Uniform Core Assessment (UCA)

GENERAL INFORMATION

Which program is this UCA intended for? *Choose one*

☐ ADH	☐ AFC	☐ GAFC	☐ One Care
☐ PACE	☐ PCA	☐ SCO	
Date of UCA Evaluation	**Interpreter Being Used?**	**Interpreter Type**	
	☐ Yes ☐ No	☐ Family ☐ Friend/Neighbor ☐ Professional ☐ Other:	

Member Demographics

First Legal Name	Middle Name/Initial		Last Name		Suffix
Street Address	**Apartment/Unit**	**City**	**State**	**ZIP Code**	**Primary Telephone**

Would you like to add a secondary telephone number? ☐ Yes ☐ No

Secondary Telephone Number	Best way to contact member/notes
Telephone:	

Is the address above where the assessment is occurring? ☐ Yes ☐ No

If no: Location Type	Street Address	Apartment/Unit	City	State	ZIP Code

Member Information

Date of Birth	Age	MassHealth ID Number	Medicare ID Number
____ / ____ / _____		#	#

MEMBER CONTACTS

Primary Care Provider Full Name	Credentials	Street Address	Unit #
City	**State**	**Zip Code**	**Telephone Number**

Does the member have an emergency contact? ☐ Yes ☐ No

Emergency Contact Full Name	Street Address	Apt/Unit	City
State	**Zip Code**	**Telephone Number**	**Relationship to Member**

Does the member have a legal guardian? ☐ Yes ☐ No

Guardian Full Name	Street Address	Apt/Unit	City	State	ZIP	Telephone Number

Does the member have any advanced directives? *Check all that apply*

☐ Health Care Proxy	☐ Living Will
☐ Medical Order for Life Sustaining Treatment (MOLST)	☐ Power of Attorney
☐ Other: _____	☐ None

ADDITIONAL INFORMATION

Name of anyone present for the assessment	Relationship to member

LIVING ARRANGEMENT

At the time of assessment, where does the member reside?

☐ Lives in private home, apartment or rented room	☐ Group home
☐ Homeless	☐ Assisted living
☐ Long-term care facility (nursing home)	☐ Rest Home (residential care home)
☐ Acute Care hospital (medical)	☐ Psychiatric hospital or unit
☐ Rehabilitation hospital	☐ Other, please specify: _____

Is the member residing in a Transitional Living Program (TLP)?	☐ Yes ☐ No
If residing in a psychiatric hospital or unit, long-term care facility, or rehabilitation hospital, has the member been there for more than 90 days?	☐ Yes ☐ No

Who does the member currently live with, excluding temporary arrangements of less than 6 months?

☐ Alone	☐ With spouse/partner
☐ With child(ren)	☐ With parents/guardian
☐ With relatives	☐ With non-relatives
☐ With paid staff	

In the past year, has the member been unable to afford housing, food, clothing, or other basic necessities? ☐ Yes ☐ No

SOCIAL CONTEXTS

Member's current marital status	What is the member's sexual orientation?
☐ Never Married	☐ Straight or heterosexual
☐ Married	☐ Lesbian/Gay
☐ Partner/significant other	☐ Bisexual
☐ Widowed	☐ Queer, pansexual, or questioning
☐ Separated	☐ Other, please specify:
☐ Divorced	☐ Unknown
	☐ Prefer not to answer

Member's sex assigned at birth:

☐ Male	☐ Female	☐ Intersex	☐ Prefer not to say

Which best describes the member's current gender identity?

☐ Male	☐ Female
☐ Transgender man/trans man	☐ Transgender woman/trans woman
☐ Genderqueer/gender nonconforming/nonbinary/neither exclusively male nor female	☐ Gender identity not listed: _____
☐ Unknown	☐ Prefer not to answer

Select one or more races as identified by the member

☐ American Indian/Native Alaskan	☐ Asian
☐ Black/African American	☐ Native Hawaiian/Other Pacific Islander
☐ White, non-Hispanic	☐ Race not listed here: _____
☐ Hispanic	☐ Prefer not to answer

Does the member identify as Hispanic/Latino?

