STATE OF HAWAII
Long Term Services and Support (LTSS)
ADULT LTSS REASSESSMENT TOOL
18 years and older

Instructions: *Compile information from health plan records and address changes from previous assessment. Refer to ADULT LTSS ASSESSMENT INSTRUCTIONS for information on completing the appropriate sections. If there are no changes, check box "No Changes"*

SECTION A. ADMINISTRATIVE INFORMATION

A1. Member

a. Member Name	b. Date of Birth	c. Medicaid ID#
_____ Last First MI	/ /	

A2. Assessment

a. Reason for Assessment
1. HCBS Reassessment
- ☐ Three (3) months
- ☐ Six (6) months
- ☐ Nine (9) months

2. NF Reassessment
- ☐ Six (6) months

b. Assessment Reference Information
- ☐ 1. Date / /
- ☐ 2. Time __:__ ☐ AM ☐ PM
- ☐ 3. Location:
- ☐ 4. Identify any safety issues that a SC may encounter during the assessment.

c. Assessor
1. Assessor Name:
2. Title:

d. Other Individual(s) at the Assessment
1. Is there a legal guardian, or representative assisting in the assessment? ☐ Yes ☐ No
2. Name of Individual: Relationship to Member:
3. Name of Individual: Relationship to Member:
4. Name of Individual: Relationship to Member:
5. Name of Individual: Relationship to Member:

A3. Legal Information ☐ No Changes

Comments:

SECTION B. DEMOGRAPHIC INFORMATION

Comments:

SECTION. C MEDICAL INFORMATION

C1. Disease Diagnosis(es) ☐ No Changes

a. Disease Diagnosis(es)

List Disease Diagnosis(es)	ICD Code	Date of Onset
		/ /
		/ /
		/ /
		/ /
		/ /

C2. Medications ☐ No Changes

Medication Name	Indication	Dose	Route	Frequency	Prescribing Physician/Provider	Compliant	Comments
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	

C3. Treatments and Therap(ies) ☐ No Changes

a. List Treatment(s) and Therapy(ies)

Treatment/Therapy	Prescribing Physician/Provider	Provider/Agency	Frequency	Comments

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C4. Medical Equipment and Supplies ☐ No Changes

a. List Medical Equipment and Supplies

Medical Equipment and Supplies	Type/Description	Prescribing Physician/Provider	Indicate Rent or Own	Vendor and Phone Number	Comments
			☐ Rent ☐ Own		
			☐ Rent ☐ Own		
			☐ Rent ☐ Own		
			☐ Rent ☐ Own		
			☐ Rent ☐ Own		

C5. HCBS Services ☐ No Changes

a. List HCBS Services

HCBS Service	Provider/Agency	Frequency	Comments

C6. Institutional Services ☐ No Changes

a. List Institutional Services

Institutional Service	Provider	Comments

C7. Physician(s) and Provider(s) ☐ No Changes

a. Physician(s) and Provider(s)

List Physician(s)/Provider(s) Name	Specialty	Address	Phone Number	Fax Number

C8. Utilization of Hospital, Emergency Room, and Physician Services ☐ No Changes

Comments:

C9. State Programs ☐ No Changes

*****Do not complete for NF*****

Comments:

SECTION D. PERSON CENTERED INFORMATION

Instructions: Compile information from health plan records and address changes from previous assessment. Refer to ADULT LTSS ASSESSMENT INSTRUCTIONS for information on completing the appropriate sections. If there are no changes, check box "No Changes"

D1. Social Supports ☐ No Changes

*****Do not complete for NF*****

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a. Social Supports

1. Family and/or friends living in the SAME residence

Name	Age	Relationship	Cell Phone	Day/Hours NOT available	Type of help	# of hours helped in LAST 7 days	Paid	Employed	Employer	Work hours/ week
							☐ Yes ☐ No	☐ Yes ☐ No		
							☐ Yes ☐ No	☐ Yes ☐ No		
							☐ Yes ☐ No	☐ Yes ☐ No		

2. Family and/or friends NOT living in the same residence and providing support to member

Name	Age	Relationship	Cell Phone	Day/Hours available	Type of help	# of hours helped in LAST 7 days	Paid	Employed	Employer	Work hours/ week
							☐ Yes ☐ No	☐ Yes ☐ No		
							☐ Yes ☐ No	☐ Yes ☐ No		
							☐ Yes ☐ No	☐ Yes ☐ No		

