Ohio Department of Medicaid

HOME CHOICE Needs Assessment

HOME CHOICE APPLICANT			
Last Name	First Name	MI	Date of Birth *(mm/dd/yyyy)*
Phone Number	Email		
Medicaid ID Number	Social Security Number	Medicare ID Number *(if applicable)*	

If the applicant is currently on a Medicaid Managed Care Plan, please indicate the specific plan provider:

☐ Aetna ☐ Buckeye ☐ CareSource ☐ Molina ☐ Paramount ☐ United Healthcare

If the applicant is currently on MyCare?

☐ Yes ☐ No

Check one below if applicable:

☐ MyCare Waiver ☐ MyCare Community Well ☐ Don't Know

Gender ☐ M ☐ F

Marital Status ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race/Ethnicity (*check one)*

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Native Hawaiian or Pacific Islander ☐ Caucasian or White ☐ Other_____

ASSESSOR		
Name	Phone Number	Assessment Date
Agency	Email	

ASSESSMENT DYNAMICS

Does the applicant need or want an interpreter to be present? ☐ Yes ☐ No

Preferred Language: [_____]

Who else is present at the assessment meeting?

☐ Facility Staff	Name [_____]	Phone: [_____]	Email: [_____]
☐ Case Manager:	Name [_____]	Phone: [_____]	Email: [_____]
☐ LTC Ombudsman	Name [_____]	Phone: [_____]	Email: [_____]
☐ Spouse/Significant Other	Name [_____]	Phone: [_____]	Email: [_____]
☐ Guardian	Name [_____]	Phone: [_____]	Email: [_____]
☐ Relative	Name [_____]	Phone: [_____]	Email: [_____]
☐ Relative	Name [_____]	Phone: [_____]	Email: [_____]
☐ Friend	Name [_____]	Phone: [_____]	Email: [_____]
☐ Friend	Name [_____]	Phone: [_____]	Email: [_____]
☐ Other	Name [_____]	Phone: [_____]	Email: [_____]
☐ Other	Name [_____]	Phone: [_____]	Email: [_____]

Does the individual have any of the following communication issues/barriers?

☐ Hearing ☐ Vision ☐ Literacy ☐ Aphasia ☐ Autism ☐ Stutters ☐ Tourette's Syndrome ☐ Other

ELIGIBILITY VERIFICATION

1. Please verify that the individual has at least one source of monthly income.

Retirement Income from Social Security ☐ Yes ☐ No ☐ Application Submitted ☐ In appeal

Supplemental Security Income (SSI) ☐ Yes ☐ No ☐ Application Submitted ☐ In appeal

Social Security Disability Insurance (SSDI) ☐ Yes ☐ No ☐ Application Submitted ☐ In appeal

Benefits from the Veterans' Administration ☐ Yes ☐ No ☐ Application Submitted ☐ In appeal

☐ **Worker's Compensation** ☐ **Private Disability Insurance** ☐ **Unemployment**
☐ **Pension (former job)** ☐ **Earned Wages (employment)**
☐ **Other, please describe:** _____

2. What is the individual's approximate or anticipated community monthly income? $_____

3. Where is the individual currently residing?

☐ Nursing Facility ☐ Hospital

4. Admission Date (of current long-term care episode)	**5.** Anticipated Discharge Date

SOME PRE-TRANSITION CONSIDERATIONS

What were the individual's housing and living arrangements prior to long-term care admission?

5. Type of Housing *(check one)*

☐ Their Own Home
☐ Rented Apartment/Home
☐ Friend or Relative's Home
☐ Group Home
☐ Assisted Living
☐ Homeless
☐ Incarceration
☐ Other

6. Living Arrangements *(check all that apply)*

☐ Lived Alone
☐ Lived with Spouse/Significant Other
☐ Lived with Caretaker
☐ Lived with Parents
☐ Lived with Children/Other Family Members
☐ Lived with Friends/Roommate
☐ Lived in Congregate Setting

