## Member Assistance Tool

**Member Name:**

**Medicaid #:**

**Date of Assessment:**

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<tr>
<th>Task</th>
<th>Frequency/Day</th>
<th>Minutes/Task</th>
<th>Days/Week</th>
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### Personal Assistance Level 1

1. Routine House Cleaning
2. Laundry
3. Shopping/Errands
4. Transportation/Escort
5. Meal Preparation
6. Other

### Personal Assistance Level 2

1. Eating/Feeding
2. Bathing
3. Dressing (Upper and Lower Body)
4. Grooming/Personal Hygiene
5. Toileting
6. Ambulation
7. Bed Mobility/Transfers
8. Manual Wheelchair Mobility
9. Medication Assistance
10. Other

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<tr>
<th>SUBTOTAL MINUTES/WEEK</th>
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### Total Minutes of Care Required/Week

### Total Minutes of Care Performed by Unpaid Support System/Week

### Total Minutes of Care Performed by Health Plan Provider/Week

### Total Hours of Care Performed by Health Plan Provider/Month (based on 7Days/Week x 31Days/Month)

**Justification for Allocation of Hours:**

**Assessor Signature**

**Print Name/Title**