APPLICANT INTERVIEW

SECTION A: DEMOGRAPHICS

Applicant's Name_____ Date of Birth____/____/____

SSN_____ Age_____ Gender: ☐ Male ☐ Female Assessment Date____/____/____

Applicant's Address_____ Assessment Time____:____ am / pm

City _____ State_____ Zip_____ County_____

Where is Applicant currently located?

☐ Hospital ☐ Nursing Facility
☐ Home alone ☐ Home with family
☐ Group Home ☐ ICF/IID
☐ Assisted Care Living Facility ☐ Other CBRA
☐ Other: _____

Where does applicant live?

☐ Home alone ☐ Home with parents
☐ Home with other family ☐ Group Home
☐ Nursing Facility ☐ ICF/IID
☐ Assisted Care Living Facility ☐ Other CBRA
☐ Other: _____

Present during interview: ☐ Family ☐ Individual ☐ Caregiver ☐ Home Health ☐ Guardian ☐ Other: _____

Describe how you were contacted and the services requested by applicant/ family member:

_____

_____

Medical Records to be submitted with assessment:

☐ None ☐ Home Health Records ☐ Hospital Records ☐ MD Records
☐ NF Chart ☐ ICAP maladaptive behavior assessment and score
☐ TABI ☐ Psychological Exam or other related documentation to support ID diagnosis
☐ Other _____

Section B: Functional Assessment

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 l assistance 4 or more days per week.
Never = Applicant can never perform the function without assistance.

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1. TRANSFER

Interview Questions:

Are you able to:

Sit down and get up from a chair by yourself? ☐ Always ☐ Usually ☐ Usually Not ☐ Never

Get in and out of the bed by yourself? ☐ Always ☐ Usually ☐ Usually Not ☐ Never

Get on/off toilet by yourself? ☐ Always ☐ Usually ☐ Usually Not ☐ Never

Do you require **physical assistance from another person** with any of the above? ☐ Yes ☐ No

Who provides this assistance? _____Describe the assistance needed/ provided:_____

_____

If physical assistance from another person is indicated; how many days per week ? ☐ 1-3 ☐ 4-6 ☐ 7 ☐ NA

Supporting Medical Condition(s): _____

Transfer Observations: _____

_____

2. MOBILITY

Interview Questions:

Are you able to walk (with or without assistive devices)? ☐ Yes ☐ No ☐ With ☐ Without

Are you able to use a wheelchair independently (manual or electric)? ☐ Yes ☐ No

Do you require **physical assistance** from another person with mobility? ☐ Yes ☐ No

Who provides assistance? _____ Describe how the person assists you _____ ____

_____

If physical assistance from another person is indicated; how many days per week? ☐ 1-3 ☐ 4-6 ☐ 7 ☐ NA

Assessor observation of applicant's gait:

☐ Steady ☐ Shuffling ☐ Limp ☐ Unsteady ☐ Balance problems ☐ not observed

☐ Deformities (specify)_____ ☐ Limb loss (specify)_____

☐ Prosthesis (specify type and if used or not)_____

Supporting Medical Condition(s): _____

Mobility Observations:_____

_____

3. EATING

Interview Question:

Are you able to eat prepared meals by yourself? ☐ Yes ☐ No

If no, do you require assistance? ☐ Yes ☐ No Who provides assistance? _____

What kind of assistance does this person provide? ☐ Physical feeding ☐ Verbal assistance ☐ one on one observation

If assistance from another person is indicated; how many days per week? ☐ 1-3 ☐ 4-6 ☐ 7 ☐ NA

Do you have a feeding tube? ☐ No ☐ Yes if yes, are you able to administer tube feedings independently? ☐ Yes ☐ No

If no, how many days per week do you require **physical assistance** with your tube feedings? ☐ 1-3 ☐ 4-6 ☐ 7 ☐ NA

Supporting Medical Condition(s): _____

Eating Observations: _____

_____

4. TOILETING

Interview Questions:

Are you able to clean yourself, including adjusting clothing, after toileting? ☐ Yes ☐ No

If no, # days per week: ☐ 1-3 ☐ 4-6 ☐ 7

If no, who provides this assistance? _____

Describe how the person assists you: _____

_____

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

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

Are you able to clean yourself, including adjusting clothing, after an incontinence episode without physical assistance from another person? ☐ Yes ☐ No

If no, who provides this assistance? _____ Describe how the person assists you: _____

_____

Do you use a catheter? ☐ Yes ☐ No ☐ NA

Do you have an ostomy? ☐ Yes ☐ No ☐ NA

If yes to either catheter/ostomy, can you manage without physical assistance from another person? ☐ Yes ☐ No

Who provides this assistance? _____Describe how the person assists you: _____

_____

Supporting Medical Condition(s): _____

Toileting Observations:_____

_____

5. ORIENTATION

Interview Questions:

Person

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What is your full name?_____Correct ☐ Yes ☐ No

Can you name the other people in the room? ☐ Yes ☐ No ☐ NA Correct? ☐ Yes ☐ No ☐ NA

OR

Can you name the people from photographs in the room? ☐ Yes ☐ No ☐ NA Correct? ☐ Yes ☐ No ☐ NA

