INITIAL EVALUATION AND SERVICE PLAN

☐ INITIAL CASE ☐ TRANSFER

Client Name (Last, First, MI)			Client No.	Telephone No.	
Address			County	Sex	Date of Birth
Name of Physician Client Sees Regularly	Physician's Address			Telephone No.	
Provider Agency Name **American Best Assisted Living, LLC**	Vendor No.	Provider Agency Address **710 Crestwood Lane Missouri City, TX 77489**		Telephone No. **(832) 406-9971**	

Describe living conditions; identify safety or health hazards:

List assistive devices or medical equipment in use:

Give dates and reasons for any hospitalization within the last three months:

Supervisory Visits: Frequency of Supervisory Visits _____

Other Services Client is Receiving

☐ None ☐ Skilled Home Health Aide ☐ Emergency Response Service ☐ Transportation ☐ Day Activity and Health Service (DAHS)

☐ Meals (specify which and frequency): _____

☐ Other (specify): _____

Do these services appear to duplicate primary home care services? _____ ☐ Yes ☐ No

If yes, notify the client's DADS case manager before requesting prior approval or initiating services. Note the date of contact and result of discussion in the comments section on Page 2.

CLIENT INFORMATION

Location of Service Delivery

☐ Client's Home ☐ Other _____

Mobility Level: Check all that apply

☐ Goes Outside Independently ☐ Goes Outside Independently With Walker, Cane, or Wheelchair ☐ Goes Outside With Help Only ☐ Moves Around Inside w/o Help ☐ Moves Around Inside Only With Help

☐ Confined to Chair and Bed, or Confined to Bed: ☐ Needs Help to Transfer ☐ Transfers Independently

Comments:

Elimination – Bowel

☐ Voluntary ☐ Occasionally Involuntary ☐ Incontinent ☐ Ostomy

Elimination – Bladder

☐ Voluntary ☐ Occasionally Involuntary ☐ Incontinent ☐ External Catheter ☐ Internal Catheter

Attendant Help Needed To (check all that apply)

☐ Change Ostomy Bag ☐ Empty Catheter Bag ☐ Change Catheter Bag

Comments:

AMERICAN BEST ASSISTED LIVING, LLC

HEALTH ASSESSMENT – Describe client (age, appearance, nutritional status, medical condition, symptoms of health problems). Describe how medical condition(s) impairs client's ability to carry out specific tasks requested on the Service Plan (below) and the type of assistance client needs.
NOTE: Use the client's self report to document this information

SERVICE PLAN – Does the client need different task than indicated on Form 2101? ☐ Yes ☐ No If yes, indicate the tasks the client needs below.

☐ Bathing		☐ Feeding/ Eating		☐ Toileting*		☐ Cleaning		☐ Escort*	
☐ Dressing		☐ Shaving/ Oral Care		☐ Transfer		☐ Laundry		☐ Shopping	
☐ Exercising		☐ Routine Hair/ Skin Care		☐ Ambulation/ Walking		☐ Meal Prep**		☐ Assist w/Self-Admin. Med.*	

***These tasks may occur PRN. If any tasks are to be provided regularly in a location outside the client's home, indicate location and frequency.**

****For meal preparation, designate which meals and frequency here:** _____

ATTENDANT SERVICE SCHEDULE

☐ Fixed Schedule ☐ Variable Schedule

	SUN	MON	TUE	WED	THUR	FRI	SAT
Attendant A							
Attendant B							

Total Auth Hrs. per Week

Name of Attendant

Name of Attendant

Comments: _____

CLIENT CERTIFICATION – I hereby agree to the above referenced service plan for Personal Assistance Services (PAS). I understand that the Primary Home Care Program only provides the tasks allowable in the program as described in 47.41 of this chapter (relating to allowable task) and agreed to on the service plan; and the provider agency is not responsible for meeting the applicant's needs other than tasks allowed under the Primary Home Care Program.

_____ Signature–Client or Responsible Person

_____ Date

SUPERVISOR CERTIFICATION - I certify that to the best of my knowledge, the information contained in this form is true and correct.

_____ Signature–Provider Agency Supervisor

Date of Evaluation

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INDIVIDUALIZED SERVICE PLAN

Client Name: _____
Last Name First Name Middle Initial

Sex: _____ Male _____ Female

Date of Birth: _____

Medicaid #: _____

Medicare #: _____

Address: _____
_____

Phone #: _____
Other #: _____

Emergency Contact: _____ _____ _____
Name Relationship Phone #

Diagnosis: _____

Allergies: _____

TYPES OF SERVICES:

✓	TASKS	FREQUENCY	✓	TASKS	FREQUENCY
	Bathing			Dressing	
	Exercising			Feeding	
	Grooming			Routine Hair/Skin Care	
	Toileting			Transfer	
	Cleaning			Walking	
	Meal Prep			Laundry	
	Shopping			Escort	
	Walking			Assist with Self-Administered Meds	
	Other:			Other:	

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	# of Hrs
Attendant A								
Attendant B								
Totals								

Location of Services: ☐ Client's Home ☐ Other _____ Back-up Services: Agency Attendants

Planned Date of Service Initiation: Within 7 days of approval from payor source

Frequency of Supervision: _____ Supplies/Equipment: N/A

Payor Source: ☐ HHSC ☐ Molina ☐ Amerigroup ☐ United Health ☐ Private Pay ☐ APS ☐ Other _____

Physician: _____ Phone # _____

Case Coordinator: _____ Phone #: _____

Other Agency In Home: _____ Phone #: _____

Agency Representative Signature: _____ Date: _____

I hereby agree to the above referenced service plan for Personal Assistance Services (PAS), in addition, I hereby acknowledge that if my priority status with HHSC is determined to be "non-priority", I may have a service interruption of up to 14 days. I understand that the Primary Home Care Program only provides the tasks allowable in the program as described in 47.41 of this chapter (relating to allowable task) and agreed to on the service plan; and the provider agency is not responsible for meeting the applicant's needs other than tasks allowed under the Primary Home Care Program.

