Health/Behavioral

Assessment

February 2010

Please note: All questions must be adapted to the individual's understanding.

Y/N

1. Have you seen a doctor in the past year?	

What kind of doctor? (You may need to explain these)

Neurology		Psychiatry	
Primary care		Gastroenterology	
Cardiology		Endocrinology	
Pediatrician		Hematology	
Rheumatology		Allergy	
Podiatry		Dermatology	
Gynecology		Urology	
Orthopedics		Neurosurgery	
Ear/Nose/Throat		Oncology	
Optometry/Ophthalmology			
Others			

Y/N

2. Do you currently have a dentist?	
a) Have you been to the dentist in the past year?	
b) Do you have any problems with your teeth?	

3. Have you been treated in the emergency room this past year?		
When?		
Why?		
4. Have you been admitted to the hospital this past year?		
When?		
Why?		
5. Do you take any prescription medicines?		

If yes, what ones?

Abilify (Aripiprazole)		Lopressor (Metoprolol)	
Adderall		Mellaril (Thioridazine)	
Anafranil (Clomipramine)		Metformin (Glucophage)	
Ativan (Lorazepam)		Mysoline (Primidone)	
Baclofen (Liorasal)		Neurontin (Gabapentin)	
Buspar (Buspirone)		Norvasc (Amlodipine)	
Catapres (Clonidine)		Paxil (Paroxetine)	
Celexa (Citalopram)		Phenobarbital	
Cogentin (Benztropine)		Pravachol (Pravastatin)	
Concerta (Methylphenidate)		Prevacid (Lansoprazole)	
Depakote (Divalproex)		Prinivil (Lisinopril)	
Desyrel (Trazadone)		Prozac (Fluoxetine)	
Detrol (Tolterodine)		Risperdal (Risperidone)	
Dilantin (Phenytoin)		Ritalin (Methylphenidate)	
Effexor (Venlafaxine)		Seroquel (Quetiapine)	
Geodon (Ziprasidone)		Symmetrel (Amantadine)	

Haldol (Haloperidol)		Synthroid (Levothyroxin)	
Inderal (Propanolol)		Tegretol (Carbamezapine)	
Keppra (Levetiracetam)		Thorazine (Chlorpromazine)	
Klonopin (Clonazepam)		Topamax (Topiramate)	
Lamictal (Lamotragine)		Vasotec (Enalapril)	
Lasix (Furosemide)		Wellbutrin (Bupropion)	
Lexapro (Escitalopram)		Xanax (Alprazolam)	
Lipitor (Atorvastin)		Zoloft (Sertraline)	
Lithium (Eskalith)		Zyprexa (Olanzapine)	

others	

a) Do you take any OTC (over-the-counter) medicines such as vitamins, Homeopathic remedies or laxatives?	
List these	

6. Do you have any health problems?	
7. In the past year is your health:	

Better?		Worse?		Same?		

8. Do you need help to take medicine?	
a) Needs oversight	
b) Needs partial assistance	
c) Needs total assistance	
9. Does the individual take seizure medication?	
a) Does the Neurologist prescribe the medication?	
10. Does the individual take behavior/psychiatric medication?	
a) Does the Psychiatrist prescribe the medication?	

11. Does the individual take medication for chronic conditions such as: diabetes, hypertension, thyroid, heart, gastrointestinal disorders, blood disorders, or respiratory disorders?	
12. Does the individual know why medication is taken?	
13. Does the individual:	
a) Require information/education about medications?	
b) Require information about side effects?	
14. Did you hear about or see reports of:	
a) Missed doses of medication	
b) Erratic medication ingestion	
c) Outdated medications, or medications that do not match med record or prescriptions?	
15. How does the person communicate?	
a) Sign language?	
b) Communication device?	
c) Spoken word?	
d) Non verbal (gestures, smiles, eye contact)?	
16. Do you have a gastrostomy tube?	
17. Do you have any problems drinking?	
a) Do you need help to drink?	
b) Do you use a sippy cup?	
c) Do you use a straw?	
d) Do you have to have thickened liquids?	
e) Do you ever cough when you drink?	
f) Do you ever choke when you drink?	

