

PARTICIPANT NAME		DCN	DATE	INITIALS
III. TECHNOLOGY ASSESSMENT (Check all that currently apply)			COMMENTS	
Vent Dependant	<input type="checkbox"/> Total			
	<input type="checkbox"/> Intermittent			
Tracheostomy	<input type="checkbox"/>			
C-PAP, BIPAP	<input type="checkbox"/>			
Oxygen	<input type="checkbox"/> Continuance, Stable			
	<input type="checkbox"/> Continuous, Unstable			
G-Tube	<input type="checkbox"/> Continuous			
	<input type="checkbox"/> Continuous with Reflux			
	<input type="checkbox"/> Bolus			
NG Tube	<input type="checkbox"/> Continuous			
	<input type="checkbox"/> Bolus			
IV Therapy	<input type="checkbox"/> Continuous			
	<input type="checkbox"/> Intermittent			
IV. INDIVIDUAL DEPENDENCIES				
1. MONITORING				
0 <input type="checkbox"/> Frequent visits by friends or neighbors and/or RN visits for state plan personal care.				
3 <input type="checkbox"/> Client is seen regularly by physician and/or seen by home health for stable condition.				
6 <input type="checkbox"/> Client is seen regularly by physician and/or home health for unstable condition.				
9 <input type="checkbox"/> Client requires intensive monitoring for unstable condition.				
COMMENTS				
2. MEDICATION				
0 <input type="checkbox"/> Client takes no prescription meds and/or only occasional prn meds .				
3 <input type="checkbox"/> Client takes prescription meds and/or prn meds on a regular basis .				
6 <input type="checkbox"/> Client needs supervision taking meds and/or needs meds set up on a regular basis .				
9 <input type="checkbox"/> Client has complex drug regimen requiring high number of meds, varying times, special instructions and/or total assistance to take meds .				
COMMENTS				
3. TREATMENT				
0 <input type="checkbox"/> No treatments ordered by physician.				
3 <input type="checkbox"/> Client has physician ordered treatments such as simple dressing, whirlpool baths, external catheter or regulated ostomy.				
6 <input type="checkbox"/> Client has physician ordered treatments that require daily attention of licensed personnel.				
9 <input type="checkbox"/> Client needs maximum type treatments requiring direct supervision by professional such as intratracheal suctioning, continuous O2, etc.				
COMMENTS				
4. RESTORATIVE SERVICES				
0 <input type="checkbox"/> No physician services ordered for range of motion, bowel and bladder programs, self-care, etc.				
3 <input type="checkbox"/> Physician ordered teaching activities to maintain current level of functioning.				
6 <input type="checkbox"/> Physician ordered services designed to help client achieve optimal level of care.				
9 <input type="checkbox"/> Physician ordered services with goal to restore client to higher level of functioning (intense-requiring professional supervision).				
COMMENTS				

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IV. INDIVIDUAL DEPENDENCIES (Continued)			
5. REHABILITATION 0 <input type="checkbox"/> No rehabilitation services required. 3 <input type="checkbox"/> Rehabilitation services ordered one time per week. 6 <input type="checkbox"/> Rehabilitation services ordered 2-3 times per week. 9 <input type="checkbox"/> Rehabilitation services ordered four or more times per week.			
COMMENTS			
6. PERSONAL CARE 0 <input type="checkbox"/> Client is independent in activities of daily living. 3 <input type="checkbox"/> Client requires minimal or occasional assistance with ADL's. 6 <input type="checkbox"/> Client requires daily assistance with ADL's and/or is incontinent of bladder or bowel 50% of the time. 9 <input type="checkbox"/> Client requires total assistance with ADL's.			
COMMENTS			
7. BEHAVIOR/MENTAL CONDITION 0 <input type="checkbox"/> Client is oriented and requires little or no assistance from others.. 3 <input type="checkbox"/> Client has occasional memory lapses and forgetfulness causing him/her to need minimal assistance of supervision. 6 <input type="checkbox"/> Client requires moderate assistance due to disorientation, mental or developmental disabilities or uncooperative behavior. 9 <input type="checkbox"/> Client requires maximum assistance due to confusion, incompetency, hostility or severe depression.			
COMMENTS			
8. MOBILITY 0 <input type="checkbox"/> Client does not need any human assistance with mobility. 3 <input type="checkbox"/> Client needs assistance transferring to a wheelchair, getting out of a chair, or cannot climb stairs without assistance. 6 <input type="checkbox"/> Client requires assistance for all ambulation. 9 <input type="checkbox"/> Client is totally dependent on others.			
COMMENTS			
9. DIETARY 0 <input type="checkbox"/> Client is on regular diet, can prepare own meals, and does not need assistance eating. 3 <input type="checkbox"/> Client requires 50% of meals to be prepared by others and needs encouragement or minimal supervision to eat. 6 <input type="checkbox"/> Client requires all meals to be prepared by others, needs to be fed by someone, or is on calculated diet for unstable condition. 9 <input type="checkbox"/> Client is unable to eat and requires tube feedings or parenteral fluids.			
COMMENTS			
TOTAL POINTS FOR SECTION IV	SERVICE COORDINATOR'S SIGNATURE	DATE	

PARTICIPANT NAME	DCN	DATE	INITIALS
V. INDIVIDUAL HISTORY			
PRIMARY			
SECONDARY			
A. PAST MEDICAL HISTORY (INCLUDING THE PRESENCER OF MENTAL RETARDATION OR DEVELOPMENTAL DELAY)			
B. SOCIAL HISTORY/ENVIRONMENT (INCLUDING AVAILABILITY OF CAREGIVERS)			
C. OTHER IDENTIFIED RECIPIENT/CAREGIVER NEEDS			