☐ Yes	☐ No	☐ Unknown	☐ Prefer not to answer

Does the member have anyone assisting them with care on a regular basis?

☐ Yes	☐ No	☐ Unknown

Who provides assistance to the member? *Check all that apply*

☐ Spouse, partner, significant other	☐ Child(ren)
☐ Parent/guardian	☐ Siblings
☐ Friend	☐ Neighbor
☐ Paid caregiver	☐ Other:

Does the member enjoy socializing with others?	☐ Yes ☐ No
Does the member engage in activities of interest, such as reading, listening to music, cooking, working, exercising, or visiting with friends/family/social events?	☐ Yes ☐ No
In the last 3 months, has the member's participation in activities or hobbies declined?	☐ Yes ☐ No

COGNITIVE FUNCTION

Does the member have or appear to have a short-term memory issue (e.g., member is unable to recall things in a brief conversation)?	☐ Yes ☐ No
In the last 3 months has there been a decline in the member's short-term memory (e.g., member is having more difficulty recalling things in a brief conversation)?	☐ Yes ☐ No
Does the member have or appear to have any procedural memory issues (e.g., member is unable to independently complete multi-step tasks)?	☐ Yes ☐ No
In the last 3 months has there been a decline in the member's procedural memory (e.g., member is having more difficulty independently completing multi-step tasks that they could complete before)?	☐ Yes ☐ No

Does the member have difficulty with organizing or planning their day (e.g., making decisions about daily activities, appointments, when to eat, what to wear, etc.)? *Choose one*	**Does the member report or exhibit any of the following?** *Check all that apply*
☐ No, fully Independent	☐ Confusions
☐ Yes, assistance required; guidance as needed	☐ Hallucinations
☐ Yes, considerable assistance; guidance needed at all times	☐ Delusions
☐ Yes, does not participate in decision making	☐ Disordered thinking

MOOD AND BEHAVIOR

Question	Response
Does the member wander without regard to needs or safety?	☐ Yes ☐ No
Does the wandering require frequent caregiver intervention?	☐ Yes ☐ No
Does the member verbally abuse others (e.g., threaten, yell, swear)?	☐ Yes ☐ No
Does the verbal abuse require frequent caregiver intervention?	☐ Yes ☐ No
Does the member physically abuse others (e.g., may include: hit, shove, scratch)?	☐ Yes ☐ No
Does the physical abuse require frequent caregiver intervention?	☐ Yes ☐ No

Question	Response
Does the member exhibit disruptive or socially inappropriate behaviors (e.g., may include: general disruptions, repetitive noises, self-injurious behavior, socially unacceptable conduct)?	☐ Yes ☐ No
Do the disruptive or socially inappropriate behaviors require frequent caregiver intervention?	☐ Yes ☐ No
Does the member resist care (e.g., resist ADL/IADL care, help with medications)?	☐ Yes ☐ No
Does the resisting of care require frequent caregiver intervention?	☐ Yes ☐ No

If the answer to any of the above behavior questions is "Yes," have the member's behaviors become worse over the past 3 months?	☐ Yes ☐ No
In the last month, has the member exhibited or described a declining interest or desire to complete their normal activities?	☐ Yes ☐ No
In the last month, has the member exhibited or described a feeling of deep sadness or depression?	☐ Yes ☐ No
In the last month, has the member exhibited or described feelings of nervousness, worrying, or repetitive anxiousness?	☐ Yes ☐ No
Does the member report feelings of loneliness?	☐ Yes ☐ No

