

APPLICANT INTERVIEW



SECTION A: DEMOGRAPHICS

Applicant's Name _____ Date of Birth ____ / ____ / ____

SSN _____ Age _____ Gender: Male Female Assessment Date ____ / ____ / ____

Applicant's Address _____ Assessment Time ____ : ____ am / pm

City _____ State _____ Zip _____ County _____

Where is Applicant currently located?

<input type="checkbox"/> Hospital	<input type="checkbox"/> Nursing Facility
<input type="checkbox"/> Home alone	<input type="checkbox"/> Home with family
<input type="checkbox"/> Group Home	<input type="checkbox"/> ICF/IID
<input type="checkbox"/> Assisted Care Living Facility	<input type="checkbox"/> Other CBRA
<input type="checkbox"/> Other: _____	

Where does applicant live?

<input type="checkbox"/> Home alone	<input type="checkbox"/> Home with parents
<input type="checkbox"/> Home with other family	<input type="checkbox"/> Group Home
<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> ICF/IID
<input type="checkbox"/> Assisted Care Living Facility	<input type="checkbox"/> Other CBRA
<input type="checkbox"/> Other: _____	

Present during interview: Family Individual Caregiver Home Health Guardian Other: _____

Describe how you were contacted and the services requested by applicant/ family member:

Medical Records to be submitted with assessment: None Home Health Records Hospital Records MD Records
 NF Chart ICAP maladaptive behavior assessment and score
 TABI Psychological Exam or other related documentation to support ID diagnosis
 Other _____

Section B: Functional Assessment

LEGEND
With the exception of behaviors (behaviors using the opposite scale) the following applies:
Always = Applicant can always perform the function without assistance.

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Usually = Applicant requires assistance 1-3 days per week.
Usually not = Applicant requires assistance 4 or more days per week.
Never = Applicant can never perform the function without assistance.

1. TRANSFER

Interview Questions:

Are you able to:

Sit down and get up from a chair by yourself? Always Usually Usually Not Never

Get in and out of the bed by yourself? Always Usually Usually Not Never

Get on/off toilet by yourself? Always Usually Usually Not Never

Do you require **physical assistance from another person** with any of the above? Yes No

Who provides this assistance? _____ Describe the assistance needed/ provided: _____

If physical assistance from another person is indicated; how many days per week? 1-3 4-6 7 NA

Supporting Medical Condition(s): _____

Transfer Observations: _____

2. MOBILITY

Interview Questions:

Are you able to walk (with or without assistive devices)? Yes No With Without

Are you able to use a wheelchair independently (manual or electric)? Yes No

Do you require **physical assistance** from another person with mobility? Yes No

Who provides assistance? _____ Describe how the person assists you _____

If physical assistance from another person is indicated; how many days per week? 1-3 4-6 7 NA

Assessor observation of applicant's gait:

Steady Shuffling Limp Unsteady Balance problems not observed

Deformities (specify) _____ Limb loss (specify) _____

Prosthesis (specify type and if used or not) _____

Supporting Medical Condition(s): _____

Mobility Observations: _____

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3. EATING

Interview Question:

Are you able to eat prepared meals by yourself? Yes No

If no, do you require assistance? Yes No Who provides assistance? _____

What kind of assistance does this person provide? Physical feeding Verbal assistance one on one observation

If assistance from another person is indicated; how many days per week? 1-3 4-6 7 NA

Do you have a feeding tube? No Yes if yes, are you able to administer tube feedings independently? Yes No

If no, how many days per week do you require **physical assistance** with your tube feedings? 1-3 4-6 7 NA

Supporting Medical Condition(s): _____

Eating Observations: _____

4. TOILETING

Interview Questions:

Are you able to clean yourself, including adjusting clothing, after toileting? Yes No

If no, # days per week: 1-3 4-6 7

If no, who provides this assistance? _____

Describe how the person assists you: _____

Maintain continence of bladder? No Yes if no, # days per week: 1-3 4-6 7

Maintain continence of bowel? No Yes if no, # days per week: 1-3 4-6 7

Are you able to clean yourself, including adjusting clothing, after an incontinence episode without physical assistance from another person? Yes No

If no, who provides this assistance? _____ Describe how the person assists you: _____

Do you use a catheter? Yes No NA

Do you have an ostomy? Yes No NA

If yes to either catheter/ostomy, can you manage without physical assistance from another person? Yes No

Who provides this assistance? _____ Describe how the person assists you: _____

Supporting Medical Condition(s): _____

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Toileting Observations: _____

