HUMAN SERVICES
DEPARTMENT

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

DEPARTMENTAL MEMORANDUM
MAD-MR: 18-13
DATE: 9/7/2018

TO: **MEDICAL ASSISTANCE DIVISION**

FROM: NSL **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 AUGUST 2018**

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. This form was revised to include the following:

- Sections IV through VII: Language previously referring to "Referral to CIS for (name of service) now omits the phrase "to CIS".
- Page 13-14, Section VIII. Goods and Services:
  - "CIS Aid Needed" was changed to "CIS Referral Needed"
  - A column was added to indicate that the assessed service was declined by the participant or their representative
- Pages 16-17:
  - Instructions corresponding to the above were clarified in Items 4, 5, and 7.

FILING INSTRUCTIONS

Please make the following replacements in the Medical Assistance Forms Manual:

INSERT MAD 387 Revised August 2018
DELETE MAD 387 Issued 09-08-17

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

Attachment: MAD 387 Revised August 2018 BISF Service Coordination Assessment

New Mexico Brain Injury Services Fund Program

SERVICE COORDINATION ASSESSMENT TOOL

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

I. DEMOGRAPHIC INFORMATION

Date of Assessment:	Assessment Conducted by:		
Participant's Name:	Social Security Number:		
Gender: ☐ Female ☐ Male	DOB:	Current Age:	
Physical Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:

Phone Number: _____

Message Number: _____

Emergency Contact: _____

Phone Number:_____

Address:_____

_____

Ethnicity: (may check more than one)
☐Anglo
☐ African American
☐ Asian
☐ Hispanic
☐ Native American
☐ Other
(specify)_____

Language: (check all that apply)

	Speak	Read	Write
English	☐	☐	☐
Spanish	☐	☐	☐
Native American	☐	☐	☐
Other	☐	☐	☐

List Language Preference: _____

Informed Consent:
Participant can provide informed consent ☐Yes ☐ 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.
☐ General Durable Power of Attorney
☐ Durable Power of Attorney for Health Care Decisions
☐ Durable Power of Attorney for Financial Decisions
☐ Treatment Guardian
☐ Conservatorship
☐ Legal Guardian

List name, address and phone number of legal entity:

Name: _____

Address: _____

Phone: _____

Education:
☐GED
☐ High School
☐ Associate's Degree
☐ Bachelor's Degree
☐ Graduate Degree
☐ Vocational/Technical Training

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐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	$	9/7/2018
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: ☐ One TBI ☐ Multiple TBI's ☐ ABI ☐ 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:
☐Seizure Disorder ☐Vestibular/Balance Issues ☐Spasticity/Tremors
☐Respiratory (☐ventilator; ☐oxygen; ☐suctioning; ☐tracheotomy; ☐nebulizer)
☐Chemotherapy/Radiation
☐Other_____
☐Other_____
☐Other _____

Compliance with Care: ☐Compliant ☐Sometimes Non-Compliant ☐Frequently Non-Compliant ☐Resistive to Care
Explanation/Example: _____

Medical Conditions/Diagnoses-Not related to BI:

Allergies:
Medication: _____

Food: _____

Environmental: _____

Pain:
☐No pain
☐Occasional pain, but does not impact daily functioning
☐Moderate pain, impacts daily functioning intermittently
☐Severe pain, impacts daily functioning

Sleep:
☐No sleep disturbances
☐Minor sleep disturbances, but does not impact daily functioning
☐Moderate sleep disturbances, impact daily functioning intermittently
☐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? ☐ Yes ☐ No
(i.e. locating providers, attending appointments, transportation to medical appointments, etc.)

Can the participant afford to pay for medical services? ☐ Yes ☐ No

Referral for BI-Related Physician Co-payments is Indicated: ☐ Yes ☐ No
Referral for Public or Private transportation is Indicated: ☐ Yes ☐ No
***Referral for Alternative Therapies is Indicated: ☐ Yes ☐ No**

* *(alternative therapies are only available to participants within the first year of service)*
IF "Yes", ENTER ON PAGES 13 – 14.

