CCO Comprehensive Assessment

Version :

Status :

Individual Name :

Individual Middle Name/Initial :

Individual Suffix :

Nickname/Preferred Name :

TABSID :

Medicaid ID :

Date of Birth :

Gender :

Preferred Gender :

Race :

Ethnicity :

Phone Number :

Street Address 1 :

Street Address 2 :

City :

State :

ZIP Code :

Living Situation :

Willowbrook Status :

Representation Status :

CAB Rep Contact 1 :

CAB Rep Contact 2 :

Expectations for Community Inclusion :

Hospital Staffing Coverage :

Eligibility Information

MCO Enrollment Date :

MCO Name :

OPWDD Eligibility :

ICF Level of Care Eligibility: Determination Date

Medicaid Expiration Date :

CC/HH Consent Date :

Communication Language

Select the option that best describes the member's expressive communication skills:

- ○ Verbal – conversational
- ○ Verbal – limited (single words or difficult to understand)
- ○ Sign Language – less than 10 words
- ○ Augmentative Communication Device – limited use
- ○ No means of expressing “yes”, “no”, or any wants/needs
- ○ Verbal – can answer basic questions
- ○ Sign Language – more than 10 words
- ○ Augmentative Communication Device – fully communicative
- ○ Uses sounds, gestures, and body language to express “yes” or “no”, but no other communication

Select the option that best describes the member's receptive communication skills

- ○ Follows simple direction within routine activities
- ○ Answers simple questions (verbally or non-verbally)
- ○ No receptive language
- ○ Follows one-step directions outside of routine
- ○ Answers most questions and follows multi-step directions

What is the member's primary language

What is the member's primary spoken language

What is the member's primary written language

Is the member able to read in their primary language?

○ Yes ○ No ○ Unknown

Is the member bi/multi-lingual?

○ Yes ○ No ○ Unknown

If the member is bi/multi-lingual what other language(s) can they use to communicate?

Does the member want to change or improve how they communicate?

○ yes ○ No

Is and interpreter or translator needed for meetings or documents

Interpreter

Translator

Interpreter and Translator

Not Applicable

Member Providers

Primary Care Physician :

Dentist :

Psychiatrist :

Psychologist/Therapist :

Eye Doctor :

Pharmacy :

Hospital:

Advanced Directives Future Planning

***Does the member have a Health Care Proxy?**

○ yes ○ No ○ Unknow

***Is the member and/or family interested in learning more about Advanced Directives and Health Care Proxies**

○ Yes ○ No ○ Unknow

***Does the member utilize the Surrogate Decision-Making Committee for medical treatments?**

○ Yes ○ No ○ Unknow

***Does the member utilize the Informed Consent Committee to approve of behavioral support plans intrusive/restrictive interventions?**

○ Yes ○ No ○ Unknow

Independent Living Skills

*** Free text to explain anything regarding consent(s) in place. If no consent concerns, note that. Be sure to call out specific areas of consent. (Such as: ability to consent to medical treatment, ability to consent financially, ability to consent sexually, etc.)**

***Choose the best option that best reflects the individual's current level of housing stability.**

○ I have a steady place to live

○ I have a place to live today, but I am worried about losing it in the future

○ I do not have a steady place to live

○ I am currently homeless/living in shelters

***Select the best option(s) that describes any issues with the individual's current living situation.**

Pets

Lead paint or pipes

Oven or stove not working

Water leaks

Mode

Lack of heat

Smoke detector missing or not working

None of the above

*** Choose the answer that best fits the general level of personal hygiene needs of the member**

○ Independent ○ Needs supervision

○ Needs assistance ○ Needs total Support

*** Explain the personal hygiene needs and expected result of providing oversight and assistance for these needs.**

***Choose the level of support needed by the individual for toileting**

○ Independent ○ Needs supervision

○ Needs assistance ○ Needs total Support

***Does the individual experience chronic constipation, and/or vomiting?**

○ Yes ○ No ○ Unknow

If the individual experiences chronic constipation, diarrhea, and/or vomiting has the condition been assessed by a medical provider in the last 12 months?

○ Yes ○ No ○ Unknow

Has the individual ever had a bowel obstruction that required hospitalization?

○ Yes ○ No ○ Unknow

*Choose the answer(s) that best fits the support or services that an individual may need when they have constipation concerns or conditions

- ○ No concerns at this time
- ○ Bowel management protocol in place
- ○ Bowel tracking protocol in place
- ○ No bowel tracking/management protocol in place at this time

*Free text to explain the services and supports and the expected result surrounding any constipation needs.