SUBSTANCE USE

In the PAST 12 MONTHS, how often has the member...	Daily	Weekly	Monthly	Less than Monthly	Never
Used tobacco or any other nicotine delivery product (e.g., e-cigarette, vaping or chewing tobacco)?	☐	☐	☐	☐	☐
Consumed more than 5 drinks (men) 4 drinks (women) containing alcohol in a single day?	☐	☐	☐	☐	☐
Taken a prescribed medication more than prescribed or not prescribed for them?	☐	☐	☐	☐	☐
Used marijuana?	☐	☐	☐	☐	☐
Used any drugs, including cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?	☐	☐	☐	☐	☐

Is the member participating in a substance use treatment program? ☐ Yes ☐ No

COMMUNICATION, HEARING & VISION

Does the member express needs, opinions, and make self understood (may be verbal, nonverbal, or combination of means of communication)? *Choose one*	**Does the member understand others?** *Choose one*
☐ Understood; communicates without difficulty	☐ Understands communication without difficulty
☐ Understood when given prompts or additional time	☐ Understands when given prompts or additional time
☐ Limited to concrete requests only	☐ Limited to concrete requests only
☐ Non-verbal communication only	☐ Understands non-verbal communication only
☐ Rarely or never understood	☐ Rarely or never understands

Does the member use any communication devices? *Select all that apply*

☐ No communication device used	☐ Speech generation device
☐ Communication board, tablet	☐ TTY
☐ Written communication	☐ Other, specify:

Does the member use any hearing devices?		
No hearing device used	☐ Yes	☐ No
Assisted Listening Device	☐ Yes	☐ No
Cochlear Implant	☐ Yes	☐ No
Hearing Aid	☐ Yes	☐ No

Other, specify:

Does the member have any hearing problems (with hearing device if used)? *Choose one*

- ☐ Hearing is adequate; no difficulty
- ☐ Minimum hearing issues; difficulty in some situations
- ☐ Moderate hearing issues; difficulty hearing conversation, requires quiet settings
- ☐ Severe hearing issues; difficulty in all situations
- ☐ Unable to hear in any situation

Does the member use any vision devices?		
No vision device used	☐ Yes	☐ No
Glasses	☐ Yes	☐ No
Contacts	☐ Yes	☐ No
Magnifying Glasses	☐ Yes	☐ No
Braille	☐ Yes	☐ No
Seeing Eye Dog	☐ Yes	☐ No

Other, specify:

Does the member have any vision problems (with glasses or visual appliance if used)? *Choose one*

- ☐ Vision is adequate; no difficulty
- ☐ Minimum vision issues; difficulty with fine/small print
- ☐ Moderate vision issues; limited vision, not able to see large print, but can identify objects
- ☐ Severe vision issues; difficulty in all situations, limited to light, color, shapes
- ☐ Unable to see in any situation

MEMBER DIAGNOSES

Please list all that apply.

Diagnoses	ICD-10 Code

TREATMENTS

Is the member prescribed oxygen? ☐ Yes ☐ No

How frequently does the member require use of oxygen? *Choose one*		
☐ Continuous	☐ Intermittent, scheduled times during the day	☐ As needed (prn)

How is the oxygen managed for the member? *Choose one*	
☐ Full self-administration	☐ Set-up help only
☐ Supervision - oversight, cueing, guidance	☐ Physical assistance in order to complete the task
☐ Totally dependent on others	☐ Not currently in use

How frequently is supervision/assistance with oxygen required? *Choose one*		
☐ Daily	☐ 3-6 times per week	☐ 1-2 times per week
☐ Several times a month	☐ Monthly or less	

Is the member prescribed BiPAP or CPAP? ☐ Yes ☐ No

How is the BiPAP or CPAP managed for the member? *Choose one*	
☐ Full self-administration	☐ Set-up help only
☐ Supervision - oversight, cueing, guidance	☐ Physical assistance in order to complete the task
☐ Totally dependent on others	☐ Not currently in use

