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 ☐ Female ☐ 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) ☐ Anglo ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ Other (specify)________________________________

Language (check all that apply)

	Speak	Read	Write
English	☐	☐	☐
Spanish	☐	☐	☐
Native American	☐	☐	☐
Other	☐	☐	☐

List Language Preference

Convey Needs - Person can convey needs
☐ Yes ☐ No ☐ Sometimes

If Yes or Sometimes, indicate mode of communication (check all that apply)
☐ Verbal
☐ Sign Language
☐ Gestures
☐ Communication Board
☐ Interpreter
☐ Other (specify) ________________________________

II. CONSENT and ADVANCE DIRECTIVES

Informed Consent - Person can provide informed consent ☐ Yes ☐ 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.

☐ General Durable Power of Attorney
☐ Durable Power of Attorney for Health Care Decisions
☐ Durable Power of Attorney for Financial Decisions
☐ Conservatorship
☐ Legal Guardian
☐ Treatment Guardian

Name: ____ Address: ____________________________________

Phone Number: _________________________________ ____

Advance Directives - Check all existing advance directives
☐ Living Will ☐ Do Not Resuscitate (DNR) Directive ☐ EMS/DNR ☐ None Identified

Name:	Social Security Number:

III. ASSESSMENT TYPE

Assessment Information - Information for assessment was obtained from
☐ Person ☐ Spouse ☐ Legal Guardian
☐ Power of Attorney ☐ Attendant ☐ Other (specify) ______________________________

Assessment Type
☐ Initial Assessment ☐Annual Assessment
☐ Assessment due to change in condition or situation (or by request)

Assessment Location - Assessment was conducted at
☐ Current Residence ☐ Temporary Residence (non-institutional)
☐ Nursing Home ☐ Hospital ☐ Other: (specify)____________________________________

IV. THIRD PARTY LIABILITY

Medicare Part A ☐ Yes ☐ No Effective Date Part B ☐ Yes ☐ No Effective Date Medicare Number	Private Insurance ☐ Yes ☐ No Effective Date If Yes, Company Name and Policy Number Describe private insurance coverage and limitations:

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)

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____

____

Medical History - Include pertinent information and past surgeries

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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:

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:

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) ☐ Is unable to respond to medical risk(s) ☐ Does not know contributing factors or corrective actions for risk(s) ☐ 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:

VII. SUPPORT AND SOCIAL RESOURCES

Primary Caregiver

	Yes	No	Comments/Individual Service Plan Implications
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.)			(Relationship of caregiver to person)
Person lives alone			
Person is homebound			
Another household member receives waiver services.			(Who and what waiver)

Person Resides	Person's Ability to Remain Alone
☐ Alone ☐ With Spouse/Partner/Family ☐ Non-Relative ☐ With Live-in Paid Caregiver(s) ☐ In Assisted Living Facility Specify names and relationship of Individual(s) who reside with person:	☐ Does not require daily assistance and can be left alone 24 hours ☐ Needs some daily assistance, but cannot be left alone at night ☐ Needs daily assistance but can be left alone at night ☐ Needs daily assistance but can be left alone for a few hours (less than 8 hours) ☐ 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.

Current Supports	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:

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: ☐ Gas ☐ Wood ☐ 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:

IX. NUTRITION

Current weight _______ ☐ Actual ☐ Estimate	Weight Change - There has been a 10-pound weight change in the last 6 months ☐Yes ☐No
Height ______________ ☐ Actual ☐ Estimate	If Yes, specify ☐ gain ☐ 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) ☐ Naso Gastric Tube ☐ 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) ☐ Low Sodium ☐ Low Fat ☐ Low Sugar ☐ Diabetic/Low Sugar ☐ Calorie/Nutritional Supplement ☐ Other Special Diet (specify) ________________________________			

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

Breakfast____

Lunch____

Dinner____

Snacks ____

Notes ____

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____

____

____

Name: Social Security Number:

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:

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:

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:

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 ______________

Name:	Social Security Number:

X. HOMEMAKER ASSESSMENT CONTINUED

SCORING

1. Communication and Cognition TOTAL ________________
2. Behaviors/Mental Health TOTAL ________________
3. ADL TOTAL (add subtotals) ________________
4. IADL TOTAL ________________

5. Grand Total (Add lines 1-4 above) ________________

HOMEMAKER HOURS - (check only one)

☐ **No Need** - Grand Total is below 2, person is not in need of homemaker services and may not need waiver services.

☐ **Minimal Need** - Grand Total is between 2 and 60, person may receive 1 to 10* hours of homemaker services per week as needed.

☐ **Moderate Need -** Grand Total is between 61 and 141, person may receive 11 to 21* hours of homemaker services per week as needed.

☐ **Extensive Need** - Grand Total is between 142 and 246 (or higher), person may receive 22 to 35* hours of homemaker services per week as needed.

Note: If Grand Total is above 230, person's need may be too great and other options including a nursing facility should be considered.

* If homemaker hours are needed beyond this range additional justification for homemaker services must be submitted to New Mexico Medicaid Utilization Review (See *New Mexico Human Services Department, Medical Assistance Division, D&E Waiver Service Standards – Homemaker Services* for details).

Notes or Additional Justification

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Name:	Social Security Number:

XI. ASSESSMENT SUMMARY
Summarize the assessment and implications for the ISP.

Name of Person Completing Assessment　　Title

Signature of Person Completing Assessment　　Date

Signature Case Manager Supervisor　　Date