7. What is the level of support for the individual's discharge/transition to the community?

Stakeholder	**Level of Support for Discharge** *(check one box per stakeholder)*			
	Fully Supports	**Has Discharge Concerns**	**Opposed to Discharge**	**Comments/Observations:**
Primary Care Physician	☐	☐	☐	
Facility Staff	☐	☐	☐	
Spouse/Significant Other	☐	☐	☐	
Friend	☐	☐	☐	
Relative	☐	☐	☐	
Guardian	☐	☐	☐	

- Other (specify)	☐	☐	☐	
- Other (specify)	☐	☐	☐	
- Other (specify)	☐	☐	☐	

Daily Living Skills/Activities	**8. Current Functional Needs** *(check one box per daily living skills/activities)*					
	Independent	**Requires Supervision or Verbal Prompts/Cues**	**Requires Some Physical Assistance**	**Total Dependence On Others**	**DME/Adaptive Device Used (Fill-in)**	**Identify DME/Adaptive Device and Service Needs in Community (Fill-in)**
Eating	☐	☐	☐	☐		
Dressing	☐	☐	☐	☐		
Bathing	☐	☐	☐	☐		
Grooming/Personal Hygiene	☐	☐	☐	☐		
Toileting	☐	☐	☐	☐		
Walking	☐	☐	☐	☐		
Stair Climbing	☐	☐	☐	☐		
Mobility in Wheelchair	☐	☐	☐	☐		
Transferring	☐	☐	☐	☐		
Taking Medications	☐	☐	☐	☐		
Meal Preparation	☐	☐	☐	☐		
Laundry	☐	☐	☐	☐		
Household Cleaning	☐	☐	☐	☐		
Home Maintenance	☐	☐	☐	☐		
Shopping	☐	☐	☐	☐		
Transportation	☐	☐	☐	☐		
Managing Appointments	☐	☐	☐	☐		
Bill Paying	☐	☐	☐	☐		
Money Management	☐	☐	☐	☐		
Comments about Functional Needs						

MEDICAL HEALTH

9. What is the last cognitive BIMS score from the last MDS assessment for the applicant?

☐ 0-5 ☐ 6-10 ☐ 11-14 ☐ 15

10. Does the individual have any medical diagnoses? ☐ Yes ☐ No

Self-reported Diagnoses

Chart Review

Notes:

Check all that apply:

- ☐ A-Fib or other Dysrhythmias
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Aphasia
- ☐ Arthritis
- ☐ Asthma, COPD, Chronic Lung Disease
- ☐ Benign Prostatic Hyperplasia (BPH)
- ☐ Cancer
- ☐ Cataracts, Glaucoma, Macular Degeneration
- ☐ Cerebral Palsy
- ☐ Cirrhosis
- ☐ Coronary Artery Disease (CAD)
- ☐ CVA, TIA, or Stroke
- ☐ Dementia
- ☐ Diabetes Mellitus
- ☐ DVT, PE, or PTE
- ☐ GERD or Ulcer
- ☐ Heart Failure
- ☐ Hemiplegia, Hemiparesis
- ☐ Hip Fracture
- ☐ Huntington's Disease
- ☐ Hyperkalemia
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hyponatremia
- ☐ Malnutrition
- ☐ Multidrug-Resistant Organism (MDRO)
- ☐ Multiple Sclerosis (MS)
- ☐ Neurogenic Bladder
- ☐ Obstructive Uropathy
- ☐ Orthostatic Hypotension
- ☐ Osteoporosis
- ☐ Other Fracture
- ☐ Paraplegia
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ PVD or PAD
- ☐ Quadriplegia
- ☐ Renal Insufficiency, Renal Failure
- ☐ Respiratory Failure
- ☐ Seizure Disorder or Epilepsy
- ☐ Septicemia
- ☐ TBI
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcerative Colitis, Crohn's, or IBD
- ☐ UTI (last 30 days)
- ☐ Viral Hepatitis
- ☐ Wound Infection
- ☐ Other, note above

11. Does the individual have any medications? ☐ Yes ☐ No

Self-reported Medications – Does the individual demonstrate knowledge of medication regimen?

