DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL ASSISTANCE PERSONAL CARE SERVICES APPLICATION AND ASSESSMENT – DHMH 302

I. ASSESSMENT INFORMATION

A. Date of Assessment: _____ **B.** Initial_____ Annual_____ Re-Assessment_____

II. APPLICANT INFORMATION

A. Applicant's Name: Last_____ First_____ M.I.____
B. Address: _____
_____
C. Date of Birth: _____ Age:_____ **D.** Gender: □ M □ F
E. Telephone Number: _____ M.A.#: _____

THE STATE OF MARYLAND REQUESTS APPLICANTS TO PROVIDE THE FOLLOWING INFORMATION VOLUNTARILY. THIS INFORMATION WILL ONLY BE USED BY AUTHORIZED PROGRAM STAFF FOR STATISTICAL PURPOSES ONLY.

F. Racial/Ethnic Origin – Select one or more. If multiracial, select all that apply (see instructions for more specific descriptions):
□ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander
□ White

G. Are you Hispanic or Latino? □ Yes □ No

H. English-speaking? □ Yes □ No If no, primary language _____

I. Applicant chose not to provide information requested in F and G.

III. SOCIAL INFORMATION

A. Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Other _____

B. Living Arrangements: (check all that apply)

□ Alone
□ With family, relationship:_____
□ With other person who is: □ Disabled □ Frail Elderly □ Otherwise unable to give care
Specify: _____
□ With able person who works full time.
□ Assisted Living Facility: License#/Exp. Date: _____License Capacity:_____
□ Other _____

C. Responsible Relative/Guardian or Emergency Contact
Name: _____
Address: _____
Telephone #: _____Relationship: _____

D. Is there any person currently assisting the applicant with activities of daily living? □ Yes □ No If yes,
Name: _____
Address:_____
Telephone #: _____Relationship:_____

E. Is there any person the applicant recommends as a personal care provider? □ Yes □ No If yes,
Name: _____
Address: _____
Telephone #: _____Relationship:_____

F. Other services received and frequency**:**

1.
□ Medicaid Waiver Services_____ □ Nutrition Program for the Elderly _____
□ Homemaker/Chore Service _____ □ Adult Evaluation Service (AERS)_____
□ Senior Care Program (MDOA)_____ □ Adult Day Care Program_____
□ Multipurpose Senior Centers_____ □ Social Work Services (DSS)_____
□ Sheltered Housing_____ □ Meals On Wheels_____
□ Home Health_____ □ Mental Hygiene Administration (MHA)_____
□ Foster Care for Adults _____ □ Developmental Disabilities Admin. (DDA)_____
□ Other, Specify_____ □ None _____

2. Contact: _____ Contact: _____Contact: _____
Agency: _____ Agency: _____ Agency: _____
Telephone #: _____Telephone #:_____ Telephone #:_____

G. Has the applicant ever been determined eligible for any type of long–term institutional care?

□ Yes □ No □ Pending

If yes, specify date of determination and type of care: _____

H. Why is the applicant seeking personal care services? _____

_____

IV. FUNCTIONAL STATUS (COGNITIVE, MENTAL and PHYSICAL):

A. COGNITIVE STATUS:

	Yes	No
1. Applicant is able to state his/her name.		
2. Applicant is able to state his/her place of residence/address.		
3. Applicant is able to state current month/day/year.		
4. Telephone Utilization: Able to acquire telephone numbers, place calls, and receive calls without the assistance or supervision of another person.		
5. Medication Management: Able to administer the correct medication in correct dosage, at the correct frequency without the assistance or supervision of another.		

B. MENTAL HEALTH STATUS:

	Yes	No
1. Does applicant exhibit any of the following behaviors and/or have these behaviors been reported by another? (Wanders, hears voices, restless, acts agitated at times or at all times, lacks motivation, symptoms of depression no longer has interest in activities that interest them)		
2. Does applicant exhibit aggressive or abusive behavior and/or have these behaviors been reported by another? (Exhibits behavior that is harmful to self or others)		

C. VITAL SIGNS:

1. Vital signs at time of assessment:
Weight _____ Height _____ Temp. _____Pulse _____Blood Pressure_____ Respiration_____