g) Do you ever gag when you drink?	
18. Do you have any problems eating/swallowing?	
a) Do you need assistance to eat?	
b) Is your food chopped?	
c) Is your food pureed?	
d) Is your food ground ?	
e) Is your food thickened?	
f) Do you ever cough when you eat?	
g) Do you ever choke when you eat?	
h) Do you ever gag when you eat?	
19. Is the individual continent of bowel?	
a) Is the individual continent of bladder?	
20. Do you currently receive the following?	
a) Speech therapy?	
b) Occupational therapy?	
c) Physical therapy?	
d) Nutritional supports?	
e) Respiratory therapy?	
f) Massage therapy?	
21. Does the individual state a need for additional services/supports from?	
a) Speech therapy?	
b) Occupational therapy?	
c) Physical therapy?	

d) Nutritional evaluation?	
e) Respiratory therapy?	
f) Massage therapy?	
22. Does the individual appear to need a:	
a) Speech therapy evaluation?	
b) Occupational therapy evaluation?	
c) Physical therapy evaluation?	
d) Nutritional evaluation?	
e) Respiratory therapy evaluation?	
f) Massage therapy evaluation?	
g) Oral motor evaluation?	
23. Does the individual appear to need Adaptive equipment evaluation?	
24. Does the individual have Adaptive Equipment?	
a) Wheelchair?	
b) Lap tray?	
c) Utensils?	
d) Positioning equipment?	
e) Shower chair?	
f) TTD?	
g) Communication device?	
h) Helmet?	
i) Splints/Brace?	
j) Hearing Aid?	

	k) Dentures?	
	l) Glasses?	
Others		
25. Does the individual appear to need Environmental modifications?		
	a) Can you use your bathroom (shower, sink, and toilet)?	
	b) Can you use your kitchen (stove, microwave, sink, and refrigerator)?	
	c) Can you access your front door?	
	d) Can you access your entryway?	
	e) Can you call for help?	
26. Does the individual appear to need:		
	a) Male preventative health care?	
	b) Female preventative health care?	
	c) Vision exam?	
	d) Hearing exam?	
27. Has anyone ever talked to you about safe habits?		
	a) Do you smoke or use tobacco products	
	b) Do you drink alcohol, beer, wine?	
	c) Has anyone ever talked to you about safe sex?	
28. Have you been told you need to stop doing certain things or certain behaviors?		
29. Do you remember what those things are that you need to stop doing?		
30. Does someone make a chart or picture showing how you are doing with your behavior issues.		

a) Can you see one of those charts or pictures?	
31. Did you hear, see or talk about any challenging behaviors the person exhibits?	
32. Does an individual residing in a Behavior Focus or Intensive Behavior, have a behavior plan with a current LRC review (if required, within past 12 months?	
33. Do people significant to the person feel a behavioral assessment is warranted?	
34. If the individual takes medication for "behavior" and they're still having problems, have they had a behavioral assessment?	
35. Does the individual receive behavioral services?	
36. Do people significant to the person feel that behavioral services are warranted?	
37. Does the person appear to be angry, confused, guilty/ashamed, anxious/worried, stressed, sad, fatigued, restless, or lonely?	
38. Does the person express feelings of being angry, confused, guilty/ashamed, anxious/worried, stressed, sad, fatigued, restless, lonely and want to talk to someone about it?	
39. Does the individual have Medicare?	
40. Does the individual have private insurance?	
41. Does the individual have private pay?	
42. Are you responsible for your health care needs?	
a) Does anyone help you with your health care needs?	
b) Do you need additional help?	
43. Do you require any special equipment in case of emergencies?	
a) Van transport?	
b) Oxygen?	
c) Generator?	

44. Did the reviewer contact the Area MCM?	
45. Did the reviewer contact the RN reviewer?	

NOTE: For any additional health concerns or questions please call Linda at the office, 1-866-254-2075 or on her cell, 813-495-0147.

Funding Source Disclaimer

Support Coordinators must coordinate access to services through all available funding sources prior to accessing waiver services.

Funding sources must be accessed in this order:

1. **Third Party Payer**
2. **Medicare**
3. **Other Medicaid Programs (ex. State plan, Medicaid Durable Medical Equipment and medical Supplies Program)**
4. **Waiver**

DD Waiver Services Coverage and Limitations Handbook pg. 2-6