DEPARTMENT OF HEALTH AND HOSPITALS
Aging and Adult Services

Community Choices Waiver (CCW)
Nursing/Therapy Evaluation Form

Caseworker _____
Phone _____
Email _____

Home Health Agency _____

Patient Name _____ Date of Birth _____

Address _____ Home Phone _____ Cell Phone _____

Language Barrier: ☐Yes ☐No If yes, explain:_____ Current Payer Source(s): ☐Medicare ☐Medicaid

Reason for Referral: _____

_____

Nursing	Physical Therapy	Occupational Therapy	Speech Therapy
• DX/Sig Medical Issues/	•DX/Functional Status_____	•DX/Functional Status_____	•DX/Functional Status _____
•Medication Issues (attach) __	•Physical Limitations _____	•Physical Limitations _____	•Physical Limitations r/t Swallowing/Feeding/Speech
•Recent Lab Values (attach)			
•Nutritional Assessment _____	•Mobility _____	•Mobility _____	
•Functional Status/Mobility			•Language/Cognitive Barriers
	•Adaptive Equipment _____	•Adaptive Equipment _____	•Adaptive Equipment_____
Cognitive Issues			
•Sensory _____	•Level of Assistance _____	•Level of Assistance _____	•Level of Assistance_____
•Family Support _____	•Fall/Injury Risk/Safety_____	•Fall/Injury Risk/Safety_____	•Risk for Complications ____
			•Motor Problems _____
•Fall/Injury Risk/Safety_____	•Teaching _____	•Teaching _____	
•Teaching _____			•Teaching _____
•Adaptive Equipment_____	☐ See Page 2	☐See Page 2	☐See Page 2
☐ See Page 2			
Environmental Eval/Main Living Area/Bathroom Access/Egress	*Environmental Eval/Main Living Area/Bathroom Access/Egress*	*Environmental Eval/Main Living Area/Bathroom Access/Egress*	*Environmental Eval/Main Living Area/Bathroom Access/Egress*

Evaluation Summary & Recommendation

Date Nursing/Therapy Assessment Performed: _____

Current Needs (Environmental, DME, other adaptive equipment/behaviors, services, etc.):

Recommended Plan Payer Source:_____

☐ Nursing* ☐ P.T. ☐ O.T. ☐ S.T.**

Significant Medical Issues/DX: _____

_____

*Medication Issues/Problems: _____

_____

*Nutritional Assessment:_____

Physical Limitations: _____

Functional Status/Mobility: _____

Adaptive Equipment: _____

**Language/Cognitive Barriers: _____

**Speech Motor Problems and Risk for Complications r/t Speech Therapy: _____

_____

Level of Assistance Needed: _____

Fall/Injury Risk and Safety Needs: _____

Family Support/Financial Issues: _____

Teaching: _____

_____

Environmental Evaluation/Main Living Area/Bathroom Access/Egress:

<u>To be completed by the Home Health Agency (HHA):</u>

Clinician Signature: _____ Date: _____

Clinician Title: _____

Name of HHA: _____Phone #: _____