3. Strong and supportive relationship with family? ☐ Yes ☐ No

b. Comments:

D2. Primary Caregiver ☐ No Changes

a. Primary Caregiver Status

1. Describe feelings on being a primary caregiver, are you ok?
2. Describe how you take care of yourself.
3. Rate your overall general health and psychological well-being
   - ☐ i. Good
   - ☐ ii. Fair
   - ☐ iii. Poor
4. Do you need help caring for member? ☐ Yes ☐ No
5. At what point do you feel you will not be able to care for member and what happens then?
6. Are there any social issues in the home that concerns you? ☐ Yes ☐ No
7. If yes, explain.
8. Do you have any other caregiving demands or responsibilities? ☐ Yes ☐ No
9. If yes, explain.

b. Comments:

SECTION E. GENERAL HEALTH

E1. Cognition ☐ No Changes

a. Repetition

1. Ability to repeat _____ (object), _____ (animal), and _____ (number)
   - ☐ i. None
   - ☐ ii. One Correct
   - ☐ iii. Two Correct
   - ☐ iv. Three Correct

b. Orientation

1. Able to report correct year ☐ Correct ☐ Incorrect
2. Able to report correct month ☐ Correct ☐ Incorrect
3. Able to report correct day of week ☐ Correct ☐ Incorrect
4. Able to report current president of the United States ☐ Correct ☐ Incorrect

c. Recall

1. Ability to recall _____ (object), _____ (animal), and _____ (number)
   - ☐ i. None
   - ☐ ii. One Correct
   - ☐ iii. Two Correct
   - ☐ iv. Three Correct

d. Score:

e. Comments:

E2. Mood, Behavior, and Psychological Well Being ☐ No Changes

Note: Disease management may be appropriate for member that has been previously diagnosed. If member does not have a behavioral health diagnosis, SC should refer member to PCP for further evaluation.

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a. Depression (PHQ-9 Foundation)
Over the LAST 2 WEEKS , how often have you been bothered by any of the following problems:

	None	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

b. Score

c. Coping Skills

1. Do you have difficulty at work, caring for things at home, or get along with people? ☐ Yes ☐ No

d. Anger

1. Do you get angry easily? ☐ Yes ☐ No
2. Have you ever felt persistent anger with self or others? ☐ Yes ☐ No
3. If yes, describe what happens when you get angry.

e. Anxiety

1. Do you get anxious easily or worry excessively? ☐ Yes ☐ No
2. Do you suffer from panic attacks? ☐ Yes ☐ No
3. Have you ever felt that something terrible is going to happen? ☐ Yes ☐ No

f. Behavior

1. Has been wandering ☐ Yes ☐ No
2. Has been verbally abusive to self and/or others ☐ Yes ☐ No
3. Have been physically abusive to self and/or others ☐ Yes ☐ No
4. Has been socially inappropriate or displayed disruptive behaviors ☐ Yes ☐ No
5. Resist caretaking ☐ Yes ☐ No

g. Social Relationships

1. Have you ever had conflict or anger with family or friends? ☐ Yes ☐ No
   If yes, explain.
2. Have you ever felt fearful of a family member or close acquaintance? ☐ Yes ☐ No
   If yes, explain.
3. Have you ever felt neglected, abused, or mistreated? ☐ Yes ☐ No
   If yes, explain.

h. Major Life Stressor(s)

1. Have you had any recent major life stressor(s)? ☐ Yes ☐ No
   If yes, explain.

i. Comments:

E3. Functional Status (If there are changes, SC must complete the Needs Assessment Tool) ☐ No Changes

a. Instrumental Activities of Daily Living (IADLs)	**Independent**	**Minimal**	**Moderate**	Total
1. Routine house cleaning	☐	☐	☐	☐
2. Laundry	☐	☐	☐	☐
3. Shopping and Errands	☐	☐	☐	☐

