



HUMAN SERVICES
DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

DEPARTMENTAL MEMORANDUM

MAD-MR: 17-13

DATE: 12/7/2017

TO: MEDICAL ASSISTANCE DIVISION

FROM: NANCY SMITH-LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISION

THROUGH: SHARI ROANHORSE-AGUILAR, BUREAU CHIEF, EXEMPT SERVICES AND PROGRAMS BUREAU

BY: LINDA GILLET, BRAIN INJURY PROGRAM / ESPB

SUBJECT: BISF Service Coordination Assessment, MAD 387 Revised 9-08-17

GENERAL INFORMATION

This form is for use by the Contracted Service Coordination Agencies of the Brain Injury Services Fund for the purpose of completing assessments for approved participants to determine their service needs. The format was revised, based on MAD 098, using primary content from the original MAD 387, Issued 7/01/14, with subsequent minor revisions pursuant to testing in the field. The major substantive changes to MAD 387 include

- The incorporation of a scoring system to justify the assignment of Homecare hours, based on ADLs/IADLs with consideration of cognitive needs (Sections VIIC, D, E, F).
- Inclusion of specific direction for Behavioral Health supports (Section VIIA).
- Direction to SCs on making referrals for other service needs (Sections IV, V, VI, VII)
- Simplification of the Assessment Acknowledgment for signature by participants.
- Inclusion of Instructions for completion of the form (pages 16 and 17).
- Section III "Medicaid": Selections for "WDI" and "Full" were replaced with "Family Planning" and "QI1".
- Section IV: Additional field for historical information on prior brain injuries.
- Section V: Minor revision of language under "Participant has a primary caregiver" and for section on DME/AT, replacement of Commode chairs, ramp and hospital bed with "Grab Bars". "Reminder Devices" and "Medical Alert System".
- Changes in LSC scoring requirements on pages 7 and 12.
- Section VII: Addition of "Suicidal, violent or combative" and assessment of "Does client pose a risk to self or others?"

FILING INSTRUCTIONS

Please make the following changes to the MAD forms manuals:

INSERT MAD 387 Revised 09-08-17

DELETE MAD 387 Issued 07-01-14

Please address any questions concerning these guidelines to Lindab.gillet@state.nm.us or call (505) 827-7218.

Attachment: MAD 387 Revised 9-08-17 BISF Service Coordination Assessment

New Mexico Brain Injury Services Fund Program

SERVICE COORDINATION ASSESSMENT TOOL



I. DEMOGRAPHIC INFORMATION

Date of Assessment: _____		Assessment Conducted by: _____																					
Participant's Name: _____		Social Security Number: _____																					
Gender: <input type="radio"/> Female <input type="radio"/> Male		DOB: _____	Current Age: _____																				
Physical Address: _____		City: _____	State: _____ Zip: _____																				
Mailing Address: _____		City: _____	State: _____ Zip: _____																				
Phone Number: _____ Message Number: _____ Emergency Contact: _____ Phone Number: _____ Address: _____ _____		Informed Consent: Participant can provide informed consent <input type="radio"/> Yes <input type="radio"/> No Legal Authority: If participant cannot provide informed consent, identify who has authority to provide consent (check all that apply). Obtain a copy of documentation from the participant and place in participant's file. <input type="checkbox"/> General Durable Power of Attorney <input type="checkbox"/> Durable Power of Attorney for Health Care Decisions <input type="checkbox"/> Durable Power of Attorney for Financial Decisions <input type="checkbox"/> Treatment Guardian <input type="checkbox"/> Conservatorship <input type="checkbox"/> Legal Guardian																					
Ethnicity: (may check more than one) <input type="checkbox"/> Anglo <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other (specify) _____		List name, address and phone number of legal entity: Name: _____ Address: _____ Phone: _____																					
Language: (check all that apply) <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th></th> <th style="text-align: center;">Speak</th> <th style="text-align: center;">Read</th> <th style="text-align: center;">Write</th> </tr> </thead> <tbody> <tr> <td>English</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Spanish</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Native American</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>			Speak	Read	Write	English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spanish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Native American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Education: <input type="checkbox"/> GED <input type="checkbox"/> High School <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Vocational/Technical Training	
	Speak	Read	Write																				
English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
Spanish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
Native American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
List Language Preference: _____		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed																					

