MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH CARE NEEDS
MEDICAL FRAGILE ADULT WAIVER

CLIENT ASSESSMENT

PARTICIPANT NAME	DCN	DATE	INITIALS

Check the problem areas with "P", and check the strong qualities with a "S"

Owns/Rents		Safe Home/Neighborhood		Pets	
Stable Living Condition		Sanitation		Heating/Cooling	
Size of Household		Bugs/Rodents			

I. CURRENT HEALTH STATUS (check all that currently apply)

Anemia, Autoimmune Deficiency, Blood Disorders		Hypertension/Renal Disease	
Arthritis & other joint limitations or injuries		Mental Impairment, Cognitive Impairment, Behavioral Illness	
Bowel/Bladder Problems		Respiratory Problems (cystic fibrosis, asthma, pulmonary dysplasia)	
Diabetes, Nutritional Disorders		Skin Problems (decubitus ulcer, lesions, rashes)	
Digestive disorders (requires gastrostomy tube, short gut syndrome)		Surgery With Residual Effects (shunts, drainage, amputation, paralysis, pain, fatigue)	
Effects of Brain Injury (CVA, TIA, memory loss)		Seizure Disorders	
Hearing Impairment (H.O.H., deafness)		Visual Impairment	
Heart Trouble (angina, congenital defect, CHF, MI)		Other	

II. PRESCRIPTION MEDICATIONS

NAME	DOSAGE

PARTICIPANT NAME	DCN	DATE	INITIALS

III. TECHNOLOGY ASSESSMENT

Check all that currently apply:		COMMENTS
Vent Dependent	☐ Total	
	☐ Intermittent	
Tracheostomy	☐	
C-PAP, BIPAP	☐	
Oxygen	☐ Continuous, Stable	
	☐ Continuous, Unstable	
G-Tube	☐ Continuous	
	☐ Continuous with Refux	
	☐ Bolus	
NG Tube	☐ Continuous	
	☐ Bolus	
IV Therapy	☐ Continuous	
	☐ Intermittent	

IV. INDIVIDUAL DEPENDENCIES

BEHAVIORAL

Determine if the participant: receives monitoring for a mental condition; exhibits one or more of the following mood or behavior symptoms: wandering, physical abuse, socially inappropriate or disruptive behavior, inappropriate public sexual behavior or public disrobing; resists care; exhibits one of the following psychiatric conditions: abnormal thoughts, delusions, or hallucinations.

- 0 ☐ Stable mental condition AND No mood or behavior symptoms observed AND No reported psychiatric conditions
- 3 ☐ Stable mental condition monitored by a physician or licensed mental health professional at least monthly OR Behavior symptoms exhibited in past, but not currently present OR Psychiatric conditions exhibited in past, but not recently present
- 6 ☐ Unstable mental condition monitored by a physician or licensed mental health professional at least monthly OR Behavior symptoms are recently exhibited OR psychiatric conditions are recently exhibited
- 9 ☐ Unstable mental condition monitored by a physician or licensed mental health professional at least monthly AND Behavior symptoms are currently exhibited OR Psychiatric conditions are currently exhibited
- 18 ☐ N/A

COMMENTS

COGNITION

Determine if the participant has an issue in one or more of the following areas: cognitive skills for daily decision making; memory or recall ability (short-term, procedural, situational memory); disorganized thinking/awareness (mental function varies over the course of the day); ability to understand others or to be understood.

- 0 ☐ No issues with cognition OR No issues with memory, mental function, or ability to be understood/understand others
- 3 ☐ Displays difficulty making decisions in new situations or occasionally requires supervision in decision making AND Has issues with memory, mental functions, or ability to be understood/understand others
- 6 ☐ Displays consistent unsafe/poor decision making or requires total supervision AND Has issues with memory, mental function, or ability to be understood/understand others
- 9 ☐ Rarely or never has the capability to make decisions OR Displays consistent unsafe/poor decision making or requires total supervision AND Rarely or never understood/able to understand others
- 18 ☐ TRIGGER: Comatose state

COMMENTS

PARTICIPANT NAME	DCN	DATE	INITIALS

IV. INDIVIDUAL DEPENDENCIES Continued

MOBILITY

Determine the participant's primary mode of locomotion: how moves, walking or wheeling? If wheeling how much assistance is needed once in the chair? Determine the amount of assistance the participant needs with bed mobility: transition from lying to sitting, turning, etc.

- 0 ☐ No assistance needed OR Only set up or supervision needed
- 3 ☐ Limited or moderate assistance needed, i.e. participant performs more than 50% of task independently
- 6 ☐ Maximum assistance needed for locomotion or bed mobility, i.e. participant needs 2 or more helpers or more than 50% of caregiver weight-bearing assistance OR Total dependence for bed mobility
- 9 ☐ N/A
- 18 ☐ TRIGGER: Participant is bedbound OR Total dependence on others for locomotion

COMMENTS

EATING

Determine the amount of assistance the participant needs with eating and drinking; includes intake of nourishment by other means (e.g. tube feeding or TPN). Determine if the participant requires a physician ordered therapeutic diet.