Does the member have a tracheostomy? ☐ Yes ☐ No

How does the member manage suctioning and daily care? *Choose one*		
☐ Full self-administration	☐ Set-up help only	
☐ Supervision - oversight, cueing, guidance	☐ Physical assistance in order to complete the task	
☐ Totally dependent on others		
How often does the member need that level of assistance? *Choose one*		
☐ Daily	☐ 3-6 times per week	☐ 1-2 times per week
☐ Several times a month	☐ Monthly or less	

Does the member require nasopharyngeal aspiration? ☐ Yes ☐ No

How is the nasopharyngeal aspiration managed? *Choose one*		
☐ Full self-administration	☐ Set-up help only	
☐ Supervision - oversight, cueing, guidance	☐ Physical assistance in order to complete the task	
☐ Totally dependent on others		
How often does the member need that level of assistance? *Choose one*		
☐ Daily	☐ 3-6 times per week	☐ 1-2 times per week
☐ Several times a month	☐ Monthly or less	

Does the member require a ventilator? ☐ Yes ☐ No

Does the member require physical assistance to manage the ventilator?	☐ Yes	☐ No

Does the member require cough assistance? ☐ Yes ☐ No

How is cough assistance managed?	
☐ Full self-administration	☐ Set-up help only
☐ Supervision - oversight, cueing, guidance	☐ Physical assistance in order to complete the task
☐ Totally dependent on others	

Does the member require oral suctioning? ☐ Yes ☐ No

How is oral suctioning managed?	
☐ Full self-administration	☐ Set-up help only
☐ Supervision - oversight, cueing, guidance	☐ Physical assistance in order to complete the task
☐ Totally dependent on others	

Is the member currently receiving chemotherapy?	☐ Yes ☐ No
Is the member currently receiving radiation treatment (includes radiation implant)?	☐ Yes ☐ No
Is the member currently receiving dialysis?	☐ Yes ☐ No
Does the member require blood glucose checks as recommended by their healthcare provider?	☐ Yes ☐ No
Does the member require physical assistance to check blood glucose levels?	☐ Yes ☐ No

MEDICATION

List all medications currently used (include vitamins and supplements)

Name	Dose	Route	Frequency	Comment

	Level of Assistance Required — *select one per route*					Frequency	
Medication Route	No medications taken	Full self-administration	Supervision - oversight, cueing, guidance	Physical Assistance to complete the task	Totally Dependent on others	Is level of assistance needed daily?	Is level of assistance needed 3-6 times per week?
Oral (PO)	☐	☐	☐	☐	☐	☐ Yes ☐ No	☐ Yes ☐ No
Intramuscular (IM)	☐	☐	☐	☐	☐	☐ Yes ☐ No	☐ Yes ☐ No
Intravenous (IV)	☐	☐	☐	☐	☐	☐ Yes ☐ No	☐ Yes ☐ No
Subcutaneous (SQ)	☐	☐	☐	☐	☐	☐ Yes ☐ No	☐ Yes ☐ No
Rectal (PR)	☐	☐	☐	☐	☐	☐ Yes ☐ No	☐ Yes ☐ No
Topical (TOP)	☐	☐	☐	☐	☐	☐ Yes ☐ No	☐ Yes ☐ No
Transdermal	☐	☐	☐	☐	☐	☐ Yes ☐ No	☐ Yes ☐ No
Inhaled	☐	☐	☐	☐	☐	☐ Yes ☐ No	☐ Yes ☐ No
Enteral Tube	☐	☐	☐	☐	☐	☐ Yes ☐ No	☐ Yes ☐ No
Eye / Ear / Nose Drops or other medical drops	☐	☐	☐	☐	☐	☐ Yes ☐ No	☐ Yes ☐ No

Is the member compliant with medications? *Choose one*

☐ Always compliant	☐ Compliant most of the time	☐ Not compliant	☐ No medications taken

