

**NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION
DISABLED AND ELDERLY WAIVER PROGRAM**

Comprehensive Individual Assessment (CIA)

See the CIA Instruction Manual (MAD 099) for detailed information to complete this document.

I. DEMOGRAPHIC INFORMATION																							
Date of Assessment		Assessment Conducted by																					
Person's Name		Social Security Number																					
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male	DOB	Current Age																				
Physical Address		City	State Zip																				
Mailing Address		City	State Zip																				
Directions to Physical Address		Phone Number																					
		Message Number																					
		Ethnicity (may check more than one) <input type="checkbox"/> Anglo <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other (specify) _____																					
Language (check all that apply) <table border="0" style="width: 100%;"> <tr> <td></td> <td style="text-align: center;">Speak</td> <td style="text-align: center;">Read</td> <td style="text-align: center;">Write</td> </tr> <tr> <td>English</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Spanish</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Native American</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>			Speak	Read	Write	English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spanish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Native American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convey Needs - Person can convey needs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes If Yes or Sometimes, indicate mode of communication (check all that apply) <input type="checkbox"/> Verbal <input type="checkbox"/> Sign Language <input type="checkbox"/> Gestures <input type="checkbox"/> Communication Board <input type="checkbox"/> Interpreter <input type="checkbox"/> Other (specify) _____	
	Speak	Read	Write																				
English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
Spanish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
Native American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
List Language Preference																							
II. CONSENT and ADVANCE DIRECTIVES																							
Informed Consent - Person can provide informed consent <input type="checkbox"/> Yes <input type="checkbox"/> No																							
Legal Authority - If person cannot provide informed consent, identify who has authority to provide consent (check all that apply). Obtain a copy of documentation from the client and place in client's file. List name, address and phone number of legal entity.																							
<input type="checkbox"/> General Durable Power of Attorney <input type="checkbox"/> Durable Power of Attorney for Health Care Decisions <input type="checkbox"/> Durable Power of Attorney for Financial Decisions		<input type="checkbox"/> Conservatorship <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Treatment Guardian																					
Name: _____		Address: _____																					
Phone Number: _____		_____																					
Advance Directives - Check all existing advance directives <input type="checkbox"/> Living Will <input type="checkbox"/> Do Not Resuscitate (DNR) Directive <input type="checkbox"/> EMS/DNR <input type="checkbox"/> None Identified																							

Name:	Social Security Number:
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III. ASSESSMENT TYPE

Assessment Information - Information for assessment was obtained from		
<input type="checkbox"/> Person	<input type="checkbox"/> Spouse	<input type="checkbox"/> Legal Guardian
<input type="checkbox"/> Power of Attorney	<input type="checkbox"/> Attendant	<input type="checkbox"/> Other (specify) _____
Assessment Type		
<input type="checkbox"/> Initial Assessment	<input type="checkbox"/> Annual Assessment	
<input type="checkbox"/> Assessment due to change in condition or situation (or by request)		
Assessment Location - Assessment was conducted at		
<input type="checkbox"/> Current Residence	<input type="checkbox"/> Temporary Residence (non-institutional)	
<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Hospital	<input type="checkbox"/> Other: (specify) _____

IV. THIRD PARTY LIABILITY

Medicare Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date Part B <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date Medicare Number	Private Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date If Yes, Company Name and Policy Number Describe private insurance coverage and limitations:
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V. MEDICAL INFORMATION

Name of Primary Care Physician (PCP)	Address and Phone Number
Name of Secondary Physician	Address and Phone Number

Medical Diagnoses – As listed on the Level of Care (ISD 379)

Medical History - Include pertinent information and past surgeries

Medications Administered – Individual who administers medication (check all that apply)

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) _____

Name:	Social Security Number:
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V. MEDICAL INFORMATION CONTINUED

Medications - List all prescription (Rx) medications the person takes. (Use page 7 for additional space.) **Note that medications should not be administered from this list.** Medication information was obtained from
 Person Medication Bottle or Container Other (specify) _____

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

List all over-the-counter medications the person takes. Include herbal and homeopathic remedies, vitamins, nutritional supplements and eye drops (use page 7 for additional space). Medication information was obtained from
 Person Medication Bottle or Container Other (specify) _____

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

Allergies - List all allergies (Note food allergies are listed under Section IX. Nutrition)
Medication
Environmental

Medication Review
PCP reviews/monitors all medications Yes No
If Yes, date of last review

If No, list physician(s) responsible for reviewing/monitoring all medications
Date of last review

Name:	Social Security Number:
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VI. MEDICAL RISK FACTORS

Medical Risk Factors - Assess the medical risk factors listed below. Place a checkmark or X in the appropriate column for each Medical Risk Factor. For any Yes response, specify risk factor and subsequent implications for the Individual Service Plan in the Comments column.

