Department of Medical Assistance Services
Technology Assisted Waiver

Provider RN Initial Home Assessment

Individual's Name_____

Nursing Agency's Name_____ Date of Supervisor's Admission Visit _____

Family Primary Caregiver's Name_____ Medicaid # _____

Primary Diagnoses _____

Document Brief Medical History

_____

_____

TECHNOLOGY / NURSING NEEDS (Circle Answer) Ventilator CPAP BIPAP – continuous intermittent

Oxygen: continuous intermittent PRN Enteral feedings: continuous Q 2 hrs. Q3hrs. Q 4 hrs+

IV/ TPN: continuous 8-16 hrs 4-7hrs <4 hrs Oral Supplements: _____
(Type, frequency, amount)

Specific Trach Care Orders: _____ Trach Change: weekly >weekly

Trach Suctioning: QHR. Q1-4 hrs Q 4 hrs+

Other wound care dressings: _____ Q 8 hrs or less >Q 8 hrs
(Specify type and location)

List Scheduled Medications:

Peritoneal dialysis (frequency and length): _____

Catheterization: Q 4 hrs Q 8 hrs Q 12 hrs QD PRN Nebulizer Treatments: _____ QID TID BID QD

Specialized monitor I/O (reason): _____frequency _____

Other Skilled Home Health Visit Nursing provided? (specify):_____

HEALTH, SAFETY, WELFARE ISSUES IDENTIFIED? Yes ☐ No ☐ If Yes, Explain and notify DMAS

_____

_____

THERAPIES (name of provider, frequency, location): _____

_____

FAMILY'S NURSING SHIFT PREFERENCES: _____

NURSES STAFFING CASE / SHIFTS COVERED:

_____

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HOME ASSESSMENT

Describe Family's Willingness and Ability to Care for the Individual (Indicate training received, note type and amount of care family is committed to provide and variations in family's schedule)

_____

_____

Describe General Condition of the Home Environment and Any Concerns (e.g. cleanliness, pests, family pets in home)

_____

Is the home setting appropriate to meet the individual's needs? (If not, notify DMAS immediately) Yes ☐ No ☐

Home Physical Standards (If inadequate, note needed changes)	Adequate	Inadequate
LARGE BATTERY LIGHT AT BEDSIDE	_____	_____
SMOKE ALARM / FIRE EXTINGUISHER	_____	_____
PLUMBING SUPPORTS WATER AND SEWAGE	_____	_____
ADEQUATE HEATING SYSTEM	_____	_____
ADEQUATE COOLING SYSTEM	_____	_____
TELEPHONE SERVICE	_____	_____

TECH WAIVER SERVICES

Check the Tech Waiver Services Requested by the Family / Caregiver or Applicant:

☐ Private Duty Nursing ☐ Respite Care ☐ Environmental Modifications

☐ Assistive Technology ☐ Transition Services

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FAMILY INFORMATION

Primary Representative / Caregiver: _____Relationship to Individual_____
(If custody not held by primary representative, identify name, address and telephone # of custodian)

_____

Current Employment of Primary Representatives / Caregivers

Name: _____
Employer_____
Phone # of employer_____
Work hours_____

Name_____
Employer_____
Phone # of employer_____
Work hours_____

Total Number of Individuals in Home_____

Name of Primary Decision Maker _____

NAMES OF HOUSEHOLD MEMBERS	AGE	RELATIONSHIP TO TECH WAIVER INDIVIDUAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Identify All Other Trained Back-up Caregivers (Give name, phone and relationship)
_____

_____

Are There Additional Caregiver Responsibilities? (Care of elderly parent or employment outside of home, etc.)

_____

Additional Comments:
_____

_____

RN Supervisor's Signature _____ Date Completed _____