MEDICAL CARE

Has the member had to stay overnight in a hospital in the last 3 months?	☐ Yes ☐ No ☐ Unknown
Has the member had to go to the emergency room, urgent care, or unplanned medical visit in the last 3 months without an overnight stay?	☐ Yes ☐ No ☐ Unknown
Does the member receive any of the following services: PCA, HHA, Skilled Nursing, Palliative Care, or Hospice Services?	☐ Yes ☐ No

Record the number of days per week for each of the services provided. *If the member is not receiving the service, put "0" in the text box.*

PCA	HHA	Skilled Nursing
_____ days/week	_____ days/week	_____ days/week

Does the member require physician-ordered licensed registered nursing observation and/or vital-sign monitoring requiring medical or nursing intervention?	☐ Yes ☐ No
How frequently does this occur?	☐ Daily ☐ 3-6 times/week ☐ 1-2 times/week ☐ Several times/month ☐ Monthly or less

Does the member require treatments involving prescription medications for uninfected postoperative or chronic conditions, as ordered by a physician, or routine dressing changes that require nursing care and monitoring?	☐ Yes ☐ No
How frequently does the member require the treatment?	☐ Daily ☐ 3-6 times/week ☐ 1-2 times/week ☐ Several times/month ☐ Monthly or less

Does the member require physician ordered physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist?	☐ Yes ☐ No

Record the number of days per week each of the following therapies has occurred or is anticipated to occur. *If the member is not receiving the therapy, put "0" in the text box.*

Physical Therapy	Speech/Language Therapy	Occupational Therapy	Respiratory Therapy	Pulmonary Therapy	Cardiac Rehabilitation
___ days/week	___ days/week	___ days/week	___ days/week	___ days/week	___ days/week

If the member receives Physical Therapy, does the member receive ROM exercises as part of an active treatment plan for a specific stage of a disease that has resulted in restricted mobility?	☐ Yes ☐ No
How often does the member receive this treatment?	☐ Daily ☐ 3-6 times/week ☐ 1-2 times/week ☐ Several times/month ☐ Monthly or less

Does the member receive gait evaluation and training administered or supervised by a registered physical therapist?	☐ Yes ☐ No
Is the gait evaluation and training needed due to a recent impairment caused by a neurological, muscular, or skeletal abnormality following an acute condition (e.g., fracture or stroke)?	☐ Yes ☐ No
Does the gait training occur in any of the following settings?	☐ Institutional ☐ Adult Day Health ☐ Home Based ☐ Outpatient PT
If the member receives gait training in an Institutional Setting or an Adult Day Health Center, how many days per week is the gait evaluation and training?	___ days/week

Does the member require skilled-nursing intervention, including observation, evaluation, or assessment, treatment, and management to prevent exacerbation of one or more chronic medical and/or behavioral health conditions at high risk for instability? Intervention must be needed at frequent intervals throughout the day.	☐ Yes ☐ No
How frequently does this occur?	☐ Daily ☐ 3-6 times/week ☐ 1-2 times/week ☐ Several times/month ☐ Monthly or less
Does the member require skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only an RN can ensure that essential unskilled care is achieving its purpose?	☐ Yes ☐ No
How frequently does this occur?	☐ Daily ☐ 3-6 times/week ☐ 1-2 times/week ☐ Several times/month ☐ Monthly or less

PREVENTION

Has the member had a dental exam in the last year?	☐ Yes ☐ No ☐ Unknown
Has the member had an eye exam in the last year?	☐ Yes ☐ No ☐ Unknown
Has the member received an influenza vaccine in the last year?	☐ Yes ☐ No ☐ Unknown
Has the member had a prostate cancer screening (e.g., physical, PSA) in the last 2 years?	☐ Yes ☐ No ☐ Unknown
Has the member had a breast cancer screening (e.g., mammogram, breast exam) in the last 2 years?	☐ Yes ☐ No ☐ Unknown
Has the member had a cervical cancer screening (e.g., PAP smear) in the last 5 years?	☐ Yes ☐ No ☐ Unknown
Has the member had a colorectal cancer screening (e.g., colonoscopy) in the last 10 years?	☐ Yes ☐ No ☐ Unknown

