VSHP Volunteer State Health Plan
801 Pine Street
Chattanooga, Tennessee 37402-2555
bcbst.com

BlueCare TennCareSelect
a state of Tennessee program

HOME VISIT LEVEL OF CARE ASSESSMENT

I. DEMOGRAPHICS Assessment Date: _____

a. Name: _____
b. Address: _____
c. Phone: _____
d. County: _____

e. DOB: _____ f. Age: ___ g. Gender:

h. Language Spoken: _____ Barrier.

i. Medicaid I.D: _____ ☐ Active ☐ Pending

j. Other Health Insurance: _____

k. Contact: _____
☐ Guardian ☐ POA ☐ Authorized Rep.

l. Phone:_____ (day) _____ (evening)

m. Relationship: _____

n. Designee
Name: _____
Address: _____
City/State/Zip: _____
Phone Number: _____
I certify that I do NOT want a designate correspondent_____

o. Usual	Current	LIVING ARRANGEMENTS (CIRCLE)
☐	☐	Own Home/Apartment
☐	☐	Relative/Friend
☐	☐	Group Home, Foster Home
☐	☐	Assisted Living, College
☐	☐	SNF
☐	☐	ICF/MR
☐	☐	Psychiatric Hospital/Unit
☐	☐	Acute Care Hospital
☐	☐	Other (Specify)
☐	☐	Family Support

p. Nearest Acute Care Facility: _____

q. Educational Level/Highest Grade Completed: _____

II. REASON FOR REQUEST

a. ☐ Home Health Services
- ☐ Skilled Services
  - # of hours/day _____
- ☐ Non-skilled services (hourly)
  - # of hours/day _____

b. ☐ SNF Admission (check one of the following)
- ☐ New Admission
- ☐ Readmit: original date of admission _____
- ☐ Transfer: from_____
  - Original date of admission _____

c. ☐ ICF/MR (name): _____

d. ☐ Waiver Services ☐ MR ☐ Elderly ☐ HCBS
- Indicate type of service _____
- Indicate # of hours for each service provided _____

e. ☐ Other _____

III. CURRENT SERVICES

a. ☐ Therapies (Home vs. Outpatient): _____
b. ☐ DME: _____
c. ☐ Needs 24 Hour Supervision due to Cognitive Impairment: _____
d. ☐ Skilled Nursing Services list/frequency): _____
e. ☐ Skilled Rehabilitation Services (list/frequency): _____

IV. SUPPORT SYSTEM

☐ YES ☐ NO

If yes, list and describe _____

V. PHYSICIANS

PRIMARY

Specialty: _____
Name: _____
Address: _____
Phone: _____ Date Last Seen: _____

OTHER

Specialty: _____
Name: _____
Address: _____
Phone: _____ Date Last Seen: _____

VII. DIAGNOSES

SOURCES OF INFORMATION (PLEASE CHECK):
☐ Physician ☐ Medical Record ☐ Record ☐ Client ☐ Caregiver
☐ Authorized Representative

PROGNOSIS
☐ Good
☐ Fair
☐ Poor

REHABILATATION POTENTIAL
☐ Improved Function
☐ Maintain Function
☐ Retard Loss of Function ☐ None

SENSORY DEFICITS
☐ Deaf ☐ Blind

IX. ALLERGIES (include medications, insects, molds, foods, animals, grasses, etc.)

_____

X. MEDICATION PROFILE - Sources of Information (Please Check):
☐ Physician ☐ Medical Record ☐ Record ☐ Client ☐ Caregiver
☐ Authorized Representative ☐ Additional Page Included

A) Medication	**RX**	**OTC**	**Dosage/Frequency**	**Route**

B) CHEMICALS (include form, frequency and amount)
ALCOHOL: _____CAFFEINE: _____
OTHER: _____ NICOTINE: _____

XI. ACTIVITIES OF DAILY LIFE

	NO HELP	SUPERVISION	HANDS ON	SOURCE	DAYS/WEEK ASST REQUIRED
a. Mobility					
1. Bed	☐	☐	☐	_____	_____
2. Transfer	☐	☐	☐	_____	_____
3. Ambulation	☐	☐	☐	_____	_____
b. Bathing	☐	☐	☐	_____	_____
c. Grooming	☐	☐	☐	_____	_____
d. Toileting	☐	☐	☐	_____	_____
• Incontinent ☐ Bowel ☐ Bladder					
• Indwelling Catheter or Ostomy					
e. Dressing	☐	☐	☐	_____	_____
f. Eating	☐	☐	☐	_____	_____

NURSING AND REHAB SERVICES: Check all that apply and indicate frequency.

