

Senior Health Insurance Company of Pennsylvania
CLAIMANT CARE NEEDS ASSESSMENT FORM

Instructions: TO BE COMPLETED BY A LICENSED CLINICIAN. If no licensed clinician is available, please provide the title and credentials at the bottom of the form. This information is necessary for the processing of your resident's long-term care claim. Please answer the questions thoroughly. If the resident requires medication administration by facility staff, please attach the current Medication Administration Record. Please complete and return form via fax to 952-983-5256 (preferred) or mail to: Senior Health Insurance Company of Pennsylvania, P.O. Box 64913, St. Paul, MN 55164.

Facility Name: _____	Resident Name: _____
Facility Address: _____	Resident Policy #: _____
Facility City/State: _____	Resident Room #: _____
Facility Phone #: _____	Resident Move-In _____
Facility Fax #: _____	Date: _____

1. Indicate the **current level of assistance in place** with the following Activities of Daily Living (ADLs). Use the following guide to indicate the level of assistance being provided by facility staff on a regular basis:
- 1 = No assistance is provided, resident is Independent
 - 2 = Resident uses equipment, does not receive assistance from another person
 - 3 = Receives cueing/prompting to initiate or complete the ADL due to memory loss
 - 4 = Receives stand-by assistance (person within arm's reach) from another person to complete the ADL
 - 5 = Receives hands-on assistance from another person to complete some or all of the ADL
 - 6 = Unable to participate in any part of the ADL

ACTIVITIES OF DAILY LIVING	LEVEL <i>(use key above)</i>	FREQUENCY
Bathing		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly
Dressing		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly
Toileting		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly
Transferring		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly
Incontinence		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly
Eating (does not include meal preparation)		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly
ADDITIONAL CARE NEEDS	LEVEL <i>(use key above)</i>	FREQUENCY
Mobility/Ambulation (indoors only)		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly
Medication Administration		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly

2. What is the resident's primary diagnosis? _____
3. Are the resident's medications being administered by staff (facility stores, sets up, dispenses medications and maintains a Medication Administration Record)? Yes No
- a. **If administered by staff**, are medications administered because this resident requires assistance or because assistance is provided to all residents? Medication admin is provided to all residents
- If resident requires medication administration, why? Medication admin is required
- b. **If not administered** by staff, indicate the current medication administration arrangement (e.g., resident administers own medication, staff does medication reminders, staff sets up meds, family does medication set-ups, etc.). _____
4. Select the type of room that best describes the resident's housing situation at the facility (select only one):
- Alzheimer's/Dementia unit (secured)
 - Alzheimer's/Dementia unit (non-secured)
 - Assisted living unit (secured)
 - Assisted living unit (non-secured)
 - Independent living apartment or unit

5. Does the resident have a known formal diagnosis of cognitive impairment? Yes No
(If yes, proceed to question 5a. If no, proceed to question 10).
- a. Provide the cognitive impairment diagnosis: _____
- b. How was that cognitive impairment confirmed (by testing, physician diagnosis etc.)? _____
- i. If confirmed through testing, has the facility completed a MMSE or other cognitive test? Yes No
 If yes, provide exam name, score and date of exam: _____

- If confirmed by diagnosis, doctor's name: _____

- c. Is supervision for safety or other safe guards addressed in the resident's service plan? Yes No
- i. If no, why not? _____
- ii. If yes, describe (indicate all that apply): Locked unit or security code to enter/exit
 Staff at door to prevent egress
 Wanderguard or similar device
 Personal supervision through a one-to-one caregiver or family member
 Alarmed doors
 Fenced exterior
 Other: _____
6. Does the resident take any dementia medication(s)? Yes No
- a. If yes, what medication(s)? _____
- b. If response to #6 was "yes" and the response to #3 was "no", who administers dementia medications? _____

7. Is there a physician order in place to ensure resident does not leave the premises without escort? Yes No
8. If resident is not on a secured unit, does the resident have an escort when leaving the facility? Yes No
9. Does the resident need assistance to evacuate in the event of an emergency? Yes No
10. Is the resident prevented from or unable to drive? Yes No
11. **Is the information in this form consistent with the facility's current service plan for this resident?** Yes No
 If no, explain all discrepancies: _____

By signing below, I declare that all of the answers given are complete and true to the best of my knowledge and belief.

Signature: _____ Date: _____

Printed Name and Title: _____ Phone # _____

Professional Credentials: RN LPN/LVN Med Tech Not professionally credentialed Other _____