ACTIVITIES OF DAILY LIVING (ADLS)

Does the member require assistance with bathing (e.g., full body bath, shower, or sponge/partial bath)? *Choose one*	
☐ Fully independent	☐ Physical assistance to complete the task
☐ Set-up help or occasional oversight	☐ Totally dependent on others
☐ Supervision & cueing throughout the entire activity	
Does the member require assistance with personal hygiene (e.g., haircare, brushing teeth, shaving, washing/drying face, handwashing) excludes baths/showers? *Choose one*	
☐ Fully independent	☐ Physical assistance to complete the task
☐ Set-up help or occasional oversight	☐ Totally dependent on others
☐ Supervision & cueing throughout the entire activity	

If the member is female at birth; Does the member require assistance with menses care? *Choose one*	
☐ Fully independent	☐ Physical assistance to complete the task
☐ Set-up help or occasional oversight	☐ Totally dependent on others
☐ Supervision & cueing throughout	☐ Not Applicable

Does the member require assistance with dressing upper body, including street clothes and undergarments, but not solely help with buttons, snaps, and zippers? *Choose one*	
☐ Fully independent	☐ Physical assistance to complete the task
☐ Set-up help or occasional oversight	☐ Totally dependent on others
☐ Supervision & cueing throughout the entire activity	
Does the member require assistance with dressing lower body, including street clothes and undergarments, but not solely help with socks, shoes, buttons, snaps, and zippers? *Choose one*	
☐ Fully independent	☐ Physical assistance to complete the task
☐ Set-up help or occasional oversight	☐ Totally dependent on others
☐ Supervision & cueing throughout the entire activity	

Does the member require assistance with eating (e.g., food, fluids, tube feeding)? *Choose one*	
☐ Fully independent	☐ Physical assistance to complete the task
☐ Set-up help or occasional oversight	☐ Totally dependent on others
☐ Supervision & cueing throughout the entire activity	☐ Not Applicable

Does the member require assistance with mobility (ambulation) - member must be physically steadied, assisted, or guided during ambulation indoors, or is unable to self-propel in a wheelchair appropriately without the assistance of another person? *Choose one*	
☐ Fully independent	☐ Physical assistance to complete the task
☐ Set-up help or occasional oversight	☐ Totally dependent on others
☐ Supervision & cueing throughout the entire activity	
Does the member require assistance with mobility (ambulation) - member must be physically steadied, assisted, or guided during ambulation outdoors, or is unable to self-propel in a wheelchair appropriately without the assistance of another person? *Choose one*	
☐ Fully independent	☐ Physical assistance to complete the task
☐ Set-up help or occasional oversight	☐ Totally dependent on others
☐ Supervision & cueing throughout the entire activity	

Does the member have any foot issues or concerns? *Select all that apply*				
☐ Pain	☐ Neuropathy	☐ Corns	☐ Calluses	☐ Structural problems
☐ Foot or nail fungus	☐ Bunions	☐ Plantar fasciitis	☐ Overlapping toes	☐ Other
If other, please specify:				

Do foot issues or concerns affect standing or ambulation? ☐ Yes ☐ No

How does the member go up and/or down stairs? *Choose one*	
☐ Fully independent	☐ Physical assistance to complete the task
☐ Set-up help or occasional oversight	☐ Totally dependent on others
☐ Supervision & cueing throughout the entire activity	☐ Does not use stairs due to physical limitations
Does the member require assistance with transferring (e.g., member must be assisted or lifted to another position)? *Choose one*	
☐ Fully independent	☐ Physical assistance to complete the task
☐ Set-up help or occasional oversight	☐ Totally dependent on others
☐ Supervision & cueing throughout the entire activity	
Does the member require assistance with positioning while in bed or a chair? *Choose one*	
☐ Fully independent	☐ Physical assistance to complete the task
☐ Set-up help or occasional oversight	☐ Totally dependent on others
☐ Supervision & cueing throughout the entire activity	

