Type of interview
- ☐ Initial
- ☐ Semi-Annual
- ☐ Annual
- ☐ Amendment
- ☐ Case Management

Client Coordinator: Dorian Cabrera

Date of Interview: _____

Case Management Comprehensive

Section A: Consumer Information

Consumer

Name: (First, M.I., Last)	Medicaid State ID#	Date Of Birth:
Current Address:		
Mailing Address(if different): SAME		
Home Phone:	Cell Phone:	Work Phone:
E-mail:		

Caregiver Information

Primary PCA Name:	Back Up PCA Name (if there is one):
Chore Worker Name:	Respite Worker Name:
Transportation Provider:	Escort Provider:
Non-Paid Caregiver/Family Member/Friend/Church Member	Care Coordinator:

Personal Representative

☐ None ☐ Guardian ☐ Power of Attorney ☐ Other (Specify):

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Language

	Yes	No
Speaks English	☐	☐
Understands English	☐	☐
Needs interpreter services	☐	☐

Basis of Case Management Eligibility

☐ CDPCA ☐ ABPCA ☐ ALI ☐ APDD ☐ CCMC ☐ IDD ☐ GRANT

Emergency Contacts:

Primary Contact

Name: (First, M.I., Last)		Relationship:
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Complete This Section for Children (Age 18 and Under)

What are the child's parent's names?

Parent's marital status: ☐ Married ☐ Divorced ☐ Never married

If the parent's are not living together, what is the non-custodial parent's name and address?

Name:

Address:

Are there siblings in the home? ☐ Yes ☐ No

Other Comments:

Semi and annual interview is a part of ongoing process within agency responsibilities. This review will not change any benefit you receive from the State. With a formal reassessment conducted by Senior and Disabilities at prescribed intervals and whenever there is a significant change in the patient's health, abilities, living situation, family involvement, etc., reassessment should identifies the type and intensity of authorize service plan required for that specific duration period.

This comprehensive case management assessment fulfills the requirements under 7 AAC 125.010 -7 AAC 125.199, review a recipient's needs semiannually in the recipient's home. If the recipient resides in a community not accessible by road or air service, a consumer- directed personal care agency shall arrange for telephone, radio, or, if feasible, in person contact with the recipient and personal care assistant to the extent allowed by the recipient's personal care service level authorization and the condition of the recipient, and request that the department waive the residence visitation requirements of this section if necessary. If the semiannual in-person visitation is waived, an in-person visitation must occur annually.

McKinley Services and I agree to carry out the responsibilities outlined in the regulation to the best of our ability.

Client/Representative _____Date_____

Client Coordinator _____ Date_____

Case Management Comprehensive Assessment Section B

Medical Information

Diagnosis	Is this new within 6 months?
Name and credential of professional making diagnosis:	Date of diagnosis:
Comments:	

Diagnosis	Is this new within 6 months?
Name and credential of professional making diagnosis:	Date of diagnosis:
Comments:	

Health Care Provider Information:

Who is your Primary doctor? ☐ None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Who is your regular dentist? None ☐

Name	Address	Phone
Date of last visit (if known):	Reason:	

Are you seeing any other doctors, such as a psychiatrist, or specialists of any kind?

☐ Yes (list below) ☐ No ☐ Don't know

Name	Specialty	Address	Phone

Any hospitalization in the last 6 months? ☐ Yes ☐ No

If yes, provide the reason;

Admission Date: Discharge Date: Name of the facility:

Any falls in the last 6 months? ☐ Yes ☐ No

If yes, provide the reason;

Admission Date: Discharge Date: Name of the facility:

Health Conditions

Do you regularly receive any of the following medical treatments?

			Days per week	Hours per day
Nursing	☐ no	☐ yes		
Physical Therapy	☐ no	☐ yes		
Occupational Therapy	☐ no	☐ yes		
Speech Therapy	☐ no	☐ yes		
Supervision for Safety	☐ no	☐ yes		
Diabetes Education	☐ no	☐ yes		
Dialysis	☐ no	☐ yes		
Respiratory Treatment	☐ no	☐ yes		
Catheter Care	☐ no	☐ yes		
Colostomy Care	☐ no	☐ yes		
Nasogastric Tube Care	☐ no	☐ yes		
Other	☐ no	☐ yes		

Cognitive Status

☐ Alert and fully oriented
☐ Cognitive deficits (e.g. orientation, attention/concentration, perception, memory, reasoning)
☐ Exhibits mental status changes consistent with psychiatric disorder

Musculoskeletal/Fine or Gross Motor Skills

☐ No Impairment of Musculoskeletal/Fine or Gross Motor Skill
☐ Impaired muscle tone
☐ Contractures
☐ Scoliosis
Paralysis: ☐ Hemiplegia ☐ Paraplegia ☐ Quadriplegia ☐ Other

Assistive Devices/Special Equipment

Do you use (or need) any of the following special equipment or aids? ☐ None
(If a consumer doesn't have an item but needs it, mark the "Needs" box)

U	N	Dentures	U	N	Hospital Bed
U	N	Cane	U	N	Medical Phone Alert
U	N	Walker	U	N	Supplies, e.g. Incontinence Pads
U	N	Wheelchair (manual, electric)	U	N	Bedside Commode
U	N	Brace (Leg, Back)	U	N	Bathing Equipment
U	N	Helmet	U	N	Lift Chair
U	N	Communication Devices	U	N	Transfer Equipment
U	N	Hearing Aid	U	N	Adaptive Eating Equipment
U	N	Glasses/Contact Lenses	U	N	Harness/Gait Belt
U	N	Weighted Blankets or Vest	U	N	Other (Specify)