

ADULT DAY SERVICE – IN – HOME AND TELEPHONIC SERVICE CHECKLIST

This form is to be used by Adult Day Service providers to document completion of in-home and telephonic Adult Day Service authorized in a participant’s service plan.

DEMOGRAPHICS

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Name of individual

Date of birth

Date

<input type="text"/>	<input type="text"/>
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Program name

MMIS ID

Name of caregiver spoken to (if present)

Staff member name and title

HEALTH STATUS

COVID-19 Checklist

YES | NO

Fever over 100.4

Sore throat

Nausea/Diarrhea

Unexplained body aches

YES | NO

Cough

Shortness of breath

Vomiting

Contact with anyone diagnosed with COVID-19 or symptoms

YES | NO

Headache

Fatigue

Loss of taste or smell

Healthcare - other

1. Other healthcare issues identified/complaint

2. Have you been hospitalized since we last spoke?

Yes No

If yes, please explain

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3. Triage

a. Symptoms

b. Onset

c. Intensity/Severity

d. Aggravating factors

e. Self-Mitigation

4. Make referral (consult with internal nursing staff)

a. Hospital

b. Physician

Health, Safety, Welfare

1. Identification of concern(s)

2. Individual(s) impacted

3. APS/Law Enforcement Referral

4. Have you communicated with your case manager about this concern?

Need/Social Determinants (questions)

1. Do you have enough food to eat?

Yes No

2. Are you able to contact your healthcare provider(s)?

Yes No

3. Are you able to participate in activities in your community?

Yes No

4. Do you have enough money to purchase food and supplies?

Yes No

5. Do you have concern with your housing?

Yes No

If **yes**, what are they?

Medication Management

1. Do you have all of your medications?

Yes No

If **no**, what medication are you out of?

2. Do you need assistance with prescription refills?

Yes No

3. Do you need help being reminded to take your medication?

Yes No

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Activities of Daily Living

1. Are you having difficulty with any of the following:

Yes No Using the bathroom Yes No Bathing/Grooming Yes No Getting dressed
Yes No Eating Yes No Moving from room to room/getting out of bed

2. Who is helping you? (only if yes to any of the above)

3. Are you communicating needs with case manager?

ADDITIONAL NEEDS/CONCERNS

ID additional care/service/social needs

CASE MANAGER COMMUNICATION

SIGNATURES:

Provider signature

Date

Participant/Authorized
representative signature (if applicable)

7/10/2020