II. ASSESSMENT TYPE

Assessment Information - Information for assessment was obtained from: (check all that apply)

- Participant Spouse Legal Guardian
 Power of Attorney Care Attendant Other (specify) _____

Assessment Type:

- Initial Assessment Annual Re-assessment Assessment due to change in condition or situation
 Reactivation

Assessment Location:

- Current Residence Temporary Residence (non-institutional) Nursing Home Hospital
 Other: (specify) _____

III. FINANCIAL AND BENEFIT INFORMATION

Are you currently receiving any of the following?	If "yes", monthly amount:	If applied, when?
a. SSI	\$	
b. SSDI	\$	
c. Aid for Dependent Children	\$	
d. Veterans Benefits	\$	
e. Workman's Compensation	\$	
f. Vocational Rehabilitation	\$	
g. Private Disability Insurance Benefits	\$	
h. Food Stamps	\$	
i. General Assistance	\$	
j. HUD	\$	
k. Child Support	\$	
l. Any other benefits (explain):	\$	
m. Earned Income from working	\$	
TOTAL FINANCIAL BENEFITS:	\$	

Are you currently receiving any of the following?

Medicaid:

- QMB SLMB Family Planning QI1

Policy or Identification #: _____

Have you applied for Medicaid benefits? Yes No

Date of application: _____

Medicare:

- Part A Part B Part D

Policy or Identification #: _____

Private Insurance:

Name of carrier: _____

Policy or Identification #: _____

Indian Health Services (IHS):

Policy or Identification #: _____

COBRA:

Policy or Identification #: _____

Other:

Explain: _____

Assessor's Comments:

IV. MEDICAL INFORMATION / RISK FACTORS	
Name of Primary Care Physician (PCP):	Address and Phone Number:
Name of Secondary Physician:	Address and Phone Number:
Number of hospitalizations within the last 90 days: _____	Number of falls within the last 90 days: _____
Number of Brain Injuries: <input type="radio"/> One TBI <input type="radio"/> Multiple TBI's <input type="radio"/> ABI <input type="radio"/> Both TBI and ABI (Enter historical or updated information) Details: _____ ICD-10 code(s) for Brain Injury: _____	
Medical Conditions/Diagnoses/Risk Factors-Related to BI: <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Vestibular/Balance Issues <input type="checkbox"/> Spasticity/Tremors <input type="checkbox"/> Respiratory (<input type="checkbox"/> ventilator; <input type="checkbox"/> oxygen; <input type="checkbox"/> suctioning; <input type="checkbox"/> tracheotomy; <input type="checkbox"/> nebulizer) <input type="checkbox"/> Chemotherapy/Radiation <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	
Compliance with Care: <input type="radio"/> Compliant <input type="radio"/> Sometimes Non-Compliant <input type="radio"/> Frequently Non-Compliant <input type="radio"/> Resistive to Care Explanation/Example: _____	
Medical Conditions/Diagnoses-Not related to BI: _____	
Allergies: _____ Medication: _____ Food: _____ Environmental: _____	
Pain: <input type="radio"/> No pain <input type="radio"/> Occasional pain, but does not impact daily functioning <input type="radio"/> Moderate pain, impacts daily functioning intermittently <input type="radio"/> Severe pain, impacts daily functioning	
Sleep: <input type="radio"/> No sleep disturbances <input type="radio"/> Minor sleep disturbances, but does not impact daily functioning <input type="radio"/> Moderate sleep disturbances, impact daily functioning intermittently <input type="radio"/> Severe sleep disturbances, impacts daily functioning on a regular basis (For Moderate or Severe sleep disturbances, consider referral for sleep study through other payer sources and enter under "Other" on pages 13-14.	
Does the participant have access to BI-related medical care? <input type="radio"/> Yes <input type="radio"/> No (i.e. locating providers, attending appointments, transportation to medical appointments, etc.)	
Can the participant afford to pay for medical services? <input type="radio"/> Yes <input type="radio"/> No	
Referral to CIS for BI-Related Physician Co-payments is Indicated: <input type="radio"/> Yes <input type="radio"/> No	
Referral to CIS for Public or Private transportation is Indicated: <input type="radio"/> Yes <input type="radio"/> No	
*Referral to CIS for Alternative Therapies is Indicated: <input type="radio"/> Yes <input type="radio"/> No	
<i>* (alternative therapies are only available to participants within the first year of service)</i>	
IF "Yes", ENTER ON PAGES 13 – 14.	