5. ORIENTATION

Interview Questions:

Person

What is your full name? _____ Correct Yes No

Can you name the other people in the room? Yes No NA Correct? Yes No NA

OR

Can you name the people from photographs in the room? Yes No NA Correct? Yes No NA

Information confirmed with: _____

Place

Can you tell me where you are? _____ Correct Yes No

What is your street address/ room number? _____ Correct Yes No

What city/ town are you in? _____ Correct Yes No

Information confirmed with: _____

Event/Situation

Describe what you would do in case of an emergency: _____

Information (must be confirmed) confirmed with: _____

Is assistance required with orientation? Yes No If yes, # of days per week 1-3 4-6 7

If yes, who provides this assistance? _____

Describe how this person assists you: _____

Supporting medical condition(s) specific to orientation: _____

Orientation Observations: _____

6. COMMUNICATION

Interview Questions:

Can you make people understand when you need something? Yes No **Speech Impairment:** Yes No

Hearing : Adequate with/without devices Not Adequate with/without devices

Vision: Adequate with/without corrective lens Not adequate with/without corrective lens

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Give applicant a simple command within their functional ability (raise right hand, touch nose, point to your pen) and document ability to follow simple command: _____

Does the applicant say at least ten words that can be understood by someone who knows him/her or as observed during the interview process?

Did there appear to be any communication deficits while completing this interview? _____

Did applicant use communication assistive device (e.g., Ipad, picture board)? Yes No

If yes, list type: _____

Supporting Medical condition(s): _____

Communication Observations: _____

7. BEHAVIOR

Assessor Observed Behavior:

Level of Consciousness:

Cooperative

Uncooperative

Awake

Drowsy

Alert

Angry/irritable

Sociable

Oriented to:

Person

Place

Withdrawn

Is there a diagnosis which would lead to a cognitive impairment? Yes No If yes, list the diagnosis: _____

Behavioral Observations: _____

8. MEDICATIONS (INCLUDES: PO, IV, IM, ENTERAL, OPTICS, TOPICALS, INHALER, AND CONTINUOUS SQ PAIN)

Interview Questions:

Are you physically or cognitively able to self-administer physician prescribed medications by the routes listed below at the time prescribed? (Self-administration does not include reminding when to take medications, encouragement to take, reading medication labels, opening bottles, having them handed to you and/ or reassurance of the correct dose.) **If no, please indicate the prescribed medication on the line provided. If none prescribed via that route, please mark NA as appropriate.**

Pills/Tablets Yes No NA _____

Eye drops Yes No NA _____

Inhaler/Nebulizer Yes No NA _____

Topicals/Patches Yes No NA _____

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Injections Yes No NA _____

Meds via Tube (G Tube, J tube, NG tube...) Yes No NA

If no to above, who provides this assistance? _____ # days per week 1-3 4-6 7 NA

Describe assistance required: Reminders Encouragement Reading Labels Opening Bottles
 Someone hands them to me preparation of medication box Other: _____

Supporting Medical Condition(s): _____

Medication Observations: _____

Are you receiving any treatments that are ordered by a physician to be performed by a licensed Nurse/ Therapist?

Yes No NA

If yes, please describe the services being requested and attach the appropriate additional required documentation: _____

Section C: APPLICANT OR DESIGNEE SIGNATURE

I HEREBY ATTEST THAT I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED ON THIS DOCUMENT AND IT ACCURATELY REFLECTS THE RESPONSES I HAVE GIVEN DURING THIS ASSESSMENT. I ALSO UNDERSTAND THAT THE COMMENTS AND OBSERVATIONS ARE THOSE OF THE QUALIFIED ASSESSOR.

Applicant Signature: _____ Date: ____/____/____

Section D: ASSESSOR CREDENTIALS AND SIGNATURE

BY MY SIGNATURE, I AGREE THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION MAY BE USED TO DETERMINE MEDICAID ELIGIBILITY AND MAY ALSO BE USED BY A JUDGE TO MAKE A HEARING DECISION. I FURTHER UNDERSTAND THAT PEOPLE WHO LIE AND PROVIDE FALSE INFORMATION THAT WOULD POTENTIALLY RESULT IN A PERSON OBTAINING TENNCARE SERVICES TO WHICH HE/SHE IS NOT ENTITLED IS CONSIDERED AN ACT OF FRAUD AND MAY BE FINED OR SENT TO JAIL.

Printed Name: _____

Signature: _____ Credentials: _____

Date: _____ Assessor Code : _____