type="checkbox"/> 3 Low	
<input type="checkbox"/> Weapons in the home	<input type="checkbox"/> Emergency Back-up Plan:	
<input type="checkbox"/> Vicious dogs		
<input type="checkbox"/> Others available in the home for support		
<b>DIRECTIONS TO LOCATE – COMMENTS:</b>		
WORKER SIGNATURE	DATE	