V. IN-HOME SUPPORTS			
Name of Primary Caregiver:			
	Yes	No	Comments/Individual Service Plan Implications (Relationship of caregiver to person)
Participant has a primary caregiver: (An individual who is able to provide care for the participant when services are not otherwise being provided. This includes caregivers who are employed outside the home or reside elsewhere.)	<input type="radio"/>	<input type="radio"/>	
Participant lives alone	<input type="radio"/>	<input type="radio"/>	
Participant is homebound	<input type="radio"/>	<input type="radio"/>	
Participant Resides: <input type="radio"/> Alone <input type="radio"/> With Spouse/Partner/Family <input type="radio"/> Non-Relative <input type="radio"/> With Live-in Paid Caregiver(s) Specify names and relationship of Individual(s) who reside with person:	Participant's Ability to Remain Alone: <input type="radio"/> Does not require daily assistance and can be left alone 24 hours <input type="radio"/> Needs some daily assistance, but cannot be left alone at night <input type="radio"/> Needs daily assistance but can be left alone at night <input type="radio"/> Needs daily assistance but can be left alone for a few hours (less than 8 hours) <input type="radio"/> Needs 24 hour supervision		
Durable Medical Equipment(DME)/Assistive Technology(AT): Does the participant require DME/AT to remain independent in their home? <input type="radio"/> Yes <input type="radio"/> No What DME/AT does the participant currently use? <input type="checkbox"/> Wheelchair (manual) <input type="checkbox"/> Wheelchair (motorized) <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Grab Bars <input type="checkbox"/> Shower Chair/Bench <input type="checkbox"/> Reminder Device <input type="checkbox"/> Medical Alert System <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Other (specify): _____	Does the participant require DME/AT that they do not currently have access to, or own? <input type="radio"/> Yes <input type="radio"/> No If so, what DME/AT do they need? Can the participant afford to pay for BI-related DME/AT? <input type="radio"/> Yes <input type="radio"/> No		
Referral to CIS for BI-Related DME/AT is Indicated: <input type="radio"/> Yes <input type="radio"/> No IF "Yes", ENTER ON PAGES 13 – 14.			

VI. HOUSING AND ENVIRONMENTAL
Housing Type: (check all that apply) <input type="checkbox"/> House (rent) <input type="checkbox"/> House (own) <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile Home <input type="checkbox"/> Senior Housing <input type="checkbox"/> Subsidized Housing <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> None (homeless)
Does the participant have a safe home or a place to live? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the participant at risk of homelessness? <input type="checkbox"/> Yes <input type="checkbox"/> No
Referral to CIS for Emergency Housing Assistance is Indicated: <input type="radio"/> Yes <input type="radio"/> No IF "Yes", ENTER ON PAGES 13 – 14.

Safety or Accessibility Problems: Check the appropriate space to identify if a safety or accessibility problem exists or is likely to exist. Describe the potential problem in the Comments section.

