New York State Department of Health
UNINSURED CARE PROGRAMS
Empire Station . PO BOX 2052 . Albany, NY 12220
1-800-542-2437

Nursing Assessment for Home Care

Patient Information:

Last Name:_____ First Name:_____ Middle Initial:____

ADAP ID Number: **555**-_____ Social Security Number: _____

Contact Person (Name & Relationship):_____

Contact Phone (Day-time):_____ ***Please submit release to allow Program contact.***

Living Situation:

Dwelling: ❑ Apartment ❑ House ❑ Other: _____ Floor:_____ # of Rooms:_____ Elevator: ❑ Yes ❑ No

Lives alone: ❑ Yes ❑ No Identify all individuals living in the home:_____

List the services, hours and days they are available and able to assist with care giving: _____

_____

Hospitalization:

Hospital Name: _____ Address:_____

Hospitalized: From: _____ To:_____ Diagnoses:_____

Hospital Contact: _____ Phone:_____

Patient Status:

Is patient alert? ❑ Always ❑ Sometimes ❑ Never

Can patient direct a home care worker? ❑ Yes ❑ No

If no, who is responsible for directing home care workers?

Name/Relationship: _____

Patient Height: _____ Patient Weight: _____

Recent significant weight loss? ❑ Yes ❑ No If Yes, amount lost: _____

Impairments:

Sensory:

	None	Partial	Total
1. Speech	❑	❑	❑
2. Sight	❑	❑	❑
3. Hearing	❑	❑	❑

Muscular/Motor:

	None	Partial	Total
1. Hand/Arm	❑	❑	❑
2. Upper Extremities	❑	❑	❑
3. Lower Extremities	❑	❑	❑

Cardiovascular / Respiratory:

	None	Partial	Total
1. Respiratory	❑	❑	❑
2. Cardiac	❑	❑	❑
3. Circulatory	❑	❑	❑

Describe impact on functional ability.

_____

_____

1. Does patient have history of *tuberculosis*? ❑ Yes ❑ No ❑ Pulmonary ❑ Extra pulmonary
2. Did patient complete therapy? ❑ Yes ❑ No
3. Does patient currently have tuberculosis? ❑ Yes ❑ No ❑ Pulmonary ❑ Extra pulmonary
4. Is patient currently on tuberculosis prophylaxis? ❑ Yes ❑ No Hx of TB prophylaxis ❑ Yes ❑ No
5. Last documented PPD: Date and result _____ Anergy results if available:_____
6. If on tuberculosis treatment, are there 3 negative AFB? ❑ Yes ❑ No Negative chest x-ray ❑ Yes ❑ No

Patient Name:_____ **ADAP ID#: 555-**_____
Agency: _____ **Provider Number**: _____

Mental Status

	Never	Partial	Total		Never	Partial	Total
1. Oriented place and time	❑	❑	❑	8. Danger to: Others (Aggressive)	❑	❑	❑
2. Anxiety	❑	❑	❑	Self	❑	❑	❑
3. Agitated	❑	❑	❑	9. Articulates needs	❑	❑	❑
4. Short term memory loss	❑	❑	❑	10. Sleep disorder	❑	❑	❑
5. Wanders	❑	❑	❑	11. Abusive to: Others	❑	❑	❑
6, Depression	❑	❑	❑	Self	❑	❑	❑
7. Impaired judgment	❑	❑	❑	12. Other Cognitive / Mental Status Information:			

Patient Ability to Take/Administer Medication:

	Never	Sometimes*	Always
1. Totally independent	❑	❑	❑
2. Needs reminding	❑	❑	❑
3. Non-compliant	❑	❑	❑
4. Needs help preparing	❑	❑	❑
5. Needs administration	❑	❑	❑

*Complete #7.

6. Patient/care giver can be taught to administer ❑ Yes ❑ No
7. Please explain:

If patient is not independent, what arrangements have been made to administer medications?

IV Infusion and Injections: **# of Times Per Week**

Patient requires home infusion via: _____
❑ Central Line ❑ Peripheral Line

Injections _____

Blood work (in the home) _____

Elimination:

	Bowel	Bladder
Continent	❑	❑
Occasionally Incontinent	❑	❑
Incontinent	❑	❑

Medical Treatment: (Check ✓ all that apply) Please list all medications on AI485:

1. Decubitus care	❑	6. Monitor vital signs	❑	11. Blood tests	❑
2. Dressings - Simple	❑	7. Tube feeding	❑	12. Ambulation exercise	❑
3. Dressings - Sterile	❑	8. Tube irrigation	❑	13. Rehabilitative therapy	❑
4. Enema	❑	9. Suctioning	❑	14. Physical therapy	❑
5. Catheter care	❑	10. Oxygen administration	❑		

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Identification of Service Needs:

	Without Help	With Cane	With Walker	With Wheelchair	With Personal Assistance	Unable
Ambulate inside	❑	❑	❑	❑	❑	❑
Ambulate outside	❑	❑	❑	❑	❑	❑
Get up from seated position	❑	❑	❑	❑	❑	❑
Get up from bed	❑	❑	❑	❑	❑	❑
Transfer to:						
Commode	❑	❑	❑	❑	❑	❑
Wheelchair	❑	❑	❑	❑	❑	❑

Indicate Patient's Personal Service Needs:

	Independent	Partial Assist	Total Assist		Independent	Partial Assist	Total Assist
Grooming	❑	❑	❑	Toileting/ Bathroom	❑	❑	❑
Dressing	❑	❑	❑	Urinal or bedpan	❑	❑	❑
Washing	❑	❑	❑	Commode	❑	❑	❑
Bathing	❑	❑	❑	Catheter	❑	❑	❑
Feeding	❑	❑	❑	Laundry	❑	❑	❑
Meal Prep	❑	❑	❑	Shopping	❑	❑	❑
Reheat Meals	❑	❑	❑	Housecleaning	❑	❑	❑

Is the patient homebound? ❑ **Yes** ❑ **No***
*If patient is not homebound, you must submit justification of home care separately.

Certification:

This assessment is based on personal observation of the patient. ❑ Yes ❑ No
This assessment is based on information relayed to me by: _____

Prepared by: (print name)_____ **Phone #:**_____
Agency Affiliation:_____ **FAX#:** _____
Signature:_____ **Date:** _____

Is any other agency/vendor providing services in the home to the patient? ❑ Yes ❑ No
If Yes, Agency Name:_____Services:_____
Have all home care insurance benefits been exhausted? ❑ Yes ❑ No
Is this patient eligible for Medicaid? ❑ Yes ❑ No Have they applied to Medicaid? ❑ Yes ❑ No
If No, state reasons:_____

FOR NEW HOME CARE APPLICANT ONLY:

How was the applicant referred to your agency?
❑ Doctor ❑ Social Worker ❑ Discharge Planner Location:_____
❑ Other Please explain:_____

(Rev. 12/2005)