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4. Meal Preparation	☐	☐	☐	☐
b. Activities of Daily Living (ADLs)	**Independent**	**Minimal**	**Moderate**	Total
1. Eating/Feeding	☐	☐	☐	☐
2. Bathing	☐	☐	☐	☐
3. Dressing upper body	☐	☐	☐	☐
4. Dressing lower body	☐	☐	☐	☐
5. Grooming/Personal hygiene	☐	☐	☐	☐
6. Toileting	☐	☐	☐	☐
7. Walks with or without assistive device Identify assistive device(s):	☐	☐	☐	☐
8. Ambulation/Locomotion	☐	☐	☐	☐
9. Do you have difficulty accessing areas of your house? ☐ Yes ☐ No	If yes, explain.			
10. Transfers	☐	☐	☐	☐
11. Medication assistance	☐	☐	☐	☐

c. Activity and Mobility

1. Do you exercise or engage in moderate physical activity? ☐ Yes ☐ No
2. How many days per week do you exercise?
3. How many total hours per week?
4. Are there any physical limitations and/or environmental barriers that make it difficult for you to exercise or perform activities? ☐ Yes ☐ No
5. If yes, explain.
6. Do you feel that you are capable of increasing physical activity? ☐ Yes ☐ No
7. If yes or no, explain.

d. Comments:

E4. Health Condition ☐ No Changes

a. Vitals
(Obtained only if Primary SC is an RN)

1. Temperature _____ F
   i. Mode
2. Pulse _____ bpm
   i. Mode
3. Respirations _____ per min
4. Oxygen Saturation _____%
   i. Mode
5. Blood Pressure _____/_____
   i. Location:
   ii. Position:
   iii. Usual blood pressure range
   - / -

b. Fall History

1. Fall(s) within the last 30 DAYS
   ☐ Yes ☐ No
2. Fall(s) within the past 31-90 DAYS
   ☐ Yes ☐ No

c. Pain

1. Communication of Pain
   ☐ i. Member is verbal and able to answer
   ☐ ii. Member is non-verbal and unable to answer
   ☐ iii. Caregiver/Authorized Representative is answering based on observation
2. Current pain ☐ Yes ☐ No
3. Location:
4. Type:
5. Frequency:
6. Intensity:
   ☐ i. Numeric Rating Scale OR
   ☐ ii. FACES Pain Rating Scale
7. Break though pain ☐ Yes ☐ No
8. Pain management:

d. Comments:

E5. Continence ☐ No Changes

a. Continence

1. Bladder Continence
   - ☐ 1. Continent
   - ☐ 2. Control with catheter or ostomy
   - ☐ 3. Incontinent
2. Bowel Continence
   - ☐ 1. Continent
   - ☐ 2. Control with ostomy
   - ☐ 3. Incontinent

b. Do you use incontinence products? ☐ Yes ☐ No

c. Comments:

E6. Skin ☐ No Changes

a. Skin

1. Do you have any history of skin breakdown or pressure sores? ☐ Yes ☐ No
2. Do you currently have any skin break down, tears, or open sores? ☐ Yes ☐ No
3. Do you have any blood, drainage, or odor from a wound? ☐ Yes ☐ No
4. Describe wound and location.

b. Comments:

E7. Pregnant Female (Assess only if applicable) ☐ No Change

*****Do not complete for NF*****

Comments:

SECTION F. TRANSPORTATION ☐ No Changes

*****Do not complete for NF*****

a. Assessor Determination

1. Is the member alert and aware of surroundings? ☐ Yes ☐ No
2. Is the member able to understand and respond to verbal commands? ☐ Yes ☐ No

b. Transportation

1. Current Mode of Transportation (Select all that apply)
   - ☐ i. Drives own vehicle
   - ☐ ii. Family or friends
   - ☐ iii. Public transportation
     - ☐ a. Bus
     - ☐ b. Handi van
   - ☐ iv. Van
     - ☐ a. Curb to curb
     - ☐ b. Door to door
   - ☐ v. Gurney
   - ☐ vi. Taxi
   - ☐ vii. Air Travel for specialist care
   - ☐ viii. Other:
2. Are you able to use public transportation or can someone regularly transport you to obtain medical services? ☐ Yes ☐ No
3. If no, explain.
4. Are you able to ambulate without assistance (with or without device, to include wheelchair)? ☐ Yes ☐ No
5. Are you able to ambulate to the local bus stop? ☐ Yes ☐ No
6. Describe.
7. If wheelchair bound, are you able to self-propel to curb side for pick up? ☐ Yes ☐ No
8. If wheelchair bound, are you able to transfer in and out of vehicle without assistance? ☐ Yes ☐ No
9. If the member needs assistance, do you have an attendant? ☐ Yes ☐ No
10. Does the member require any medical equipment when traveling? ☐ Yes ☐ No
11. If yes, list medical equipment (e.g., ventilator, suction machine, feeding pump, etc.)