*Choose the level of support needed by the individual for hand/face washing

- ○ Independent
- ○ Needs assistance
- ○ Needs supervision
- ○ Needs total Support

*Choose the answer(s) that best fits the support or service that a member needs when he/she has dental or oral care needs

- ○ No concerns at this time
- ○ Pre-sedation
- ○ See Medical Immobilization Protective Stabilization/Sedation plan (MIPS)
- ○ Dental hygiene support
- ○ Dentures
- ○ Other

* Free text to explain the services and supports and the expected result for any dental or oral care that an individual needs

*Choose the level of support needed by the individual to trim their nails/toe nails

- ○ Independent
- ○ Needs assistance
- ○ Needs supervision
- ○ Needs total Support

* Choose the level of support needed by the individual when they sneeze, cough, or blow their nose.

- ○ Independent
- ○ Needs assistance
- ○ Needs supervision
- ○ Needs total Support

*Choose the level of support needed by the individual to wear PPE/Masks

- ○ Independent
- ○ Needs assistance
- ○ Does not/cannot wear a mask
- ○ Needs supervision
- ○ Needs total Support

*Choose the level of support needed by the individual to move safely

- ○ Independent
- ○ Needs assistance
- ○ Needs supervision
- ○ Needs total Support

*Choose the answer(s) that best fits the support or service need(s) when the individual is at a risk for falls

- ○ Independent
- ○ Needs assistance
- ○ Needs supervision
- ○ Needs total Support

*Free text to explain the services and supports and the expected result when a member is at a risk for falls. Describe areas where assistance is needed/required.

*Has the individual indicated that they've fallen in the last 3 months?

- ○ Yes
- ○ Unknow
- ○ No

How many times has the member fallen in the past 3 months?

- ○ 1
- ○ 3
- ○ 2
- ○ 4 or more

*Are there any concerns or conditions with the individual's vision?

- ○ Yes
- ○ Unknow
- ○ No

*Explain the services and supports and the expected result regarding any concerns or conditions with the individual's vision

*Are there any concerns or conditions with the individual's hearing?

- ○ Yes
- ○ Unknow
- ○ No

*Explain the services and supports and the expected result regarding any concerns or conditions with the individual's hearing

*Choose the answer(s) that best fits the support or service that an individual need when they have skin integrity concerns or conditions

- No concerns at this time
- Requires positioning schedule
- Requires daily skin inspections
- Requires adaptive equipment
- Requires skin barrier cream or other treatment
- Provide education to person where appropriate

*Free text to explain the services and supports and the expected result regarding the individual's skin integrity needs. (Include history of previous skin breakdown)

*Choose the answer(s) that best fits the support or service that an individual needs when they have nutritional needs.

- No concerns at this time
- Requires modified consistency diet for foods
- Requires modified consistency diet for fluids
- Requires reduced calorie diet
- Requires high calorie diet
- Requires element added to diet (i.e. fiber, calcium, etc.)
- Restricted fluids
- Required element removed from diet(i.e.Concentrated sweets, salt, fat,etc.)
- Enteral nutrition (Tube feeding)
- Requires dietary supplement
- Requires assistance with meal preparation
- Requires education
- Requires assistance with meal planning
- Requires supervision during meals
- Adaptive equipment needed during meals
- Individual can maintain an adequate diet that meets their needs

Free text to explain the services and supports and the expected result for any choking, aspiration, and/or swallowing needs.

*Is the individual at risk for choking?

○ Yes ○ No

*Choose the answer(s) that best fits the support or services that an Individual needs when they have choking, aspiration, or swallowing needs.

- ○ No concerns at this time
- ○ Requires modified consistency of foods
- ○ Consistency of liquids
- ○ Avoid high risk foods
- ○ Requires supervision
- ○ Formal training/dining plan needed

Free text to explain the services and supports and the expected result for any choking, aspiration, and/or swallowing needs.

Is a swallowing Evaluation needed for the individual?

○ Yes ○ No

○ Unknown

*Choose the answer(s) that best fits the support or services that an individual needs when they have acid reflux (GERD)

- ○ No concerns at this time
- ○ Requires modified consistency of foods
- ○ Consistency of liquids
- ○ Avoid high risk foods
- ○ Requires supervision
- ○ Formal training/dining plan needed

Free text to explain the services and supports and the expected result surrounding any acid reflux (GERD) needs.

