

APPENDIX C
SOURCE ASSESSMENT ADDENDUM

Member: _____

Date: _____

1. Home Assessment:

List people who live in the home:

Name/Relationship	Age	Work: FT, PT, Night	Status: Permanent, Temporary, Intermittent	School: Yes or No

Is there usually someone with you at night? Y ____ N ____

Do you have someone who could stay with you if you were sick? Y ____ N ____

If yes, provide name and contact information: _____

Plans for evacuation or disaster: _____

2. Physical Environment:

Features:	Yes	No	Features:	Yes	No
Electrical hazards			Space heater(s)		
Stove/refrigerator on premises			Telephone		
Signs of careless smoking			Smoke detectors		
Washer/dryer on premises			Running water		
Other fire hazards			Indoor toilets		
Pets (specify)			Adequate ventilation		
Satisfied with living situation			Planning to move		

Comments: _____

3. Medications:

Pharmacy name and telephone number: _____

How do you get your medications? _____

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4. Psychosocial:

In the past year have there been any significant changes in your life, such as:

	Yes	No		Yes	No
Illness/injury			Change in marital status		
Change in job, residence			Victim of crime or Exploitation		
Losses or deaths			Other (specify)		

5. Advance Directives:

Do you have a signed Advance Directive? Yes ____ No ____

If yes, where is the copy kept? _____

Does the family know of the Advance Directive? Yes ____ No ____

6. Proxy Decision Makers:

Name: _____ Relationship: _____

Telephone: _____

Type: guardian ____ payee ____ power of attorney ____

7. Financial Information:

Monthly Income \$ _____

Social Security _____

SSI _____

Other _____

Checking Account? Yes ____ No ____

Savings Accounts? Yes ____ No ____

Who manages money for member? _____

8. Nutrition:

Has your doctor told you to eat a special diet? _____

Are you compliant with your diet order? Yes ____ No ____

Do you use alcohol? Yes ____ No ____; tobacco? Yes ____ No ____; or recreation drugs?

Yes ____ No ____

If yes, what drugs? _____

9. Home Monitoring:

If applicable, in addition to your doctor, who is responsible for monitoring ____ BS ____ BP

____ weight? ____ self care ____ others assisting _____

How often? _____

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List any monitoring equipment and supplies you have (blood pressure cuff, One-Touch type machine, scales, etc.)

10. Labwork:

Do you currently require any ongoing labwork/diagnostics or other medical procedures (blood machine, scales, etc)?

Procedure _____ Frequency _____

Reason _____ Provider _____

11. IADL/ADL:

Instrumental Activities of Daily Living

Category:	WHO helps and WHEN? (include ALL assistance – family/friends AND formal services)
Telephone	
Shopping	
Food preparation	Breakfast/Lunch/Supper
Housekeeping	
Laundry	
Mode of Transportation	
Medications	
Finances	

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Basic Activities of Daily Living – If assistance is required:

Category	WHO helps and WHEN? (ALL informal AND paid support)
Bed mobility:	
Transfer:	
Locomotion:	
Dressing:	
Eating:	
Toilet use:	
Personal hygiene:	
Bathing:	
Continence:	

Are existing caregivers willing/able to continue providing assistance at current levels?

Yes ____ No ____ Comments: _____

12. Physician Information

Doctor's Name _____ Phone No. (____) _____

Reason _____

Doctor's Name _____ Phone No. (____) _____

Reason _____

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13. Medical Treatment

Do you currently receive any of the following medical treatments? (If yes, list who provider and telephone number.)

Treatments:	Provider/Telephone Number:
Pressure sore treatment	
Wound or other skin care treatment	
Skilled therapy (PO/OT/speech)	
Colostomy/ostomy care	
Oxygen	
Other	

14. Other Programs

Cross reference with other programs:

15. Education

What is the highest grade completed in school? _____

16. Special Equipment

<input type="checkbox"/> Bed Rail	<input type="checkbox"/> Hospital Bed	<input type="checkbox"/> Incontinence pads
<input type="checkbox"/> Catheter	<input type="checkbox"/> High toilet seat	<input type="checkbox"/> Glasses
<input type="checkbox"/> Brace (back)	<input type="checkbox"/> Prosthesis _____	<input type="checkbox"/> Cane/walker
<input type="checkbox"/> Blood glucose monitor	<input type="checkbox"/> Adaptive eating equipment	<input type="checkbox"/> Grab bars
<input type="checkbox"/> Bathing equipment	<input type="checkbox"/> Bedside commode	<input type="checkbox"/> Other vision
<input type="checkbox"/> Lift (manual/electric)	<input type="checkbox"/> Wheelchair (manual/electric)	<input type="checkbox"/> Dentures
<input type="checkbox"/> Other _____		

Care Manager Signature _____ Date _____

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SOURCE SERVICES RECOMMENDED

Issues Noted	Services Recommended	Provider Assigned	Member Choice, PCP Choice, Rotation List	Frequency	Participant Feedback
			MC PC RL		
			MC PC RL		
			MC PC RL		
			MC PC RL		
			MC PC RL		

Member Signature

Date

Case Manager Signature

Date