Senior Health Insurance Company of Pennsylvania

CLAIMANT CARE NEEDS ASSESSMENT FORM

Instructions: *TO BE COMPLETED BY A LICENSED CLINICIAN. If no licensed clinician is available, please provide the title and credentials at the bottom of the form. This information is necessary for the processing of your resident's long-term care claim. Please answer the questions thoroughly. If the resident requires medication administration by facility staff, please attach the current Medication Administration Record.*
Please complete and return form via fax to 952-983-5256 (preferred) or mail to: Senior Health Insurance Company of Pennsylvania, P.O. Box 64913, St. Paul, MN 55164.

Facility Name: _____
Facility Address: _____
Facility City/State: _____
Facility Phone #: _____
Facility Fax #: _____

Resident Name: _____
Resident Policy #: _____
Resident Room #: _____
Resident Move-In Date: _____

1. Indicate the **current level of assistance in place** with the following Activities of Daily Living (ADLs). Use the following guide to indicate the level of assistance being provided by facility staff on a regular basis:
   - 1 = No assistance is provided, resident is Independent
   - 2 = Resident uses equipment, does not receive assistance from another person
   - 3 = Receives cueing/prompting to initiate or complete the ADL due to memory loss
   - 4 = Receives stand-by assistance (person within arm's reach) from another person to complete the ADL
   - 5 = Receives hands-on assistance from another person to complete some or all of the ADL
   - 6 = Unable to participate in <u>any</u> part of the ADL

ACTIVITIES OF DAILY LIVING	***LEVEL*** *(use key above)*	***FREQUENCY***
Bathing		❑ Daily ❑ Weekly
Dressing		❑ Daily ❑ Weekly
Toileting		❑ Daily ❑ Weekly
Transferring		❑ Daily ❑ Weekly
Incontinence		❑ Daily ❑ Weekly
Eating (does not include meal preparation)		❑ Daily ❑ Weekly
ADDITIONAL CARE NEEDS	***LEVEL*** *(use key above)*	***FREQUENCY***
Mobility/Ambulation (indoors only)		❑ Daily ❑ Weekly
Medication Administration		❑ Daily ❑ Weekly

2. What is the resident's primary diagnosis? _____

3. Are the resident's medications being administered by staff (facility stores, sets up, dispenses medications and maintains a Medication Administration Record)? ❑ Yes ❑ No
   a. **If administered by staff**, are medications administered because this resident requires assistance or because assistance is provided to all residents?
      ❑ Medication admin is provided to all residents
      ❑ Medication admin is required
      If resident requires medication administration, why? _____
   b. **If not administered** by staff, indicate the current medication administration arrangement (e.g., resident administers own medication, staff does medication reminders, staff sets up meds, family does medication set-ups, etc.). _____

4. Select the type of room that best describes the resident's housing situation at the facility (select only one):
   - ❑ Alzheimer's/Dementia unit (secured)
   - ❑ Alzheimer's/Dementia unit (non-secured)
   - ❑ Assisted living unit (secured)
   - ❑ Assisted living unit (non-secured)
   - ❑ Independent living apartment or unit

5. Does the resident have a known formal diagnosis of cognitive impairment? ❑ Yes ❑ No

   (If yes, proceed to question 5a. If no, proceed to question 10).

   a. Provide the cognitive impairment diagnosis: _____

   b. How was that cognitive impairment confirmed (by testing, physician diagnosis etc.)? _____

      i. If confirmed through testing, has the facility completed a MMSE or other cognitive test? ❑ Yes ❑ No

         If yes, provide exam name, score and date of exam: _____
         _____

         If confirmed by diagnosis, doctor's name: _____
         _____

   c. Is supervision for safety or other safe guards addressed in the resident's service plan? ❑ Yes ❑ No

      i. If no, why not? _____

      ii. If yes, describe (indicate all that apply):

      ❑ Locked unit or security code to enter/exit
      ❑ Staff at door to prevent egress
      ❑ Wanderguard or similar device
      ❑ Personal supervision through a one-to-one caregiver or family member
      ❑ Alarmed doors
      ❑ Fenced exterior
      ❑ Other: _____

6. Does the resident take any dementia medication(s)? ❑ Yes ❑ No
   a. If yes, what medication(s)? _____
   b. If response to #6 was "yes" and the response to #3 was "no", who administers dementia medications? _____
      _____

7. Is there a physician order in place to ensure resident does not leave the premises without escort? ❑ Yes ❑ No

8. If resident is not on a secured unit, does the resident have an escort when leaving the facility? ❑ Yes ❑ No

9. Does the resident need assistance to evacuate in the event of an emergency? ❑ Yes ❑ No

10. Is the resident prevented from or unable to drive? ❑ Yes ❑ No

11. **Is the information in this form consistent with the facility's current service plan for this resident?** ❑ Yes ❑ No

    If no, explain all discrepancies: _____
    _____

By signing below, I declare that all of the answers given are complete and true to the best of my knowledge and belief.

Signature: _____ Date: _____

Printed Name and Title: _____ Phone # _____

Professional Credentials: ❑ RN ❑ LPN/LVN ❑ Med Tech ❑ Not professionally credentialed ❑ Other _____