

COLLATERAL INTERVIEW



Applicant Last _____ First Initial _____

RESPONDENT INFORMATION

Name: _____ Relationship to Applicant: _____

Title (if applicable): _____ Agency (if applicable): _____

Date of Interview: _____ Location of Interview: _____

Hands-on caregiver? Yes No, # of days per week _____ for _____ months / years

LEGEND

With the exception of behaviors (behaviors using the opposite scale) the following applies:

Always = Applicant can always perform the function without assistance.

Usually = Applicant requires assistance 1-3 days per week.

Usually not = Applicant requires assistance 4 or more days per week.

Never = Applicant can never perform the function without assistance.

I. TRANSFER/ MOBILITY

Rise from a chair independently? Always Usually Usually Not Never

Get on and off the toilet independently? Always Usually Usually Not Never

Get in and out of bed independently? Always Usually Usually Not Never

If this applicant requires physical assistance with transfer, # days per week physical assistance is required:

1-3 4-6 7 N/A

Walk independently without physical assistance from another person ?

Always Usually Usually Not Never NA

If answered UN or N, can he/she use a wheelchair independently, either manual or electric?

Always Usually Usually Not Never NA

Usual method of mobility? Walk Wheelchair

Assistive devices: Cane/Quad Cane Walker Lift Chair Wheelchair Gait belt

Other(specify): _____

Gait Description, if observed(pace, steadiness):

Is this applicant able to walk or operate wheelchair without **physical assistance** from another person? Yes No

If no, # days per week assistance required 1-3 4-6 7 NA

What medical condition(s) does he/she have to support the need for physical assistance with Transfer/ Mobility?

Transfer/Mobility Comments: _____

COLLATERAL INTERVIEW



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II. EATING/TOILETING

Is He/She able to:

Eat prepared meals without assistance from others? Yes No If no, # days per week: 1-3 4-6 7

Administer tube feeding independently? Yes No If no, # days per week: 1-3 4-6 7 NA

If assistance is indicated, describe the type of assistance provided: _____

What medical condition(s) does he/she have to support the need for physical assistance, constant one-on-one observation and verbal assistance? _____

Toilet Independently? Yes No, If no,# days per week: 1-3 4-6 7

Maintain continence of bladder? Yes No If no, # days per week: 1-3 4-6 7 NA

Maintain continence of bowel? Yes No If no,# days per week: 1-3 4-6 7 NA

Clean self after incontinence episode? Yes No N/A

Does applicant use a catheter? Yes No N/A

Does applicant have an ostomy? Yes No N/A

If yes, how often is assistance required? Always Usually Usually Not Never

Eating/Toileting Comments: _____

III. Orientation

Is He/She able to:

Oriented to name? Always Usually Usually Not Never

Able to identify family members? Always Usually Usually Not Never

Oriented to place? Always Usually Usually Not Never

Aware of current circumstances in order to make decisions that prevent risk of harm? Always Usually Usually Not Never

If any answer other than Always, please provide **specific** examples: _____

Orientation Comments: _____

IV. COMMUNICATION

Follow simple directions? Always Usually Usually Not Never

Communicate basic needs with or without assistive aid? Always Usually Usually Not Never

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Communication Comments: _____

V. BEHAVIOR

Does applicant require persistent behavioral intervention/supervision? Yes No NA

Describe the established and persistent behaviors which are not primarily related to a mental health condition or substance abuse disorder: _____

Describe the persistent staff or caregiver intervention/supervision required/provided _____

If behavioral intervention/supervision is indicated, who is presently providing this intervention? _____

Behavior Comments: _____

VI. MEDICATION

****Please get this information from person responsible for dispensing medications****

Information obtained from? _____

Is He/She able to take pills from a medcup/hand, get them to their mouth, and swallow them (refusal doesn't indicate inability) on the appropriate schedule? Yes No

Is He/She receiving any injections (not including sliding scale insulin), topicals, eye drops, or inhalers? Yes No

If yes, are they able to self-administer? Yes No

If no, # of days per week assistance is required: 1-3 4-6 7 NA

If no, to any of the above, describe intervention(s): _____

Medication Comments: (If unable to self-administer, describe limitations and number of days assistance is needed)

VII. SIGNATURE

BY MY SIGNATURE, I AGREE THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION MAY BE USED TO DETERMINE MEDICAID ELIGIBILITY AND MAY ALSO BE USED BY A JUDGE TO MAKE A HEARING DECISION. I FURTHER UNDERSTAND THAT PEOPLE WHO LIE AND PROVIDE FALSE INFORMATION THAT WOULD POTENTIALLY RESULT IN A PERSON OBTAINING TENNCARE SERVICES TO WHICH HE/SHE IS NOT ENTITLED IS CONSIDERED AN ACT OF FRAUD AND MAY BE FINED OR SENT TO JAIL.

Signature of person providing information: _____ Date: _____

Signature of person providing **medication** information: _____ Date: _____

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If by telephone, I _____ certify that I have conducted this interview with _____ and have read back the responses to all questions and have obtained permission to sign this document on their behalf. Signature: _____ Date: _____

Printed Name: _____

Signature: _____ Credentials: _____

Date: _____ Assessor Code: _____