12. Reason member is unable to get to curb side alone (Select all that apply)
- ☐ i. No attendant
- ☐ ii. Attendant is unable to help member to curb side
- ☐ iii. Member is bedbound
- ☐ iv. Member is non ambulatory
- ☐ v. Member is unable to transfer or receive assistance

c. Comments:

SECTION G. EMERGENCY PLANNING ☐ No Changes

Comments:

SECTION H. MEMBER NEEDS ☐ No Changes

Refer to: ☐ 1. Social Worker ☐ 2. Nurse

SECTION I. SUMMARY/ADDITIONAL INFORMATION ☐ No Changes

Document, at a minimum, the following:

1. Status of all items on the service plan
2. Changes for areas identified on this tool
3. Update on all disease specific conditions of the member
4. Any concerns related to home environment
5. Any changes related to emergency planning
6. Any reference to other service coordinator consultants (i.e., nurse or social worker)
7. Any other pertinent areas that SC identified upon reassessment

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Instruction: *Complete this section only if member has a change in residence, i.e., moved to a different home.*

HOME ENVIRONMENT ASSESSMENT

a. Current Home

1. Currently Living In (Select all that apply)
   - ☐ i. Own House
   - ☐ ii. Own Apartment
   - ☐ iii. Rented House
   - ☐ iv. Rented Apartment
   - ☐ v. Section 8
   - ☐ vi. Public Housing
   - ☐ vii. Hawaiian Homestead
   - ☐ viii. Relative/Friend's House
   - ☐ ix. Other:
2. Does the neighborhood appear safe? ☐ Yes ☐ No
3. Does the building have a secured lobby? ☐ Yes ☐ No
4. If yes, entry code and/or entry directions.
5. Is there an elevator in the building? ☐ Yes ☐ No
6. Is the home accessible to wheelchairs or other assistive devices? ☐ Yes ☐ No
7. Accessible Locations (Select all that apply)
   - ☐ i. Doorways
   - ☐ ii. Hallway
   - ☐ iii. Bathroom
   - ☐ iv. Exits

	Adequate	Inadequate	N/A	Comments
b. Exterior Assessment				
Walkways free of clutter	☐	☐	☐	
Ramps/handrails safe	☐	☐	☐	#Exits ☐ Accessible Locations
Stairs safe	☐	☐	☐	#steps Locations
Safe water source	☐	☐	☐	Water catchment
Other:	☐	☐	☐	
c. Interior Assessment				
Clear pathway to exit/entry	☐	☐	☐	
Sturdy floors (other structural)	☐	☐	☐	
Handrails safe	☐	☐	☐	
Stairs safe	☐	☐	☐	#steps Locations
Free of trash accumulation/Trash Disposal	☐	☐	☐	
Lighting	☐	☐	☐	
Tacked down rugs and carpets	☐	☐	☐	
Visible cords/electrical circuits safe	☐	☐	☐	
Telephone service and accessibility	☐	☐	☐	
Smoke/fire detector or fire extinguisher operational	☐	☐	☐	Locations
Grab bars/support structures	☐	☐	☐	Locations
Bathing/hand washing facilities	☐	☐	☐	☐ Hot water ☐ Running water
Food preparation areas clean	☐	☐	☐	
Cooking appliances safe	☐	☐	☐	☐ Stove ☐ Fridge ☐ Freezer ☐ Microwave
Food storage safe	☐	☐	☐	
Pets in house (cats, dogs, etc.) secured	☐	☐	☐	
Laundry	☐	☐	☐	☐ Washer ☐ Dryer
Insects/other pests or rodents	☐	☐	☐	
Smoke free house	☐	☐	☐	
Guns/weapons (locked/unlocked)	☐	☐	☐	
Sufficient space for equipment/supplies	☐	☐	☐	☐ Generator
Home ventilation	☐	☐	☐	☐ Too hot ☐ Too cold
Other:	☐	☐	☐	