



## Service Worker Comprehensive Assessment

This form helps the Iowa Medicaid Enterprise to have a clear picture of your medical and daily care needs. It is important for you to complete and return this form so we can determine whether or not you qualify for a home- and community-based services (HCBS) waiver.

This form may be completed by you or by someone who cares for you. Read the instructions carefully and answer each question. If you need more space, use the back of the form. If you need help completing this form, contact the worker listed below. **Be sure to sign this form on page 9 before returning it.** Once you have completed the form, please return it to:

Worker name:		Title: Social Worker II	
Agency: Department of Human Services			
Address:			
City:		State: IA	ZIP code:
Phone:		Email:	
Signature:		Date:	

### Tell us about yourself:

Name:		Date of birth:	Medicaid ID number:
Current address:			County:
City:		State:	ZIP code:
Home phone:		Work phone:	Cell phone:
Email address:		Height:	Weight:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Marital status:		Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have a job or do volunteer work?  Yes  No

If yes, list where you go to work, how often, and what you do there:

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Do you drive?  Yes  No

Do you live alone?  Yes  No

If not, please use the chart below to tell us who lives in your household. (If you need more lines, please list in the narrative on Page 7.)

Name:	Relationship to you:	Age:	Does this person help care for you?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Has anyone moved in or out of the house in the last year?  Yes  No

If yes, who? \_\_\_\_\_

**Emergency contact:**

Name:		Relationship:
Address:		
City:	State:	ZIP code:
Home phone:	Work phone:	Cell phone:
Email address:		

Does anyone not in your household care for you (unpaid)?  Yes  No

<b>Name:</b>		<b>Relationship:</b>
Address:		
City:	State:	ZIP code:
Home phone:	Work phone:	Cell phone:
Email address:		

Is there anyone that you would **not** want to be involved with your care if you were sick or needed help?  Yes  No

Name:	Relationship:
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**Tell us about your medical care:**

Doctor's name:		Phone number:		
Office name/address:				
Dentist's name:				
Eye doctor's name:				
<b>Services:</b> Do you receive any of the following services?		Days Per Week	Provider Name	Provider Phone
Nursing:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Physical therapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Occupational therapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Speech therapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Supervision for safety:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Diabetes education:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Respiratory treatment:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Nasogastric tube care:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other (specify):	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Do you have a plan for home therapy?  Yes  No

If so, what therapist oversees this plan? \_\_\_\_\_

**Assistive devices:** In this section, check whether or not you use the device listed. On the line for each item, provide details including how often it is used and who helps if needed.

Oxygen:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tracheostomy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ventilator:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pull-ups or Depends:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Glasses:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing aids:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Medical conditions and equipment:** Check whether or not you have the condition or use the equipment listed. On the line for each item, provide details regarding how often the condition occurs or the equipment needs to be used and who helps if needed.

Allergies:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood sugar checks:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel program:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Who changes and how often? Check type: <input type="checkbox"/> Indwelling <input type="checkbox"/> Urethral <input type="checkbox"/> Suprapubic
Chest percussion:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colostomy bag:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Control of bladder:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Control of bowels:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dialysis:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dietary needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Feeding pump:	<input type="checkbox"/> Yes <input type="checkbox"/> No
G-tube:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Implanted port:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inhalation therapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Injections:	<input type="checkbox"/> Yes <input type="checkbox"/> No
IV therapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Open wound:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rashes:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures:	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered yes to any of the items on page 4, please give a detailed explanation about those items.

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**Mobility:** Please indicate your need for the following devices or help. Mark 'yes' or 'no' and use the line for each item to explain how often the device or assistance is needed and who helps.

Help transferring to or from chair, bed, stool:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Assistance in or out of a vehicle:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Positioning:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Someone to stand near when walking or transferring:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Slide board:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mechanical lift:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Walker:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cane:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Wheelchair:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Brace:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Helmet:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Crutches:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Communication devices:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Weighted blankets or vest:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Harness or gait belt:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Wound care:** Please describe any wound care you are receiving.

Type of Wound	Types of Treatment	How often is dressing changed?	Who provides treatment?
Bed sore:			
Surgical wound:			
Other open area:			

**Activities of daily living:** For each activity listed, place a check mark to state whether you can do the activity alone, can do it with help such as a verbal reminder, help from a device or piece of equipment, or help from someone else, or you cannot do it. On the next line, please write what kind of help you need, who helps you, and how often help is required (daily, weekly, etc.)

	No help needed	Verbal reminder	Help from a device	Help from a person	Dependent
Bathing or showering:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing or combing hair:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shaving:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brushing teeth or denture care:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Putting on or taking off clothes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buttoning or zipping clothing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Putting shoes or socks on:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making meals:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No help needed	Verbal reminder	Help from a device	Help from a person	Dependent
Toileting:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housekeeping:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money management:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication management:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Other services:** Please use the chart below to tell us about any other services that you receive (such as nursing, home health, in-home health-related care, etc.):

Type of service	Provider name	Provider phone	How often is service received?

**Complete this section for children (ages 17 and under).**

*(If the child currently lives in an institutional setting, please note this in the narrative section.)*

Parent's marital status:       Married                       Divorced                       Never married

Parent's contact information (if different from the child):

Home phone:	Work phone:
Cell phone:	Email address:

If the parents are not living together, what is the noncustodial parent's name and address?

Name:		Phone:
Address:		
City:	State:	ZIP code:

Is your child involved with area education agency (AEA) services?       Yes       No

Are any siblings receiving waiver service?       Yes       No

School name:	Grade:	IEP: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of school contact:		Phone number:

**Please complete the section below for all ages:**

**Narrative:**

Please use the space below and on the following page to tell us more about yourself. Include some information about a "typical" day in your life. Who helps you? What they do and when? Do you feel safe in your home? Include any risk factors you have that were not identified by the questions on this form and tell how these are addressed.

If you are completing this for your child, please include any behavioral or safety concerns. Also explain the types of help that your child requires on a regular basis and how your child's needs may differ from other children of the same age.

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**The following sections are to be completed by the service worker only.**

Complete this section only if the member is taking medications.

1. Are any medications kept in a special place, like a locked container or the refrigerator?  Yes  No
2. What pharmacy does the member use? \_\_\_\_\_
3. How does the member remember to take medications? (check all that apply)
  - By following directions       Calendar       RN set-up       Caregiver administers
  - Bubble wrap or blister pack       Pill minder       Medpass machine       Egg carton/envelopes
  - Other

Comments:

\_\_\_\_\_

4. How well does the member self-administer medication?
  - Independent       Verbal prompt       Device       Caregiver administers
  - Can take independently with someone checking to make sure medication is taken

Comments:

\_\_\_\_\_

\_\_\_\_\_

**Interdisciplinary team members consulted (including member):**

Name	Title (if applicable)	Relationship to member

Additional records reviewed:

\_\_\_\_\_

\_\_\_\_\_

**Court Involvement:**

- None       Child in need of assistance (CINA)
- Involuntary commitment       Child protection
- Probation or parole       Delinquency
- Other (Identify) \_\_\_\_\_       Foster care

Comments:

\_\_\_\_\_

\_\_\_\_\_