***Choose the level of support needed by the member for meal preparation.**

- ○ Independent
- ○ Needs supervision
- ○ Needs assistance
- ○ Needs total Support

***Choose the level of support needed by the member for meal planning.**

- ○ Independent
- ○ Needs supervision
- ○ Needs assistance
- ○ Needs total Support

***Choose the number of times the individual has indicated they are worried about food in the past 12 months.**

- ○ Often True
- ○ Sometimes True
- ○ Never True

***Choose the number of times the individual has indicated they ran out of food in the past 12 months.**

- ○ Often (monthly)
- ○ Sometimes True (every few months, certain time of the year.I.e. holidays, winter, depending on work schedule)
- ○ Never True

***Has the individual indicated that electric, gas, oil, or water companies threated to shut off services in the past 12 months?**

- ○ Yes
- ○ No
- ○ Already shut off

Explain the budgeting needs and the expected result of providing oversight and assistance for budgeting.

***Does the member want to learn to manage their own money?**

- ○ Yes
- ○ No

***Is the individual currently taking any medication that were prescribed by a medical provider?**

- ○ Yes
- ○ No
- ○ Unknown

***Choose the answer that best describes the individual's ability to administer their medications.**

- ○ Independent with taking medications at this time
- ○ Needs assistance with taking medications
- ○ Requires total support with taking medications
- ○ Does not take medications at this time

What is the individual's preferred method of medication reminder?

- ○ Phone
- ○ Email
- ○ Text
- ○ Face To Face
- ○ Written reminder
- ○ Alarm
- ○ Pill reminder

***Does the individual ever refuse to take or choose not to take their medication(s)?**

- ○ Never
- ○ Sometime
- ○ Often
- ○ Almost Always

If the individual refuses and/or chooses not to take their medication(s), why?

Explain the services and supports and the expected result regarding medication administration.

***Does the individual own or have access to their own phone?**

- ○ Yes
- ○ No
- ○ Unknown

***Is the individual able to independently call 911 in an emergency?**

- ○ Yes
- ○ No
- ○ Unknown

***Is the individual able to independently access the internet?**

- ○ Yes
- ○ No
- ○ Unknown

*Is the individual able to independently access and call all applicable contact in their phone?

○ Yes ○ No

○ Unknown

*Choose the answer(s) that best fits the transportation needs of the individual when using public transportation.

○ Independent ○ Needs Assistance

○ Needs total support

Explain the transportation needs and the expected result of providing oversight and assistance for transportation.

*Has the individual lacked reliable transportation for medical appointments, meetings, work, or from getting things needed for daily living in the past 12 months?

○ Yes ○ No

*Is the individual interested in Driver's Education/Learning to drive?

○ Yes ○ No

Does the individual need/want education or support with vehicle ownership?

○ Yes ○ No

*Does the member want to become more indepent with using transportation?

○ Yes ○ No

*Are there any concerns with behavior or psychiatric health?

○ Yes ○ No ○ Unknown

How is the individual's mental health? Are they experiencing any of the following?

*Can the individual clearly communicate health concerns?

○ Yes ○ No

○ Unknown

*Can the individual independently coordinate and attend all necessary health services and medical appointments.

○ Yes ○ No

○ Unknown

*Does the individual have support to help with ADLs and/or IADLs?

○ Yes ○ No

*Does the individual have difficulty remembering names, any concerns with the member's ability to schedule and attend health services and appointments.

Explain the services and supports and the expected result regarding names, places, where they put something, or things that have happened?

○ Yes ○ No

○ Unknown

*Does the individual have any fire safety needs or are there any concerns with the ability of the individual regarding fire safety? This should be based on a current evaluation of the fire evacuation capacity of the individual based on actual performance.

○ Yes ○ No ○ Unknown

Describe the fire safety needs of the individual and any concerns with the ability of the individual regarding fire safety.

*Has the individual been provided information regarding how fires are started, stopped, avoided, etc. in a manner appropriate to them?

○ Yes ○ No ○ Unknown

*Can the individual independently and voluntarily evacuate during a fire/fire drill?

○ Yes ○ No ○ Unknown

*Describe the Individual's ability to maintain safety in an emergency situation and when staff or other care givers are unavailable. Include in the emergency protocol: disaster preparedness, emergency locations, people that should be notified in an emergency and other step that the individual, caregivers, and staff need to take in emergency situations.

*Is a detailed back up plan in place for situations when scheduled HCBS providers are unavailable or do not arrive as scheduled? If yes, the provider must have a plan that is readily available for individual, caregivers and staff to use for oversight entities to review.

- ○ Yes
- ○ No
- ○ Unknown

*Choose the answers(s) that best fits the supervision needs of the member:

- ○ No concerns at this time
- ○ 1:1
- ○ Required adaptive equipement (monitoring system, night lighting, bed rails, bed alarm)
- ○ Other
- ○ Line of Sight
- ○ Requires period bed checks
- ○ Requires sleep chart