- 0 ☐ No assistance needed AND No physician ordered diet
- 3 ☐ Physician ordered therapeutic diet OR Set up, supervision, or limited assistance needed with eating
- 6 ☐ Moderate assistance needed with eating, i.e. participant performs more than 50% of the task independently
- 9 ☐ Maximum assistance needed with eating, i.e. participant requires caregiver to perform more than 50% for assistance
- 18 ☐ TRIGGER: Total dependence on others

COMMENTS

TOILETING

Determine the amount of assistance the participant needs with toileting. Toileting includes: using the toilet (bedpan, urinal, commode), changing incontinent episodes, managing catheters/ostomies, and adjusting clothing.

- 0 ☐ No assistance needed OR Only setup or supervision needed
- 3 ☐ Limited or moderate assistance needed, i.e. participant performs more than 50% of task independently
- 6 ☐ Maximum assistance needed, i.e. participant needs 2 or more helpers or more than 50% of caregiver weight-bearing assistance
- 9 ☐ Total dependence on others
- 18 ☐ N/A

COMMENTS

PARTICIPANT NAME	DCN	DATE	INITIALS

IV. INDIVIDUAL DEPENDENCIES Continued

BATHING

Determine the amount of assistance the participant needs with bathing. Bathing includes taking a full body bath/shower and the transferring in and out of the bath/shower.

- 0 ☐ No assistance needed OR Only setup or supervision needed
- 3 ☐ Limited or moderate assistance needed, i.e. participant performs more than 50% of task independently
- 6 ☐ Maximum assistance, i.e. participant needs 2 or more helpers or more than 50% of caregiver weight-bearing assistance OR Total dependence on others
- 9 ☐ N/A
- 18 ☐ N/A

COMMENTS

DRESSING & GROOMING

Determine the amount of assistance the participant needs with personal hygiene, dressing upper body, and dressing lower body.

- 0 ☐ No assistance needed OR Only setup or supervision needed
- 3 ☐ Limited or moderate assistance needed, i.e. participant performs more than 50% of task independently
- 6 ☐ Maximum assistance needed, i.e. participant needs 2 or more helpers or more than 50% of caregiver weight-bearing assistance OR Total dependence on others
- 9 ☐ N/A
- 18 ☐ N/A

COMMENTS

REHABILITATION

Determine if the participant has the following medically ordered therapeutic services: physical therapy, occupational therapy, speech-language pathology and audiology services, and cardiac rehabilitation.

- 0 ☐ None of the above therapies ordered
- 3 ☐ Any of the above therapies ordered, 1 time per week
- 6 ☐ Any of the above therapies ordered, 2-3 times per week
- 9 ☐ Any of the above therapies ordered, 4 or more times per week
- 18 ☐ N/A

COMMENTS

PARTICIPANT NAME	DCN	DATE	INITIALS

IV. INDIVIDUAL DEPENDENCIES Continued

TREATMENTS

Determine if the participant requires any of the following treatments: catheter/ostomy care, alternate modes of nutrition (tube feeding, TPN), suctioning, ventilator/respirator, or wound care (skin must be broken).

0 ☐ None of the above treatments needed
3 ☐ N/A
6 ☐ One or more of the above treatments are needed
9 ☐ N/A
18 ☐ N/A

COMMENTS

MEAL PREP

Determine the amount of assistance the participant needs to prepare a meal. This includes: planning, assembling ingredients, cooking, and setting out the food and utensils.

0 ☐ No assistance needed OR Only setup or supervision needed
3 ☐ Limited or moderate assistance needed, i.e. participant performs more than 50% of task
6 ☐ Maximum assistance, i.e. caregiver performs more than 50% of task OR Total dependence on others
9 ☐ N/A
18 ☐ N/A

COMMENTS

MEDICATION MANAGEMENT

Determine the amount of assistance the participant needs to safely manage their medications. Assistance may be needed due to a physical or mental disability.

0 ☐ No assistance needed
3 ☐ Setup help needed OR Supervision needed OR Limited or moderate assistance needed, i.e. participant performs more than 50% of task
6 ☐ Maximum assistance needed, i.e. caregiver performs more than 50% of task OR Total dependence on others
9 ☐ N/A
18 ☐ N/A

COMMENTS

PARTICIPANT NAME	DCN	DATE	INITIALS

IV. INDIVIDUAL DEPENDENCIES Continued

SAFETY

Determine if the participant exhibits any of the following risk factors: vision impairment, falling, balance (moving to standing position, turning to face the opposite direction, dizziness, or unsteady gait).

After determination of the preliminary score, history of institutionalization in the last 5 years and age will be considered to determine the final score.

- Institutionalization - long term care facility, RCF/ALF, mental health residence, psychiatric hospital, inpatient substance abuse, or settings for persons with intellectual disabilities.
- Age - 75 years or over

0 ☐ No difficulty or some difficulty with vision AND No falls in last 90 days AND No recent problems with balance
3 ☐ Severe difficulty with vision (sees only lights and shapes) OR Has fallen in last 90 days OR Has current problems with balance
6 ☐ No vision OR Has fallen in the last 90 days AND Has current problems with balance OR Preliminary score of 0 AND Age AND Institutionalization OR Preliminary score of 3 AND Age or Institutionalization
9 ☐ Preliminary score of 6 AND Institutionalization
18 ☐ TRIGGER: Preliminary score of 6 AND Age OR Preliminary score of 3 AND Age AND Institutionalization

COMMENTS

TOTAL POINTS FOR SECTION	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