Does the assistance with positioning while in bed or a chair part of the written plan of care? ☐ Yes ☐ No

Does the member require assistance with passive range of motion exercises? ☐ Yes ☐ No

How much exercise or physical activity has the member participated in during the last 3 days? *Choose one*				
☐ None	☐ Less than 1 hour	☐ 1-2 hours	☐ 2-3 hours	☐ 4 hours or more

Has the member had any falls in the last 3 months? ☐ Yes ☐ No

Does the member have concerns with balance or have an unsteady gait? ☐ Yes ☐ No

Does the member require assistance with toileting (e.g., member is incontinent (bladder or bowel) or requires assistance or routine catheter or colostomy care)? *Choose one*	
☐ Fully independent	☐ Physical assistance to complete the task
☐ Set-up help or occasional oversight	☐ Totally dependent on others
☐ Supervision & cueing throughout the entire activity	
Does the member have issues with bladder continence? *Choose one*	
☐ Continent; complete control of bladder	☐ Infrequent incontinence; less than daily episodes of incontinence
☐ Continent with control achieved by schedule/training	☐ Frequent incontinence; daily, but some control
☐ Continent with catheter or ostomy	☐ Incontinent; no control of bladder, multiple episodes of incontinence daily
Does the member have issues with bowel continence? *Choose one*	
☐ Continent; complete control of bowel	☐ Infrequent incontinence; less than daily episodes of incontinence
☐ Continent with control achieved by schedule/training	☐ Frequent incontinence; daily, but some control
☐ Continent with catheter or ostomy	☐ Incontinent; no control of bowel
Does the member have or use any of the following for toileting? *Select all that apply*	
☐ Urinary catheter	☐ Toileting schedule
☐ Pads/Briefs	☐ Other, specify:
☐ Ostomy	
Does the member require assistance with insertion, sterile irrigation, and replacement of catheters? *Choose one*	
☐ Fully independent	☐ Physical assistance to complete the task
☐ Set-up help or occasional oversight	☐ Totally dependent on others
☐ Supervision & cueing throughout the entire activity	
How often does the member need this assistance? *Choose one*	
☐ Daily	☐ Several times a month
☐ 3-6 times per week	☐ Monthly or less
☐ 1-2 times per week	

Does the member currently use any of the following assistive devices? *Check all that apply*				
☐ Cane	☐ Prosthesis	☐ Walker	☐ Urinal	☐ Shower chair
☐ Crutches	☐ Ramp access	☐ Wheelchair, electric	☐ Commode	☐ Mechanical lift
☐ Service animal	☐ Scooter	☐ Wheelchair, manual	☐ Grab bars	☐ Other Assistive Device
☐ Leg braces	☐ Stair glide	☐ Bed pan	☐ Raised toilet seat	☐ No Device Used
If other, please specify:				

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)

Does the member require assistance with meal preparation? *Choose one*		
☐ Fully independent	☐ Some help	☐ Dependent
Does the member require assistance with ordinary, routine housework (e.g., dishes, laundry, making bed, tidying up)? *Choose one*		
☐ Fully independent	☐ Some help	☐ Dependent
Does the member require assistance with managing their finances (e.g., paying bills, balancing expenses)? *Choose one*		
☐ Fully independent	☐ Some help	☐ Dependent
Does the member require assistance with shopping (e.g., choosing and purchasing items)? *Choose one*		
☐ Fully independent	☐ Some help	☐ Dependent
Does the member require assistance with transportation (e.g., driving, taking public transportation, getting in/out of transportation)? *Choose one*		
☐ Fully independent	☐ Some help	☐ Dependent