Issue	Yes	No	Comments/Individual Service Plan Implications
Structural Damage/Dangerous Floors	<input type="radio"/>	<input type="radio"/>	
Structural Barriers to Access e.g. stairs or steps	<input type="radio"/>	<input type="radio"/>	
Electrical Hazards	<input type="radio"/>	<input type="radio"/>	
Fire Hazards	<input type="radio"/>	<input type="radio"/>	
Unsanitary Conditions/Odors	<input type="radio"/>	<input type="radio"/>	
Infestations of Insects or other Pests	<input type="radio"/>	<input type="radio"/>	
Poor Lighting	<input type="radio"/>	<input type="radio"/>	
Insufficient Hot Water	<input type="radio"/>	<input type="radio"/>	
Insufficient Heat/Air Conditioning Check Source(s) of Heat: <input type="checkbox"/> Gas <input type="checkbox"/> Wood <input type="checkbox"/> Electric	<input type="radio"/>	<input type="radio"/>	
Plumbing Problems	<input type="radio"/>	<input type="radio"/>	
Laundry Facilities in the home	<input type="radio"/>	<input type="radio"/>	If not in the home, distance to nearest laundry facility
Telephone in Home	<input type="radio"/>	<input type="radio"/>	If not in the home, distance to nearest telephone
Accessible Bathroom	<input type="radio"/>	<input type="radio"/>	
Accessible Entry/Exit	<input type="radio"/>	<input type="radio"/>	
Other Accessibility Issues (specify)	<input type="radio"/>	<input type="radio"/>	
Able to Evacuate in an Emergency	<input type="radio"/>	<input type="radio"/>	
Concerns about Participant Safety in the Home or Neighborhood	<input type="radio"/>	<input type="radio"/>	
Other (specify)	<input type="radio"/>	<input type="radio"/>	
Referral to CIS for EMod is Indicated: <input type="radio"/> Yes <input type="radio"/> No Referral to CIS for PLSC is Indicated <input type="radio"/> Yes <input type="radio"/> No ENTER ITEMS MARKED "Yes" ON PAGES 13 – 14.			

VII. PERSONAL SUPPORT ASSESSMENT

A. COMMUNICATION AND COGNITION

COMMUNICATION (check only one)

(the ability to express oneself in one's own language, including non-English languages, formal sign language or other generally recognized non-verbal communication, with or without the use of assistive technology)

- 0 Can fully communicate with no notable impairment
- 2 Can relay information, but struggles to carry on a conversation
- 5 Can communicate only basic needs to others
- 10 No effective communication

MEMORY (check all that apply)

- 0 No notable memory impairments
- 2 Usually able to remember most information with some assistance (prompting or cueing)
- 5 Unable to remember things over several days or weeks
- 10 Unable to recall things a few minutes later

COGNITION FOR DAILY DECISION MAKING (other than medications and finances, which are addressed in IADL section) (check only one)

- 0 Independent (can make and understand own decisions)
- 2 Needs some assistance in making or understanding decisions (reminding, planning, adjusting routine or cueing, but usually able to make routine decisions)
- 5 Needs moderate assistance (reminding, planning, adjusting routine or cueing, even with familiar routine)
- 10 Needs assistance from another person most or all of the time in order to be safe

VII.A. Communication and Cognition TOTAL _____

Referral to CIS SLP is Indicated (minimum score of 7): Yes No

Referral to LSC is Indicated in at least one area: Yes No

ENTER ITEMS MARKED "Yes" ON PAGES 13 – 14.

For scores ≥ 7 , consider a Neuropsychological Evaluation and enter under "Other" on pages 13-14.

VII. PERSONAL SUPPORT ASSESSMENT CONTINUED

B. BEHAVIORS/MENTAL HEALTH

Brain Injuries often result in changes in behavioral and mental health related to neurochemical and metabolic changes in brain function. When BISF Program participants understand that these changes are organic in nature and through no fault of their own, it may reduce the stigma associated with seeking Outpatient Mental Health supports. Refusal to engage such supports to address medically unmanaged depression, anxiety or other mental/behavioral health issues MUST be noted on any ILP and may affect continuation of services for those, who are unwilling to take the necessary steps that are helpful in improving day-to-day function and moving them out of crisis. Oftentimes, "referral for" Mental Health Therapy begins with a conversation; whereas, "referral to" APS or Crisis Intervention through Law Enforcement is non-negotiable.