D. MEDICATION: (Prescribed and Over-the-Counter; use additional sheet if needed)

MEDICATIONS	DOSAGE	ROUTE	FREQUENCY

E. Diet: _____

F. Allergies: _____

Name: _____ M.A. # _____

G. Assessment of Activities of Daily Living and Instrumental Activities of Daily Living

1. Dependency In Activities Of Daily Living (ADL)	**Self Care**	**Needs Assistance**	**PC Provided By**	**Frequency MAPC Service**	**Comments**
a. Transfer(hoist/lift): ☐ Bed ☐ Chair ☐ Commode ☐ Tub ☐ Wheelchair			☐ PC Aide ☐ Family		
b. Mobility – Devices Used: ☐ Artificial Limb ☐ Braces ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ None Other (Describe):			☐ PC Aide ☐ Family		
c. Bath: ☐ Bed-bath ☐ Shower ☐ Sink ☐ Tub Other (Describe):			☐ PC Aide ☐ Family		
d. Medication Reminder: ☐ A.M. ☐ Mid-Day ☐ P.M.			☐ PC Aide ☐ Family		
e. Grooming: ☐ Dental ☐ Hair Care ☐ Nails ☐ Shaving ☐ Skin Care Other (Describe):			☐ PC Aide ☐ Family		
f. Toileting (Bed Pan and Commode): A. Bowels: ☐ Constipation ☐ Diarrhea ☐ Impaction ☐ Incontinent ☐ Ostomy ☐ Training ☐ No Problem B. Bladder: ☐ Catheter ☐ Incontinent ☐ Retention ☐ Training ☐ No Problem Other (Describe):			☐ PC Aide ☐ Family		
g. Dressing (Assist with): ☐ Buttons ☐ Hooks ☐ Shoelaces ☐ Zippers Other (Describe):			☐ PC Aide ☐ Family		
h. Eating: A. Feeding ☐ By Mouth ☐ Parenteral ☐ Tube Feeding B. Meal Preparation ☐ Cut Food ☐ Prepare Special Diet Other (Describe):			☐ PC Aide ☐ Family		
2. Instrumental Activities Of Daily Living (IADL)					
a. Monitor Safety with:			☐ PC Aide ☐ Family		
b. Assist with Household Services: ☐ Change Bed Linens ☐ Laundry ☐ Make Bed ☐ Straighten Living and Kitchen Area			☐ PC Aide ☐ Family		
c. Escort: ☐ Shopping (Food and Clothing) ☐ Clinic/Doctor's Appointment ☐ Workplace			☐ PC Aide ☐ Family		
d. Other (Describe):					

V. WORKPLACE INFORMATION

A. Does the applicant work? ☐ Full-time or ☐ Part-time
Name and location of work site:_____
Workdays and hours:_____

B. Does the applicant need personal care in the workplace? ☐ Yes ☐ No
If yes, please list ADLs and IADLs required and frequency needed: _____
_____

C. Are there additional supports available in the workplace? ☐ Yes ☐ No
If yes, list additional supports: _____

VI. MEDICAL INFORMATION

Is the applicant under the care of a physician? ☐ Yes ☐ No If yes,
Physician's Name: _____ Phone Number: _____
Physician's Address: _____
Diagnoses and Significant Past Medical History (list all chronic medical conditions that apply to applicant): _____
_____
_____

VII. REFERRALS TO OTHER SERVICES: _____

VIII. APPLICANT CERTIFICATION

This is to certify that I am requesting personal care services and that the above information is true, accurate and complete to the best of my knowledge and belief. I understand that services under the Personal Care Services Program will be paid for by the federal and State governments and that any false claims, statements, documents or concealment of material facts will be prosecuted under applicable federal and State laws.

Signature:_____ Date: _____
(APPLICANT OR APPLICANT'S REPRESENTATIVE)

Witness:_____ Date: _____

IX. CASE MONITOR'S INFORMATION AND CERTIFICATION

A. Case Monitor's Name: _____ Agency:_____
B. Jurisdiction: _____
C. Telephone Number: _____
D. Assessed Level of Service and Frequency: _____

E. This is to certify that the above information is accurate and complete to the best of my knowledge and professional judgment.

Case Monitor's Signature: _____ Date: _____

X. AUTHORIZATION OF SERVICE:

☐ Approved ☐ Disapproved

Justification (Level is based on the complexities of ADL and IADL, frequency of services, degree of dependency of recipient and lack of support system):

Level _____ Frequency_____

Signature of Coordinator or Supervisor:_____ Date:_____