SKIN

Does the member have any current skin problems? *Check all that apply*			
☐ Pressure ulcers	☐ Any open wounds	☐ Rashes	☐ None
☐ Burns	☐ Eczema or dermatitis	☐ Infections	☐ Other, please specify:
☐ Bruises	☐ Skin tears or cuts	☐ Skin Cancer	
☐ Surgical wounds	☐ Pruritus/itching	☐ Psoriasis	

Does the member require treatment and/or application of dressings when the physician or PCP has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions)? ☐ Yes ☐ No

How much assistance is required? *Choose one*	
☐ Full self-administration	☐ Physical assistance to complete the task
☐ Set-up help only	☐ Totally dependent on others
☐ Supervision - oversight, cueing, guidance	
How frequently does the member require assistance? *Choose one*	
☐ Daily	☐ Several times a month
☐ 3-6 times per week	☐ Monthly or less
☐ 1-2 times per week	

Does the member require use of a hot pack, hydrocollator, paraffin bath, or whirlpool treatment due to a condition that is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications? ☐ Yes ☐ No

How does the member manage this treatment? *Choose one*	
☐ Full self-administration	☐ Physical assistance to complete the task
☐ Set-up help only	☐ Totally dependent on others
☐ Supervision - oversight, cueing, guidance	
How often does the member require assistance with this treatment? *Choose one*	
☐ Daily	☐ Several times a month
☐ 3-6 times per week	☐ Monthly or less
☐ 1-2 times per week	

PAIN

Does the member complain or show evidence of pain? *Choose one*			
☐ No pain	☐ Present, less than daily	☐ Present, daily	☐ Constant pain

Where is the location of the member's pain?

Does the member feel that the pain disrupts their normal activities?	☐ Yes ☐ No
Does the member feel that medications control the pain?	☐ Yes ☐ No ☐ No medications taken

NUTRITION

In the last 90 days, has the member had an unintended weight loss or gain? ☐ Yes ☐ No

Does the member's PCP require the member to measure intake or output based on medical necessity? ☐ Yes ☐ No

How much assistance does the member require with measuring intake and/output? *Choose one*	
☐ Full self-administration	☐ Physical assistance to complete the task
☐ Set-up help only	☐ Totally dependent on others
☐ Supervision - oversight, cueing, guidance	
How frequently is assistance required with intake and output? *Choose one*	
☐ Daily	☐ Several times a month
☐ 3-6 times per week	☐ Monthly or less
☐ 1-2 times per week	

What is the member's mode of nutritional intake? *Check all that apply*	
☐ Oral; can swallow all textures/consistencies of foods/liquids	☐ Gastrostomy tube feeding
☐ Oral but modified; e.g., soft, ground, pureed, thickened liquids	☐ Jejunostomy feeding
☐ Nasogastric tube feeding	☐ Parenteral feeding

How much assistance does the member require with the feedings? *Choose one*	
☐ Full self-administration	☐ Physical assistance to complete the task
☐ Set-up help only	☐ Totally dependent on others
☐ Supervision - oversight, cueing, guidance	
How frequently is assistance with feeding required? *Choose one*	
☐ Daily	☐ Several times a month
☐ 3-6 times per week	☐ Monthly or less
☐ 1-2 times per week	

SAFETY INDICATORS

Member Status Check - Are there any indicators of the following?	**Response**
Abused, neglected, or mistreated by others	☐ Yes ☐ No
Unreasonably confined (i.e., physically restrained)	☐ Yes ☐ No
Unexplained injuries (i.e., bruises, broken bones, or burns)	☐ Yes ☐ No
Fearful of caregiver, family, or other individual	☐ Yes ☐ No
Self Neglect (inability, unwillingness to care for basic needs)	☐ Yes ☐ No
Financial abuse (exploitation, misuse)	☐ Yes ☐ No

Signature of nurse assessor: _____

Title of nurse assessor: _____

Date Completed: _____