

# Wyoming Community Choices Home and Community Based Service Waivers

## Case Manager Monthly Evaluation

*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. Do not leave any area on this form blank.*

Participant Name: \_\_\_\_\_ Case Manager Name: \_\_\_\_\_

Participant Physical Address: \_\_\_\_\_  
Street City Zip

Date of Visit: \_\_\_\_\_ Time Visit Started: \_\_\_\_\_ Time Visit Ended: \_\_\_\_\_

Do you live with anyone? Yes  No  Whom? \_\_\_\_\_

Do you have a Power of Attorney? Yes  No  Whom? \_\_\_\_\_

Do you have a Primary Care Physician? Yes  Name: \_\_\_\_\_ No

When was your last appointment with your primary care provider? \_\_\_\_\_

When is your next appointment with your primary care provider? \_\_\_\_\_

Do you take any medications for pain or anxiety? Yes  No

Have you had any Emergency Room or Hospital visits within the last 30 days?

Type of Visit: \_\_\_\_\_ Date of visit: \_\_\_\_\_ Date Visit Ended: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

### 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 include): 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 response using the following: 1=Improving 2= Maintaining 3=Deteriorating 4= New diagnosis impacts the assessed area, (list new diagnosis)
Physical		
Emotional		
Social		
Cognitive		
Risk/Safety		
Other/Comments		

## Depression Screening

*This screening does not diagnose depression, it is a tool to assess the participants overall condition.*

<b>Over the last two weeks, how often have you been bothered by any of the following problems?</b>	Not at all	Several days	More than half the day	Nearly everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure, or that you let your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking 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	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
<b>Total _____ =</b>	_____	+ _____	+ _____	+ _____

**PHQ-9 score ≥ 10: Likely major depression**

Questions: 2, 6 or 9 need IMMEDIATE ACTION if score is anything other than 0 or “Not At All”

For question #2: Give the Suicide Helpline number to this client and make them an appointment as soon as possible with any of the following: PCP, counselor, psychiatrist. Suggest talking to a friend, preacher, teacher, or someone else they trust about their feelings.

For question #6: Give the Suicide Helpline number to this client and make them an appointment as soon as possible with any of the following: PCP, counselor, psychiatrist. Suggest talking to: a friend, preacher, teacher, or someone else they trust about their feelings.

For question #9: Please see the bottom of this form for the Suicide Helpline. Call this number with this client. If the client refuses to call, you can call to get help/advice anyhow. If they cannot be taken right away to their PCP, counselor, or psychiatrist they need to be assessed *immediately* at the EMERGENCY ROOM, CALL 911. This client should be with someone able to help them at ALL TIMES until they can be seen by a professional.

**5-9 MILD**

- Does this client have a counselor and attend regular sessions?
- Please make this client an appointment with their PCP to discuss possible depression.
- Fax the PHQ-9 to the PCP and also the counselor, if they have one.

**10-14 MODERATE**

- Does this client have a counselor and attend regular sessions? Schedule their next appointment within the week, sooner if possible.
- Please make this client an appointment with their PCP to discuss depression within the week, sooner if possible.
- Fax the PHQ-9 to the PCP and also the counselor, if they have one.

**15-19 MODERATELY SEVERE**

- Does this client have a counselor and attend regular sessions? Schedule their next appointment within the week, sooner if possible.
- Please make this client an urgent same-day appointment with their PCP to discuss depression. Or an urgent same-day with their counselor or psychiatrist if they have one.
- Fax the PHQ-9 to the PCP and also the counselor, if they have one.

**>20 SEVERE**

**This person needs to be evaluated immediately by: PCP or their counselor or psychiatrist or taken to the ER if none of the previously mentioned can see the client immediately.**

*If indication of risk for depression, what action did you take:*

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*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 satisfaction with services using the following: E= Excellent S= Satisfactory P= Poor	Additional Comments <i>(If level of satisfaction is Poor, what changes to the plan can be made)</i>	Mark with an X if verification of the service was completed	How was this verified? <i>(i.e. Written verification from provider, CNA notes, SN notes, utilization record in EMWS)</i>
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:*

- 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/Concerns:*

## 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:*

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*Additional Comments:*

## Additional Comments

\_\_\_\_\_  
Participant/POA/Authorized Representative Signature (required)/Date

\_\_\_\_\_  
Case Manager Signature Date

\_\_\_\_\_  
Participant/POA/Authorized Representative Printed (required)

\_\_\_\_\_  
Case Manager Printed