Medical Risk Factor	Yes	No	Comments/Individual Service Plan Implications
Ambulation			
Range of Motion Exercises			
Clinical Monitoring by RN (check all that apply) <input type="checkbox"/> Is unable to respond to medical risk(s) <input type="checkbox"/> Does not know contributing factors or corrective actions for risk(s) <input type="checkbox"/> Has history of failure to self-manage health resulting in multiple ER visits or hospitalization			
Medication Management			
IV Medications, Fluids or IV Line Flushes (Groshong, Hickman catheters, Portacath Care)			
Intravenous (IV) Therapy, Total Parenteral Nutrition (TPN)			
Chemotherapy			
Transfusions			
Pain Control			
Specialized Skin Care			
Wound Care			
Decubiti Care			
Tube Feeding (syringe, PEG, PEJ)			
Bladder Program			
Dialysis			
Ostomy Related Skilled Services			
Bowel Program			
Oxygen or Other Respiratory Therapy			
Suctioning			
Tracheostomy Care			
Radiation			
Universal Precautions (Should be in place for ALL clients)			
Visual Deficit			
Hearing Loss			
Diabetic Testing or Injections			
Hospitalization in the Last 90 Days			
Outpatient Hospital Services in the last 90 days (Include Emergency Room visits)			
Other (specify)			

Name:	Social Security Number:
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VII. SUPPORT AND SOCIAL RESOURCES

Primary Caregiver				
	Yes	No	Comments/Individual Service Plan Implications (Relationship of caregiver to person)	
Person has a primary caregiver (An individual who is able to provide care for the person when waiver services are not being provided. This includes caregivers who are employed outside the home or reside elsewhere.)				
Person lives alone				
Person is homebound				
Another household member receives waiver services.			(Who and what waiver)	
Person Resides <input type="checkbox"/> Alone <input type="checkbox"/> With Spouse/Partner/Family <input type="checkbox"/> Non-Relative <input type="checkbox"/> With Live-in Paid Caregiver(s) <input type="checkbox"/> In Assisted Living Facility Specify names and relationship of Individual(s) who reside with person:	Person's Ability to Remain Alone <input type="checkbox"/> Does not require daily assistance and can be left alone 24 hours <input type="checkbox"/> Needs some daily assistance, but cannot be left alone at night <input type="checkbox"/> Needs daily assistance but can be left alone at night <input type="checkbox"/> Needs daily assistance but can be left alone for a few hours (less than 8 hours) <input type="checkbox"/> Needs 24 hour supervision			
Current supports - Identify whether current supports are available, the frequency of supports in a typical week (or other frequency if supports not provided weekly) and relationship of individual who provides current support.				
	Yes	No	Frequency of Supports (Per Week)	Comments/Individual Service Plan Implications
Personal care assistance (bathing, dressing, getting out of bed, toileting or eating)				
Housekeeping (laundry, cleaning, meal preparation)				
Home delivered meals				
Transportation				
Companionship				
Shopping/errands				
Therapy Services (physical, speech, occupational)				
Money management assistance				
Adult day healthcare				
Durable medical equipment/ Assistive Device (specify)				
Other (specify)				
Person requires new or additional services (specify)				
Changes that have occurred that require the addition of services				

Name:	Social Security Number:
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VIII. ENVIRONMENTAL ASSESSMENT

Housing Type (check all that apply)
 House Apartment Mobile Home Other (specify) _____
 Senior Housing Subsidized Housing

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: <input type="checkbox"/> Gas <input type="checkbox"/> Wood <input type="checkbox"/> Electric			
Plumbing Problems			
Laundry Facilities			If not in the home, distance to nearest laundry facility
Accessible Shopping			Distance to nearest grocery store
Accessible Transportation			
Accessible Bathroom			
Accessible Entry/Exit			
Other Accessibility Issues (specify)			
Telephone in Home			If not in the home, distance to nearest telephone
Able to Evacuate in an Emergency			
Concerns about Her/His Safety in the Home or Neighborhood			
Other (specify)			