CLIENT SIGNATURE: _____ DATE: _____

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MEDICATION LIST

Client Name (Last, First, Middle)	Date of Birth	Client No.

Client Address	Telephone Number (Inc. A/C)
	( )
Physician Name	Telephone Number (Inc. A/C)
	( )
Physician Address	

CURRENT MEDICATIONS	DOSAGE	ROUTE	FREQUENCY

SPECIAL DIET:
Diagnosis:
Allergies:

Reviewed:

Date/initial _____ Date/initial _____ Date/initial _____

Date/initial _____ Date/initial _____ Date/initial _____

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ATTENDANT ORIENTATION/SUPERVISORY VISIT

Client Name (please print)	Client No.

Date	Orientation / Supervisory Visit. Conducted	Frequency of Supv. Visits	Location of Service Delivery
	☐ Client's Home ☐ Telephone		☐ Client's Home ☐ Other _____

ATTENDANT NAME	AO	SV	SA
A	☐	☐	☐
B	☐	☐	☐

1. Describe client's symptoms and functional limitations which cause need for personal care. For Family Care clients, describe client's condition. Be specific about changes since last visit. **(Complete this item at every visit.)**

2a. Tasks/Service Plan: Indicate tasks to be performed (complete on every visit). During supervisory visit, ask client or family what tasks are provided by attendant. Observe or ask about performance: **S = Satisfactory U = Unsatisfactory**

* Personal Care Task	FREQ.	PERFORM. A	PERFORM. B
☐ Bathing*			
☐ Dressing*			
☐ Exercising*			
☐ Feeding*			
☐ Grooming*			
☐ Routine Hair/Skin Care*			
☐ Toileting*			
☐ Transfer			
☐ Ambulation/Walking			
☐ Cleaning			
☐ Laundry			
☐ Meal Preparation*			
☐ Escort			
☐ Shopping			
☐ Assist w/Self-Admin. Med*			

b. **Enter the total number of hours of service that the client is authorized to receive per week:** _____ Hrs.

3. **Does the client continue to need services?** ☐ Yes ☐ No

Is a change in task/hours or service termination needed? ☐ Yes ☐ No

If yes, specify needed changes and explain: _____

Service Plan Adequate? ☐ Yes ☐ No

Attendant continues to be competent. ☐ Yes ☐ No ☐ N/A

Attendant delivering authorized task ☐ Yes ☐ No ☐ N/A

Date Caseworker notified of changes needed	Caseworker Name

4. **Is the client satisfied with the services provided by the attendant? (N/A for attendant orientation, or no attendant)** ☐ Yes ☐ No ☐ N/A

5. **Ask the client to describe the attendant's schedule: Is attendant following the schedule? (N/A for attendant orientation only, or no attendant)** ☐ Yes ☐ No ☐ N/A

6. **If any task in Item 2A is marked "U," if items 4 and/or 5 are marked "No," or if other training needs have been identified, describe service delivery problems, attendant training needs, and corrective actions below. If no problems are identified, enter "None, N/A, No comments," etc., as appropriate.**

I WAS PRESENT AT THE SUPERVISORY VISIT.

☐ **Universal Precautions reviewed.** ☐ **Safety training reviewed.**

Signature–Client

Signature–Supervisor

Signature–Attendant

Signature–Attendant

Agency Name	Vendor No.

AMERICAN BEST ASSISTED LIVING, LLC

Client Name	Client No.

7. Orientation (complete when orienting attendant)

☐ **7-1 Attendant instructed about client's health condition and how it may affect provision of tasks.**

☐ **7-2 Attendant instructed about tasks to be provided, work schedule, and safety and emergency procedures.**

☐ **7-3 Attendant instructed to report to** _____ _____
the following health problems (document symptoms): (print name) (telephone no.)

_____

_____

_____

_____

☐ **7-4 Attendant instructed to report the following to the supervisor as soon as possible:**

- Client Hospitalized
- Incidents that affect the client's condition
- Changes in Client's Needs
- Unable to Work Scheduled Hours
- Client Absent from Home/Moved
- Suspicions or allegations of Abuse, Neglect or Exploitation
- Other _____

_____

_____

☐ **7-5 Client provided with a verbal explanation and written copy of the agency's complaint procedure .**

☐ **7-6 Attendant provided with HIV/ Hepatitis Training. Attendant provided with Universal Precautions Training.**

☐ **7-7 Attendant competent to provide personal care tasks checked in item 2a.**

I CERTIFY THAT I RECEIVED ORIENTATION ON ITEMS 2 AND 7.

_____
Signature–Supervisor

_____
Signature–Attendant

_____
Signature–Attendant

ATTENDANT SCHEDULE (for use by provider agency)

ATT.	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	TOTAL HOURS
A								
B								
TOTAL HRS.								

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