SELF-INJURIOUS, SUICIDAL OR DISRUPTIVE BEHAVIOR (behaviors that cause or could cause injury to self or others) (check only one)

- 0 Not self-injurious, suicidal, violent or combative
- 2 Occasionally self-injurious, suicidal, violent or combative.
- 5 Frequently self-injurious, suicidal, violent or combative.
- 10 Chronically self-injurious, suicidal, violent or combative.

Comments _____

Does client pose a risk to self or others? Yes No

Referral for Mental Health Therapy is indicated (minimum score of 2 in this section): Yes No

Referral to Adult Protective Services (APS) is indicated: Yes No

Referral to local law enforcement Crisis Intervention Team is indicated: Yes No

MENTAL HEALTH NEEDS (check only one)

- 0 Has no current mental health diagnosis
- 2 Has current mental health diagnosis and is currently stable with or without medications.
- 5 Has current mental health diagnosis, is not regularly taking prescribed medications, and presents as unstable.
- 10 Has current mental health diagnosis and is currently not stable. Requires mental health services or supports regardless of whether services or supports are currently received.

Psychiatric Diagnoses: _____

Current Services: _____

Concerns: _____

Additional services recommended, but refused: _____

Referral for Mental Health Therapy is indicated (minimum score of 5 in this section): Yes No

SUBSTANCE ABUSE (check only one)

- 0 No active substance abuse problems at this time
- 2 History of substance abuse problem in the past 5 years. No evidence suggests a likelihood of recurrence with or without supports or interventions.
- 5 Person or others indicate(s) a current problem, or evidence suggests possibility of a current problem or high likelihood of recurrence without significant on-going support or interventions.
- 10 In the past year, the person has had significant problems due to substance abuse. Examples are police interventions, detox, inpatient treatment, job loss, major life changes.

Referral for Mental Health Therapy is indicated (minimum score of 5 in this section): Yes No

VII.B. Behaviors/Mental Health TOTAL _____

Referral to CIS for Mental Health Therapy is Indicated: Yes No

IF "Yes", ENTER ON PAGES 13 – 14.

VII. PERSONAL SUPPORT ASSESSMENT CONTINUED

C. ACTIVITIES OF DAILY LIVING (ADLs)

AMBULATION (check only one)

- 0 Independent (without any assistance)
 2 Needs some assistance (walks with assistive device, verbal cueing, or uses wheelchair)
 5 Needs moderate assistance (walks with the support of someone else)
 10 Needs total assistance

FALLS (check only one)

- 0 Independent (no episodes of falling)
 2 Needs some assistance (has fallen, but infrequently)
 5 Needs moderate assistance (averages 1– 5 falls a week)
 10 Needs total assistance (averages more than 5 falls a week)

TRANSFERS (check only one)

- 0 Independent (with or without special equipment, manual or electric wheelchair)
 2 Needs some assistance (verbal assistance or assistive device)
 5 Needs moderate assistance (regular standby or physical assistance)
 10 Needs total assistance (requires attendant and special equipment like transfer board or belt)

BLADDER (may check catheter, plus one other)

- 0 Independent
 2 Needs some assistance (incontinent 1 time per week or less)
 5 Needs moderate assistance (incontinent 2 times per week, but not daily)
 10 Needs total assistance (incontinent daily)
 Catheter (external/indwelling) – **Refer for private duty nursing services or other skilled service, per payer of last resort (Enter Page 13).**

BOWEL (may check specified bowel program, plus one other)

- 0 Independent
 2 Needs Some assistance (incontinent 1 time per week or less)
 5 Needs moderate assistance (incontinent 2 times a week, but not daily)
 10 Needs total assistance (incontinent daily)
 Specified bowel program, assisted or needs total assistance – **Refer for bowel and bladder services, private duty nursing services or other skilled services, per payer of last resort (Enter Page 13).**

Additional information (optional) _____

TOILETING (check only one)

- 0 Independent
 2 Needs some assistance (occasional assistance, cueing or prompting)
 5 Needs moderate assistance (regular assistance for some tasks)
 10 Needs total assistance

BATHING (check only one)

- 0 Independent
 2 Needs some assistance (occasional assistance, cueing or prompting)
 5 Needs moderate (regular assistance for some tasks)
 10 Needs total assistance

VII.C. ADLs Subtotal _____

Referral to CIS for PT/OT is indicated (minimum score of 4 with assistance required in at least 2 of above ADLs): Yes No

IF "Yes", ENTER ON PAGES 13 – 14.