Health and Safety Risks (check all that apply):

☐ No Risk Factors
☐ Person is currently failing or is at high risk of failing to obtain nutrition, self-care, or other safety issues
(Explain)_____
☐ There are statements or evidence of possible abuse, neglect, self-neglect, or financial exploitation. If yes, has APS been contacted? ☐ Yes ☐ No
(Explain) _____
☐ At imminent risk of institutionalization in a nursing home if needed assistance is not received.
(Explain) _____
Referral to APS is indicated: ☐ Yes ☐ No

Medication Administration:

☐ Self ☐ Family Member ☐ Non-Family Member ☐ Nurse ☐ Other (specify)_____

Medication Box Used: ☐ Yes ☐ No

If Yes, the medication box is prepared by: (check all that apply)

☐ Self ☐ Family Member ☐ Non-Family Member ☐ Nurse ☐ Other (specify) _____

Medications - List all prescription (Rx) medications the participant takes.

Name of Rx Medication	Dose	Method of Administration	Frequency	Reason for Taking Medication	Ordered By

Can the participant afford to pay for BI-related prescription medications? ☐ Yes ☐ No

Referral for BI-Related Prescription Medications is Indicated: ☐ Yes ☐ No
IF "Yes", ENTER ON PAGES 13 – 14.

V. IN-HOME SUPPORTS

Name of Primary Caregiver:

	Yes	No	Comments/Individual Service Plan Implications
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.)	☐	☐	(Relationship of caregiver to person)
Participant lives alone	☐	☐	
Participant is homebound	☐	☐	

Participant Resides: ☐ Alone ☐ With Spouse/Partner/Family ☐ Non-Relative ☐ With Live-in Paid Caregiver(s) Specify names and relationship of Individual(s) who reside with person:	Participant's Ability to Remain Alone: ☐ Does not require daily assistance and can be left alone 24 hours ☐ Needs some daily assistance, but cannot be left alone at night ☐ Needs daily assistance but can be left alone at night ☐ Needs daily assistance but can be left alone for a few hours (less than 8 hours) ☐ Needs 24 hour supervision
Durable Medical Equipment(DME)/Assistive Technology(AT): Does the participant require DME/AT to remain independent in their home? ☐ Yes ☐ No What DME/AT does the participant currently use? ☐ Wheelchair (manual) ☐ Wheelchair (motorized) ☐ Walker ☐ Cane ☐ Grab Bars ☐ Shower Chair/Bench ☐ Reminder Device ☐ Medical Alert System ☐ Other (specify): _____ ☐ Other (specify): _____	Does the participant require DME/AT that they do not currently have access to, or own? ☐ Yes ☐ No If so, what DME/AT do they need? Can the participant afford to pay for BI-related DME/AT? ☐ Yes ☐ No

Referral for BI-Related DME/AT is Indicated: ☐ Yes ☐ No
IF "Yes", ENTER ON PAGES 13 – 14.

VI. HOUSING AND ENVIRONMENTAL

Housing Type: (check all that apply)
☐ House (rent) ☐ House (own) ☐ Apartment ☐ Mobile Home ☐ Senior Housing ☐ Subsidized Housing
☐ Other (specify) _____ ☐ None (homeless)

Does the participant have a safe home or a place to live? ☐ Yes ☐ No

Is the participant at risk of homelessness? ☐ Yes ☐ No

Referral for Emergency Housing Assistance is Indicated: ☐ Yes ☐ 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	☐	☐	
Structural Barriers to Access e.g. stairs or steps	☐	☐	
Electrical Hazards	☐	☐	
Fire Hazards	☐	☐	
Unsanitary Conditions/Odors	☐	☐	
Infestations of Insects or other Pests	☐	☐	
Poor Lighting	☐	☐	
Insufficient Hot Water	☐	☐	
Insufficient Heat/Air Conditioning Check Source(s) of Heat: ☐ Gas ☐ Wood ☐ Electric	☐	☐	
Plumbing Problems	☐	☐	
Laundry Facilities in the home	☐	☐	If not in the home, distance to nearest laundry facility
Telephone in Home	☐	☐	If not in the home, distance to nearest telephone
Accessible Bathroom	☐	☐	
Accessible Entry/Exit	☐	☐	
Other Accessibility Issues (specify)	☐	☐	
Able to Evacuate in an Emergency	☐	☐	
Concerns about Participant Safety in the Home or Neighborhood	☐	☐	
Other (specify)	☐	☐	

