





**MISSOURI DEPARTMENT OF HEALTH  
BUREAU OF SPECIAL HEALTH CARE NEEDS  
CLIENT ASSESSMENT, continued**

Client Name:		DCN:	Date:	Initials:
<b>III. TECHNOLOGY ASSESSMENT</b> Check all that currently apply			Comments	
Vent Dependent	Total			
	Intermittent			
Tracheostomy				
C-PAP, BIPAP				
Oxygen	Continuous, Stable			
	Continuous, Unstable			
	PRN			
G-Tube	Continuous			
	Continuous with Reflux			
	Bolus			
NG Tube	Continuous			
	Bolus			
IV Therapy	Continuous			
	Intermittent			
<b>IV. INDIVIDUAL DEPENDENCIES</b>				
<b>1. MONITORING:</b>				
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:				
<b>2. MEDICATION:</b>				
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:				
<b>3. TREATMENT:</b>				
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:				



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<b>IV. INDIVIDUAL DEPENDENCIES (continued)</b>			
<b>4. RESTORATIVE SERVICES:</b>			
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:			
<b>5. REHABILITATION:</b>			
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:			
<b>6. PERSONAL CARE</b>			
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 and bowel 50% of the time.			
9 <input type="checkbox"/> Client requires total assistance with ADL's.			
COMMENTS:			
<b>7. BEHAVIOR/MENTAL CONDITION</b>			
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 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 maximal assistance due to confusion, incompetency, hostility or severe depression.			
COMMENTS:			
<b>8. MOBILITY</b>			
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:			
<b>9. DIETARY</b>			
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:			
<b>TOTAL points for Section IV _____</b>			
<b>SERVICE COORDINATOR'S SIGNATURE/ DATE:</b>			



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PDW and PC Guidelines  
Attachment 4

Client Name:	DCN:	Date:	Initials:
<b>V. INDIVIDUAL HISTORY</b>			
<b>Diagnosis:</b>			
Primary:			
Secondary:			
<b>A. Past Medical History (including the presence of mental retardation or developmental delay)</b>			
<b>B. Social History/Environment (including availability of caregivers):</b>			
<b>C. Other Identified Recipient/Caregiver Needs:</b>			