VII. PERSONAL SUPPORT ASSESSMENT CONTINUED

D. ACTIVITIES OF DAILY LIVING (ADLs) cont...

GROOMING/HYGIENE (check only one)

- 0 Independent
 2 Needs some assistance (occasional assistance, cueing or prompting for bathing, teeth brushing, etc)
 5 Needs moderate assistance (regular assistance for some tasks)
 10 Needs total assistance

SKIN CARE (may check skin infections/ulcers, plus one other)

- 0 Independent
 2 Needs some assistance (preventative - lotion)
 5 Needs moderate assistance (significant skin issues)
 10 Needs total assistance (frequent repositioning)
 Skin infection/ulcers (bed sores) – **Refer for private duty nursing services or other skilled care, per payer of last resort (Enter Page 13).**

DRESSING (check only one)

- 0 Independent
 2 Needs some assistance (occasional assistance, cueing or prompting)
 5 Needs moderate assistance (regular assistance for some tasks)
 10 Needs total assistance

EATING (may check fed with nasal/gastric tube, plus one other)

- 0 Independent
 2 Needs some assistance (safety issues/cueing; e.g., do they forget to eat?)
 5 Needs moderate assistance (fed at all meals or special diet preparation)
 10 Needs total assistance
 Fed with nasal/gastric tube – **Refer for private duty nursing services or other skilled care, per payer of last resort (Enter Page 13).**

MEDICATIONS: (may check all medications set-up or administered, plus one other)

- 0 Independent
 2 Needs some assistance (reminders for medications or cueing)
 5 Needs moderate assistance (supervision and hand-over-hand assistance with medications)
 10 All medications need to be set-up or administered. **If yes, arrangements must be made or in place for the set-up and/or administration of medications.**

IMPACT OF DISABILITY ON OVERALL FUNCTIONING (cognitive and emotional) (check only one)	
<input type="radio"/> 0 No Impact <input type="radio"/> 2 Some Impact <input type="radio"/> 5 Moderate Impact <input type="radio"/> 10 Severe Impact Describe: _____	- 6
VII.D. ADLs Subtotal _____	
VII.C and VII.D. ADLs TOTAL (enter page 12) _____	

VII. PERSONAL SUPPORT ASSESSMENT CONTINUED	
E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)	
ANSWER TELEPHONE (pick-up phone and talk/listen)	
<input type="radio"/> 0 Independent <input type="radio"/> 2 Requires assistance <input type="radio"/> 4 Requires total assistance	
MAKE A TELEPHONE CALL (get phone, dial the number and talk/listen)	
<input type="radio"/> 0 Independent <input type="radio"/> 2 Requires assistance <input type="radio"/> 4 Requires total assistance	
SCHEDULE APPOINTMENTS AND PLAN PERSONAL EVENTS	
<input type="radio"/> 0 Independent <input type="radio"/> 2 Requires assistance <input type="radio"/> 4 Requires total assistance	
SHOPPING (choose, pick-up and carry items)	
<input type="radio"/> 0 Independent <input type="radio"/> 2 Requires assistance <input type="radio"/> 4 Requires total assistance	
TRANSPORTATION (arrange for transportation and get into/out of vehicle)	
<input type="radio"/> 0 Independent <input type="radio"/> 2 Requires assistance <input type="radio"/> 4 Requires total assistance	
PREPARE MEALS (use stove to prepare meals)	
<input type="radio"/> 0 Independent <input type="radio"/> 2 Requires assistance <input type="radio"/> 4 Requires total assistance	
HEATING PRE-PREPARED FOOD (use microwave or make a sandwich)	
<input type="radio"/> 0 Independent <input type="radio"/> 2 Requires assistance	

LAUNDRY (operate washer and dryer, load clothes, iron)
<input type="radio"/> 0 Independent <input type="radio"/> 2 Requires assistance <input type="radio"/> 4 Requires total assistance
LIGHT HOUSEKEEPING (dust, sweep, vacuum)
<input type="radio"/> 0 Independent <input type="radio"/> 2 Requires assistance <input type="radio"/> 4 Requires total assistance
VII.E. IADL TOTAL (enter in table below) _____
Life Skills Coaching is Indicated in at least one area: <input type="radio"/> Yes <input type="radio"/> No
IF "Yes", ENTER ON PAGES 13 – 14.