Referral for EMod is Indicated: ☐ **Yes** ☐ **No**
Referral for PLSC is Indicated ☐ **Yes** ☐ **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 18-13

Referral for SLP is Indicated (minimum score of 7): ☐ **Yes** ☐ **No**
Referral for 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 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 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)
☐ 0 No Impact ☐ 2 Some Impact ☐ 5 Moderate Impact ☐ 10 Severe Impact Describe:
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)

☐ 0 Independent
☐ 2 Requires assistance
☐ 4 Requires total assistance

MAKE A TELEPHONE CALL (get phone, dial the number and talk/listen)

☐ 0 Independent
☐ 2 Requires assistance
☐ 4 Requires total assistance

SCHEDULE APPOINTMENTS AND PLAN PERSONAL EVENTS

☐ 0 Independent
☐ 2 Requires assistance
☐ 4 Requires total assistance

SHOPPING (choose, pick-up and carry items)

☐ 0 Independent
☐ 2 Requires assistance
☐ 4 Requires total assistance

TRANSPORTATION (arrange for transportation and get into/out of vehicle)

☐ 0 Independent
☐ 2 Requires assistance
☐ 4 Requires total assistance

PREPARE MEALS (use stove to prepare meals)

☐ 0 Independent
☐ 2 Requires assistance
☐ 4 Requires total assistance

HEATING PRE-PREPARED FOOD (use microwave or make a sandwich)

☐ 0 Independent
☐ 2 Requires assistance

LAUNDRY (operate washer and dryer, load clothes, iron)
☐ 0 Independent ☐ 2 Requires assistance ☐ 4 Requires total assistance
LIGHT HOUSEKEEPING (dust, sweep, vacuum)
☐ 0 Independent ☐ 2 Requires assistance ☐ 4 Requires total assistance
VII.E. IADL TOTAL (enter in table below) _____
Life Skills Coaching is Indicated in at least one area: ☐ Yes ☐ 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		☐ **PT/OT (VII.C)**
2.	VII.E IADL TOTAL		☐ **LSC**
3.	**TOTAL for ADLs and IADLS (ADD LINES 1-2 ABOVE; see table below; enter hours at right and on page 13)**		☐ **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**
☐ **No Need**	**< 4**	No HC services
☐ **Minimal Need**	**4-30**	3-5 hours of HC services per week
☐ **Moderate Need**	**31-50**	6-10 hours of HC services per week
☐ **Extensive Need**	**51-70**	11-15 hours of HC services per week
☐ **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: ☐ Yes ☐ No
IF "Yes", ENTER PAGE 13.

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

Assistive Equipment	☐	☐ Source: _____	☐	Equip. type: _____ _____
Transportation	☐	☐ Source: _____	☐	Type: _____ Frequency: _____
Other: _____	☐	☐ Source: _____	☐	**Type: _____ Frequency: _____**
Other: _____	☐	☐ Source: _____	☐	**Type: _____ Frequency: _____**

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:

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

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, which must correspond to entries under Section VIII, "Goods and Services".

5) Sections VII A-E include mechanisms for objective scoring and provide direction based on minimum scoring that will result in noted referrals or recommendations for referrals. If the scoring and scoring requirements indicate a need for the service, the "Yes" box will be checked.

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 or those that are specifically declined by the participant or their authorized representative.

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 submitted to HSD with any Exception Requests for Continued Services (MAD 400). It 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.
Original Issue: MAD 387 Issued 7/1/2014
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