Name: _____	Social Security Number: _____
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IX. NUTRITION

Current weight _____ <input type="checkbox"/> Actual <input type="checkbox"/> Estimate	Weight Change - There has been a 10-pound weight change in the last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No
Height _____ <input type="checkbox"/> Actual <input type="checkbox"/> Estimate	If Yes, specify <input type="checkbox"/> gain <input type="checkbox"/> loss Reason for gain or loss _____ _____

Eating Issues - Identify any of the following problems the person may have that make it difficult to eat.

Issue	Yes	No	Comments/Individual Service Plan Implications
Swallowing Problems			
Tube Fed (specify) <input type="checkbox"/> Naso Gastric Tube <input type="checkbox"/> Stomach Feeding Tube PEG, PEJ			
Tooth or Mouth Problems			
Nausea			
Taste Problems			
Unable to Eat Certain Foods			
Food Allergies			List allergies
Doctor-ordered Diet (specify) <input type="checkbox"/> Low Sodium <input type="checkbox"/> Low Fat <input type="checkbox"/> Low Sugar <input type="checkbox"/> Diabetic/Low Sugar <input type="checkbox"/> Calorie/Nutritional Supplement <input type="checkbox"/> Other Special Diet (specify) _____			

Typical Meals - Briefly describe what the person eats and drinks during a typical day.

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Notes _____

Name:	Social Security Number:
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X. HOMEMAKER ASSESSMENT

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

COMPLIANCE WITH CARE (check only one)

- 0 Compliant
- 2 Sometimes non-compliant with care
- 5 Frequently non-compliant with care
- 10 Resistive to care

Explanation/example _____

Communication and Cognition TOTAL _____

Name: _____ Social Security Number: _____

X. HOMEMAKER ASSESSMENT CONTINUED

BEHAVIORS/MENTAL HEALTH

SELF-INJURIOUS OR DISRUPTIVE BEHAVIOR (behaviors that cause or could cause injury to self or others) (check only one)

- 0 Not self-injurious and does not have any disruptive or violent behavior
- 2 Some self-injurious, violent, disruptive and/or combative behaviors that require occasional interventions weekly or less
- 5 Frequent self-injurious, violent, disruptive and/or combative behaviors that require interventions every day, but not always one-on-one
- 10 Self-injurious, violent, disruptive and/or combative behaviors that require one-on-one interventions most awake hours

Comments _____

MENTAL HEALTH NEEDS (check only one)

- 0 Has no current mental health diagnosis
- 2 Has current mental health diagnosis and is currently stable without medications.
- 5 Has current mental health diagnosis and is currently stable with medications.
- 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.

Current Diagnosis (specify) _____

Current services _____

Concerns _____

Additional services recommended: _____

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.

HEALTH AND SAFETY RISKS (check all that apply)

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

Behaviors/Mental Health TOTAL _____

Name:	Social Security Number:
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X. HOMEMAKER ASSESSMENT CONTINUED

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) - **Person must have bowel and bladder services, private duty nursing services or other skilled service.**

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 - **Person must have bowel and bladder services, private duty nursing services or other skilled services.**

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

ADLs Subtotal _____

Name:	Social Security Number:
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X. HOMEMAKER ASSESSMENT CONTINUED

ADLs CONTINUED

GROOMING/HYGIENE (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

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) - **Person must have private duty nursing services or other skilled care**

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)
- 5 Needs moderate assistance (Fed at all meals or special diet preparation)
- 10 Needs total assistance
- Fed with nasal/gastric tube - **Person must have private duty nursing services or other skilled care**

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)
- All medications need to be set-up or administered. **If yes, arrangements must be made for private duty nursing services or other non-waiver services for set-up and/or administration of medications.**

IMPACT OF DISABILITY AND DISABILITY-RELATED BEHAVIORS ON ADLs (check only one)

- 0 No Impact
 - 2 Some Impact
 - 5 Moderate Impact
 - 10 Severe Impact
- Describe: _____

ADLs Subtotal _____

ADLs TOTAL _____

Name:	Social Security Number:
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X. HOMEMAKER ASSESSMENT CONTINUED

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

IADL TOTAL _____