Chart Review

Notes:

Check all that apply:

- ☐ Antianxiety
- ☐ Antibiotic
- ☐ Anticoagulant
- ☐ Antidepressant
- ☐ Antipsychotic
- ☐ Diuretic
- ☐ Hypnotic
- ☐ Opioid

BEHAVIORAL HEALTH

12. Does the individual have any behavioral health diagnoses or history of treatment? ☐ Yes ☐ No

Please indicate those that apply:

☐ Anxiety Disorders	☐ Manic Depression/Bipolar	☐ Psychotic Disorders
☐ Depression/Mood Disorders	☐ Obsessive Compulsive Disorder	☐ Schizophrenia
☐ Dissociative Disorders	☐ Personality Disorders	☐ Somatic Symptom Disorders
☐ Factitious Disorders	☐ Post Traumatic Stress Disorder	☐ Stress Response Syndromes
☐ History of Psychiatric Treatment	☐ Previous Mental Health CM	☐ Suicidal Attempts/Thoughts
☐ Impulse Control Disorders	☐ Previous Psychiatric Hospital Stay	☐ Other: (specify) _____

Chart Review

13. Has the individual been a danger to him or herself, or to others, in the last 90 days?
(e.g. attempted suicide, made suicidal gestures, expressed suicidal ideation, assaultive to other children or adults, reckless and puts self in dangerous situations, attempts to or has sexually assaulted other individuals) ☐ Yes ☐ No

Chart Review

14. Has the individual exhibited bizarre or unusual behavior in the last 90 days?
(History or pattern of fire-setting; animal cruelty; excessive, compulsive or public masturbation; appears to hear voices or respond to other internal stimuli (including alcohol or drug induced); repetitive body motions (e.g. head banging) or vocalizations (e.g. echolalia); smears feces; etc.) ☐ Yes ☐ No

Chart Review/Observation

15. Does the individual have problems making and maintaining healthy relationships and/or social adjustment?
(Unable to form positive relationships with peers; provokes and victimizes others; does not form bond with caregiver; regularly involved in physical fights with others; verbally threatens people; damages possessions of self or others; runs away; steals; regularly lies; mute; confined due to serious law violations; does not seem to feel guilt after misbehavior, etc.) ☐ Yes ☐ No

Chart Review/Observation

16. Does the individual have significant problems managing his/her feelings? *(Severe temper; screams uncontrollably; cries inconsolably; withdrawn and uninvolved with others; regularly expresses strong emotions such as the feeling that others are out to get them; excessive preoccupation, etc.)* ☐ Yes ☐ No

Chart Review/Observation

SUBSTANCE USE

17. Does the individual have any Substance Use Diagnoses? ☐ Yes ☐ No

Please indicate those that apply:

- ☐ Received CM services from a substance abuse provider in the past
- ☐ Had past hospitalizations or rehabilitations for substance use
- ☐ Needs help connecting to community alcohol treatment resources
- ☐ Needs help connecting to community drug treatment resources
- ☐ Individual is currently using in facility

Self-reported Diagnoses

Chart Review

HOUSING NEEDS

18. Does the individual need assistance finding housing after discharge?

- ☐ Yes, the individual needs help finding housing.
- ☐ No, the individual will look for housing on their own.
- ☐ No, the individual will be returning to their own housing or has found new housing

(If housing already in place, please complete the additional information below).

Address	City	County	Zip Code

Is rent/mortgage current? ☐ Yes ☐ No ☐ N/A	Rent/Mortgage Amount:
How is rent/mortgage currently paid?	How will rent/mortgage be paid?

Housing Comments *(if the individual needs any physical changes or home modifications to current housing, note below).*

19. Does the individual need any of the following accommodations or accessibility features for their housing?

- ☐ Designed for Wheelchair Use
- ☐ Ramps or Flat Entries
- ☐ Service Animal Accommodations
- ☐ Features for Low-Vision or Blind
- ☐ Lighted Paths to Entrance
- ☐ Elevators
- ☐ Widened Doorways
- ☐ Shatter-Proof Glass
- ☐ Mold Resistant
- ☐ Features for Auditory Needs (speaking alarms, flashing smoke detectors, etc.)
- ☐ Accessible Bathroom (toilet, sink, grab bars, handrails, roll-in shower, etc.)
- ☐ Accessible Kitchen (sink, counter, cabinets, etc.)
- ☐ Accessible Appliances (controls up front, etc.)
- ☐ Memory Prompts in Design of Living Space
- ☐ Automatic Doors or Electronic Key Cards
- ☐ No Stairs Inside Home or Common Areas
- ☐ Other (specify): _____