VII.F. PERSONAL SUPPORT ASSESSMENT CONTINUED

SCORING

Line	PERSONAL SUPPORT CATEGORY (ADLs and IADLs)	SCORE	REFERRAL TO: (regardless of payer source)
1.	VII.C+D. ADL TOTAL		<input type="checkbox"/> PT/OT (VII.C)
2.	VII.E IADL TOTAL		<input type="checkbox"/> LSC
3.	TOTAL for ADLs and IADLS (ADD LINES 1-2 ABOVE; see table below; enter hours at right and on page 13)		<input type="checkbox"/> Homemaker/ Companion # of Hours: _____

HOMEMAKER/COMPANION (HC) HOURS - (use total in line 3; check only one)		
Level of Need	Score	Number of HC Hours Indicated
<input type="radio"/> No Need	< 4	No HC services
<input type="radio"/> Minimal Need	4-30	3-5 hours of HC services per week
<input type="radio"/> Moderate Need	31-50	6-10 hours of HC services per week
<input type="radio"/> Extensive Need	51-70	11-15 hours of HC services per week
<input type="radio"/> Severe Need	71-90	16-20 hours of HC services per week

Note: If the Grand Total is >90, the participant's needs may be too great and other options including a nursing facility should be considered.

Referral to CIS for Homemaker/Companion services is Indicated: <input type="radio"/> Yes <input type="radio"/> No
IF "Yes", ENTER PAGE 13.

VIII. GOODS AND SERVICES			
Description of Goods/Services	Receiving Aid from Another Source (check if "yes")	CIS Aid Needed (check if "yes")	Hours, Frequency, Type
Homemaker (refer to pgs. 9-12 for details)	<input type="checkbox"/> Source: _____	<input type="checkbox"/>	Hrs/wk: _____ Hrs/mo: _____ Frequency: _____
Home Health Aide/Nursing	<input type="checkbox"/> Source: _____	<input type="checkbox"/>	Hrs/wk: _____ Hrs/mo: _____ Frequency: _____
Emergency Housing Costs	<input type="checkbox"/> Source: _____	<input type="checkbox"/>	Rent Only: _____ Deposit: _____ Utility Deposit: _____
Professional Organizer/Life Skills Coaching	<input type="checkbox"/> Source: _____	<input type="checkbox"/>	Hrs/wk: _____ Hrs/mo: _____ Frequency: _____
Environmental Modification	<input type="checkbox"/> Source: _____	<input type="checkbox"/>	Mod type: _____ _____
Physician Co-pay	<input type="checkbox"/> Source: _____	<input type="checkbox"/>	Frequency: _____ Co-pay: _____
Prescription Medications	<input type="checkbox"/> Source: _____	<input type="checkbox"/>	Pharmacy: _____
Respite Care	<input type="checkbox"/> Source: _____	<input type="checkbox"/>	Hrs/wk: _____ Hrs/mo: _____ Frequency: _____
Therapy <input type="checkbox"/> Physical <input type="checkbox"/> Occupational <input type="checkbox"/> Speech	<input type="checkbox"/> Source: _____	<input type="checkbox"/>	Hrs/wk: _____ Hrs/mo: _____ Frequency: _____
Alternative Therapy <input type="checkbox"/> Acupuncture <input type="checkbox"/> Massage <input type="checkbox"/> Chiropractic	<input type="checkbox"/> Source: _____	<input type="checkbox"/>	Hrs/wk: _____ Hrs/mo: _____ Frequency: _____
Psychotherapy/Outpatient Mental or Behavioral Health Services	<input type="checkbox"/> Source: _____	<input type="checkbox"/>	Hrs/wk: _____ Hrs/mo: _____ Frequency: _____
Automobile Retrofit	<input type="checkbox"/> Source: _____	<input type="checkbox"/>	Mod type: _____ _____

