Wyoming Department of Health
Commit to your health.

Wyoming
Community Choices
Home and Community Based Service Waivers

Case Manager Monthly Evaluation

Participant Name: _____ **Month: _____**

Participant Physical Address: _____
Street City ZIP

Participant Mailing Address (if different) _____
Address City ZIP

Case Manager Name: _____ Primary Care Physician Name: _____

Date of Visit: _____ Time Visit Started: _____ Time Visit Ended: _____

Case Managers are required to complete a face-to-face visit with each participant, every month in their home or at the Assisted Living Facility.

Home Assessment

Home Visit: *Describe the overall condition of the participant, including any health concerns noted on the day of the home visit; the general condition of the home environment and the participant's bedroom; and summarize your discussion and concerns noted on the day of the home visit.*

Area Assessed	How information was obtained (Methods could included: Your own observation of the participant/home Conversation with the Participant Conversation with the family Conversation with other services providers/caretakers	Indicate the level of the participant response using the following: 1=Improving 2= Maintaining 3-Deteriorating 4= New diagnosis impacts the assessed area
Physical		
Emotional		
Social		
Cognitive		
Risk/Safety		
Other		

Additional Comments:

Health Risk Assessment

Health Risk: *Case Manager should ask over the last 2 weeks, how often have you been bothered by any of the following problems?*

Question	Not at all	Several days	More than half the day	Nearly everyday
Little interest or pleasure in doing things?				
Feeling down, depressed, or helpless				
Trouble falling or staying asleep?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself, or that you are a failure and have let your family down?				
Trouble concentrating?				
Moving or speaking slowly or being to get fidgety or restless?				
Thoughts that you would be better off dead or of hurting yourself in some way?				

If indication of Health Risk What action did you take:

_____

_____

_____

_____

_____

_____

Additional Comments:

Services

Services: *Check services the participant is receiving, describe the service satisfaction and that the Case Manager has verified that service provider has provided the service on the plan*

Area Assessed	Indicate the level of the participant's satisfaction with each waiver services using the following: E= Excellent S= Satisfactory P= Poor	Additional Comments	Check if Case Manager has verified that service provider has provided the services on the Care Plan for the month	How was this verified?
Case Management				
Personal Care Attendant				
Respite Care				
Home Delivered Meals				
Lifeline Installation				
Lifeline Monthly				
Non-Medical Transportation				
Adult Day Care				
Skilled Nursing				
Direct Services Worker				
Fiscal Management				
Assisted Living Facility				

Please check all that apply:

Nurse Supervision Documented – Yes ☐ No ☐ PERS Unit physically checked that it is working properly Yes ☐ No ☐
Direct Service Worker Logs and Timesheets checked by case manager Yes ☐ No ☐ Participant directed Back-up plan reviewed Yes ☐ No ☐ Update/changes made to Back-up plan Yes ☐ No ☐

Additional Comments:

Visit Outcomes

Case Manager should Review the following (Check Y-Yes or N-No)

	Y	N
APS information provided/reviewed		
Other Medicaid services needed		
Other Medicaid services referral made		
Other non Medicaid services needed		
Other non Medicaid services referral made		
Safety Planning reviewed		
Incident or critical event occurred		
Change in Plan needed		

If Answered Yes to any of the above explain what action was taken:

_____
_____
_____
_____
_____
_____
_____
_____

Additional Comments:

Additional Comments

_____ _____

Participant/POA/Authorized Representative Signature (required)/Date Case Manager Signature Date

_____ _____

Participant/POA/Authorized Representative Printed (required) Case Manager Printed