20. Does the individual need or request any of the following amenities?

- ☐ Laundry in Apartment
- ☐ Laundry in Building
- ☐ Parking Garage
- ☐ Off-Street Parking
- ☐ Designated Parking Space
- ☐ Air Conditioning
- ☐ Pets Allowed
- ☐ Smoking Allowed
- ☐ Does Not Allow Smoking
- ☐ Security System
- ☐ Security Staff on Site
- ☐ Environmental Control Unit
- ☐ Individually Controlled Water Temp
- ☐ Housing with On-Site Services
- ☐ Ground Floor
- ☐ Higher Floor
- ☐ Addition Space/Bedroom for Medical Equipment
- ☐ Other *(specify):* _____
- ☐ Close to Public Transportation
- ☐ Close to Grocery Store
- ☐ Large Apartment Complex
- ☐ Small-Scale Multi-Family Apartment
- ☐ Single-Family Home/Duplex
- ☐ Assisted Living

HOUSING HISTORY

21. Does the individual have any of the following barriers or issues that will make obtaining housing difficult?

- ☐ No experience as lease holder for rental housing
- ☐ No ability to document rental history
- ☐ Cannot provide suitable housing references
- ☐ History of destruction of property
- ☐ Low income/garnishments
- ☐ Housing court involvement
- ☐ Eviction history (Subsidized housing)
- ☐ Eviction history (Non-subsidized housing)
- ☐ Past due accounts with utility companies or HEAP
- ☐ Owes money to a housing authority
- ☐ Other (specify): _____

CREDIT HISTORY

22. Does the individual have access to personal identification? (check all that apply)

☐ Birth Certificate ☐ Social Security Card ☐ Government Issued Photo ID

23. How does the individual describe their credit history *(including any money owed)***?**

- ☐ Poor credit history
- ☐ Low credit score
- ☐ Past Bankruptcy
- ☐ High debt to income ratio/balance
- ☐ High housing to income ratio/balance
- ☐ High credit card debt

List of Money Owed and to Whom

Owed To:	Amount Owed:

CRIMINAL HISTORY

24. Has the individual ever been arrested or convicted of a felony (that appears on Criminal Offense Record Inquiry)?
☐ Yes ☐ No

25. Does the individual have any outstanding court involvement such as warrant or unresolved court appointment?
☐ Yes ☐ No

26. Has the individual ever been arrested or convicted of domestic violence?
☐ Yes ☐ No

27. Has the individual ever been arrested or convicted of a sex offense crime?
☐ Yes ☐ No

If yes, is the individual required to register as a sex offender?

☐ Yes ☐ No

Comments

EMPLOYMENT

28. Is the individual currently employed? ☐ Yes ☐ No

-If Yes, provide the employer's name.	Monthly income amount

DISCHARGE PLANNING

29. Are there any case managers who need to be included in discharge planning? *Please identify managed care, MyCare, behavioral health, and home & community based waiver case managers.*

Name	CM Type	Organization	Phone	Email

30. Is there anyone the individual wants to have included in discharge planning, who may be <u>willing to assist with hands-on care or backup supports</u> when they move to the community? *Please identify family, friends, community groups and others.*

Name	Relationship/Affiliation	Phone Number	Email	Level of Support
				Choose an item.
				Choose an item.
				Choose an item.
				Choose an item.
				Choose an item.

				Choose an item.
				Choose an item.
				Choose an item.

ASSESSOR SUMMARY

31. In Assessor's professional opinion, what is the individual's potential for community living? Yes No
Can their needs be met in the community? ☐ Yes ☐ No
Does the individual need a waiver assessment? ☐ Yes ☐ No
For what waiver?
☐ **Assisted Living** ☐ **Level One** ☐ **My Care Ohio** ☐ **Ohio Home Care** ☐ **PASSPORT** ☐ **SELF**
If so, you must assist the applicant in completing the LTSSQ.
Please explain and provide any additional information that the Transition Coordinator and the HOME Choice staff need to know to make a final decision.

CLA NOTES