☐ Catheter care, indwelling	___ X daily or ___X weekly
☐ Dressings, sterile, Stage 3 or 4 decubiti	___ X daily or ___ X weekly
☐ Dressings, sterile, multiple Stage 2 decubiti	___ X daily or ___ X weekly
☐ Dressings, sterile, other	___ X daily or ___ X weekly
☐ Injections, fixed-dose insulin	___ X daily or ___ X weekly
☐ Injections, sliding scale insulin	___ X daily or ___ X weekly
☐ Injections, other: IV, IM, Sub-Q	___ X daily or ___ X weekly
☐ Intravenous fluid administration	___ X daily or ___ X weekly
☐ Isolation precautions	___ X daily or ___ X weekly
☐ Occupational Therapy by OT or OT asst	___ X daily or ___ X weekly
☐ Ostomy Care	___ X daily or ___ X weekly
☐ Oxygen administration, stationary system	___ X daily or ___ X weekly
☐ Physical Therapy by PT or PT assistant	___ X daily or ___ X weekly
☐ Respiratory Therapy by RT, RT asst or nurse	___ X daily or ___ X weekly
☐ Suctioning, tracheal/tracheostomy	___ X daily or ___ X weekly
☐ Teaching catheter/ostomy care	___ X daily or ___ X weekly
☐ Teaching self-injection	___ X daily or ___ X weekly
☐ Total parenteral nutrition	___ X daily or ___ X weekly
☐ Tube feeding, gastrostomy or nasogastric	___ X daily or ___ X weekly
☐ Ventilator services	___ X daily or ___ X weekly
☐ Other _____	___ X daily or ___ X weekly

XII. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

	NO HELP	SUPERVISION	HANDS ON	SOURCE
a. Shopping	☐	☐	☐	_____
b. Meal Preparation	☐	☐	☐	_____
c. Environmental				
1. House Cleaning	☐	☐	☐	_____
2. Heavy Chores	☐	☐	☐	_____
3. Yard work/Maintenance	☐	☐	☐	☐ _____
d. Laundry	☐	☐	☐	_____
e. Community Access				
1. Telephoning	☐	☐	☐	_____
2. Transportation	☐	☐	☐	_____
3. Legal/Financial	☐	☐	☐	_____
4. Emergency call system	☐	☐	☐	_____

XIII. MEDICATION ADMINISTRATION

_____

XIV. COMMUNICATION

- Can patient express basic needs and wants (e.g. assistance with toileting, presence of pain)? _____
  - # days/week problem occurs: _____
- Can patient understand and follow very simple instructions (i.e. how to perform basic activities of daily living) without continual staff intervention? _____
  - # days/week problem occurs: _____

XV. BEHAVIOR

Check if item interferes with functioning and describe below

	CHECK (X)	SOURCES OF INFORMATION
a. Disoriented to person	☐	_____
b. Disoriented to place	☐	_____
c. Disoriented to time	☐	_____
d. Confusion	☐	_____
e. Withdrawn, isolates self	☐	_____
f. Hyperactive	☐	_____
g. Mood swings	☐	_____
h. Inappropriate fears, suspicions	☐	_____
i. Abusive to self	☐	_____
j. Drug/Alcohol abuse	☐	_____
k. Exhibits bizarre behavior	☐	_____
l. Neglect of self	☐	_____
m. Verbally abusive or aggressive	☐	_____
n. Physically abusive or aggressive	☐	_____
o. Wanders – mentally	☐	_____
p. Wanders – physically	☐	_____
q. Forgetfulness	☐	_____
1. Short-Term	☐	_____
2. Long-Term	☐	_____
r. Agitation	☐	_____
s. Smokes carelessly	☐	_____
t. Has difficulty concentrating	☐	_____
u. Has difficulty sleeping	☐	_____
v. Cannot make own decisions	☐	_____
w. Other	☐	_____

COMMENTS: Describe behavior(s) and level of supervision needed to prevent harm:

_____

XVI. SOCIAL WORKER ASSESSMENT

a. Check if experiencing any of the following psychosocial or environmental problems:
   - ☐ Problems with primary support group
   - ☐ Problems related to the social environment
   - ☐ Educational problems
   - ☐ Occupational problems
   - ☐ Housing problems
   - ☐ Economic problems
   - ☐ Problems with access to health care services
   - ☐ Problems related to interaction with the legal system/crime
   - ☐ Other psychosocial and environmental problems : _____

b. Check if current agency/community services involvement:
   - ☐ CPS/APS
   - ☐ BHO/Substance Abuse/Mental Health
   - ☐ Food Stamps/WIC
   - ☐ VA Services
   - ☐ County Office on Aging/Disability
   - ☐ Local Neighborhood Center
   - ☐ Church
   - ☐ Other _____

Social Worker Recommendations: _____

PROBLEM LIST IDENTIFIED: _____