Information confirmed with: _____

Place

Can you tell me where you are?_____ Correct ☐ Yes ☐ No

What is your street address/ room number?_____ Correct ☐ Yes ☐ No

What city/ town are you in?_____ Correct ☐ Yes ☐ No

Information confirmed with: _____

Event/Situation

Describe what you would do in case of an emergency: _____

Information (must be confirmed) confirmed with: _____

Is assistance required with orientation? ☐ Yes ☐ No If yes, # of days per week ☐ 1-3 ☐ 4-6 ☐ 7

If yes, who provides this assistance? _____

Describe how this person assists you: _____

_____

Supporting medical condition(s) specific to orientation:_____

_____

Orientation Observations: _____

_____

6. COMMUNICATION

Interview Questions:

Can you make people understand when you need something? ☐ Yes ☐ No **Speech Impairment:** ☐ Yes ☐ No

Hearing : ☐ Adequate with/without devices ☐ Not Adequate with/without devices

Vision: ☐ Adequate with/without corrective lens ☐ Not adequate with/without corrective lens

Give applicant a simple command within their functional ability (raise right hand, touch nose, point to your pen) and document ability to follow simplecommand:_____

Does the applicant say at least ten words that can be understood by someone who knows him/her or as observed during the interview process?

_____

_____

Did there appear to be any communication deficits while completing this interview? _____

Did applicant use communication assistive device (e.g., Ipad, picture board)? ☐ Yes ☐ No

If yes, list type: _____

Supporting Medical condition(s): _____

Communication Observations:_____

_____

7. BEHAVIOR

Assessor Observed Behavior:

☐ Cooperative ☐ Uncooperative

☐ Angry/irritable ☐ Sociable

☐ Withdrawn

Level of Consciousness:

☐ Awake ☐ Drowsy ☐ Alert

☐ Oriented to: ☐ Person ☐ Place

Is there a diagnosis which would lead to a cognitive impairment? ☐ Yes ☐ No **If yes, list the diagnosis:** _____

_____

_____

Behavioral Observations: _____

_____

8. MEDICATIONS (INCLUDES: PO, IV, IM, ENTERAL, OPTICS, TOPICALS, INHALER, AND CONTINUOUS SQ PAIN)

Interview Questions:

Are you physically or cognitively able to self-administer physician prescribed medications by the routes listed below at the time prescribed? (Self -administration does not include reminding when to take medications, encouragement to take, reading medication labels, opening bottles, having them handed to you and/ or reassurance of the correct dose.) **If no, please indicate the prescribed medication on the line provided. If none prescribed via that route, please mark NA as appropriate.**

Pills/Tablets ☐ Yes ☐ No ☐ NA _____

Eye drops ☐ Yes ☐ No ☐ NA _____

Inhaler/Nebulizer ☐ Yes ☐ No ☐ NA _____

Topicals/Patches ☐ Yes ☐ No ☐ NA _____

Injections ☐ Yes ☐ No ☐ NA _____

Meds via Tube (G Tube, J tube, NG tube…) ☐ Yes ☐ No ☐ NA

If no to above, who provides this assistance? _____ # days per week ☐ 1-3 ☐ 4-6 ☐ 7 ☐ NA

Describe assistance required: ☐ Reminders ☐ Encouragement ☐ Reading Labels ☐ Opening Bottles
☐ Someone hands them to me ☐ preparation of medication box ☐ Other: _____

Supporting Medical Condition(s): _____

Medication Observations: _____

Are you receiving any treatments that are ordered by a physician to be performed by a licensed Nurse/ Therapist?

☐ Yes ☐ No ☐ NA

If yes, please describe the services being requested and attach the appropriate additional required documentation: _____

_____

Section C: Applicant or Designee Signature

I HEREBY ATTEST THAT I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED ON THIS DOCUMENT AND IT ACCURATELY REFLECTS THE RESPONSES I HAVE GIVEN DURING THIS ASSESSMENT. I ALSO UNDERSTAND THAT THE COMMENTS AND OBSERVATIONS ARE THOSE OF THE QUALIFIED ASSESSOR.

Applicant Signature: _____Date: _____/_____/_____

Section D: Assessor Credentials and 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.

Printed Name: _____

Signature: _____ Credentials: _____

Date: _____Assessor Code :_____

Section E: Assessor Recertification of Assessment

BY MY SIGNATURE, I CERTIFY I HAVE MET WITH THIS APPLICANT FACE TO FACE, I HAVE THOUROUGHLY REVIEWED THIS DOCUMENTATION WITH THE APPLICANT, AND THE APPLICANT HAS VERBALIZED THAT THE INFORMATION CONTAINED IN THIS DOCUMENT IS AN ACCURATE REFLECTION OF THEIR FUNCTIONAL ABILITIES. I FURTHER CERTIFY THE INFORMATION CONTAINED HEREIN IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE AND THAT THIS RECERTIFICATION IS BEING COMPLETED WITHIN 365 DAYS OF THE ORIGINAL COMPLETION DATE OF THIS ASSESSMENT.

Printed Name:_____

Signature: _____ Credentials: _____

Date: _____Assessor Code :_____