Assistive Equipment	<input type="checkbox"/>	<input type="checkbox"/>	Equip. type: _____ _____
Source: _____	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____ Frequency: _____
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	
Source: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Source: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Source: _____	<input type="checkbox"/>	<input type="checkbox"/>	

IX. ASSESSMENT SUMMARY

Short-Term vs. Long-Term Needs:

Participant Strengths:

Identified Barriers:

Solutions to Barriers

Concluding Comments on Participant Needs/Discharge Plan:

X. ASSESSMENT ACKNOWLEDGEMENT

Acknowledgement of Participation in the BISF Program Service Coordination Assessment

I willingly participated in the completion of this assessment.

I understand the purpose of the assessment and that it is needed to establish what my specific needs are.

I understand that the BISF program may not be able to cover all of the needs identified in this assessment.

I understand that my Service Coordinator will work with me to identify other resources that are available to cover some of the needs identified in this assessment.

By signing below, I, or my legal guardian, acknowledge that we have been informed about and understand the information reviewed with the Service Coordinator and willingly participated in the assessment process.

Assessor Printed Name:	Title:
Assessor Signature:	Date:

Participant Printed Name:	
Participant Signature:	Date:



Brain Injury Services Fund (BISF) Service Coordination Assessment Tool

Form Instructions

PURPOSE:

This form is for use by contracted Service Coordination Agencies of the Brain Injury Services Fund (BISF) Program. It is to be completed by Service Coordinators with BISF applicants and participants upon a) initial approval of Program eligibility; b) requests to continue services beyond one service year; c) reactivation of services following any period of service inactivation; and d) when updates are required due to changes in the participant's condition or situation.

INSTRUCTIONS:

- 1) Participants will be informed of purpose of the assessment as it pertains to the development of the ILP goals and identification of crisis needs and their right to not answer any assessment questions they choose. Participants will be informed that all services identified in the assessment are not guaranteed and are subject to geographic and funding limitations.
- 2) The Service Coordinator will assess for all areas listed on the assessment and complete the assessment with the participant and/or guardian, documenting all responses as well as information known to the Service Coordinator. The Service Coordinator will only leave sections blank in the event that the participant/guardian chooses not to answer.
- 3) Referrals are at the discretion of the Service Coordination Agency and not necessarily directed by the participant.
- 4) Sections IV, V, and VI include boxes for noted referrals to Crisis Interim Services (CIS).
- 5) Sections VII A-E include mechanisms for scoring and provide direction based on minimum scoring that will result in noted referrals.
- 6) Sections VII C and D relate to ADLs and IADLs. Total scores for ADLs and IADLs will be entered into Section VII.F and used to determine the level of need and corresponding number of Homecare hours.
- 7) All Goods and Services assessed as a need will be entered into Section VIII to document all identified Crisis Interim Services (CIS) that are needed to manage the participant's brain injury-related crisis needs. This section will also capture needs that will be paid using other payer sources.

- 8) The Service Coordinator will complete the Assessment Summary in Section IX to document short-term vs. long-term needs, participant strengths, identified barriers to progress, solutions to barriers, and concluding comments on participant needs / discharge plan.
- 9) The Service Coordinator and the participant/guardian will both sign the assessment in Section X once all questions have been completed.
- 10) Following the assessment, the Service Coordinator will use total scores to make service referrals to Crisis Interim Services or other payer sources, according to the service corresponding to the participant's total score.
- 11) Services can only be initiated for participants when the assessment is complete, all required signatures have been obtained and all other intake documents are signed and on file, including the Independent Living Plan (ILP).

ROUTING:

The assessment will be filed in the participant's master case record, along with any updated assessments, and will be referred back to as necessary.

FORM RETENTION:

Permanent.

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