Purpose of form

Form 02CB033E, Level of Function and Environmental Assessment, is an assessment performed by the physical or occupational therapist and documents the member's current level of function and the ability or inability of the environment to meet the member's need(s). This form documents the needed permanent modifications to the environment to meet the member's need(s).

Instructions

Member name: Enter the member's name as it appears on their Oklahoma Department of Human Services (OKDHS) case. (No nicknames.)

Last name; first name; middle initial

Medicaid number: Enter the nine digit Client ID # assigned by OKDHS.

Address: Enter the member's street address, city, county, and zip code.

Phone number: Enter the member's phone number.

Gender: Mark the appropriate box to indicate the member's gender.

Date of birth: Enter the member's date of birth

HEALTH STATUS.

Enter the date of the assessment.

Enter the primary diagnosis and secondary diagnosis.

Enter the member's past medical or surgical history.

Enter the member's current level of function.

CURRENT ASSESSMENT.

Enter the member's strength levels. Specify deficits.

Describe the member's ability to move through the range of motion. Specify deficits.

Describe the member's neurological status. Specify deficits.

Describe the member's cognition. Specify deficits.

Describe the member's proprioception. Specify deficits.

Enter the member's pain rating on a scale of 0-10 with 0 being no pain and 10 being the worst ever experienced. Enter the location, frequency, and duration of the pain.

Describe the condition of the member's skin.

Describe the member's visual ability.

Describe the member's hearing ability.

Describe the member's ability to feel sensation.

Describe the member's coordination.

Describe the member's ability to move through the environment from one location to another.

Describe the member's endurance.

Describe the member's ability to roll and change positions in bed.

Describe the member's ability to move from a lying position to a sitting position.

Describe the member's ability to move from a sitting posture to a standing posture.

Describe the member's ability to transfer to and from the toilet or bedside commode.

Describe the member's ability to transfer in and out of a shower or bathtub.

Describe the member's ability to transfer from bed to a stationary chair or wheelchair.

Describe the member's ability to propel a wheelchair on a level surface.

Describe the member's ability to propel a wheelchair on an uneven surface.

Describe the member's ability to transfer in and out of a vehicle.

Describe the member's weight bearing status.

Describe the member's ability to perform transfers from the floor.

Describe the member's gait.

Describe the member's posture.

Describe the member's balance.

List the available assistive or adaptive equipment. If available and not used, please explain why.

Enter additional comments.

ENVIRONMENTAL ASSESSMENT.

Describe how the member currently enters and exits the home.

List the alternative entrances and exits to the home and describe the member's ability to use them.

Describe the width of member's currently used wheelchair or walker.

Enter the measurement of door clearance at proposed EM site(s).

Describe the distance from the door threshold to the ground at each exit door.

Describe the measurements of existing porch and ramp including the length, width, depth, and condition.

List the handrails and other support structures at the exit doors including the member's ability to use them.

Describe precautionary and safety concerns about the member's environment.

Describe the minimum clear floor space in the bathroom.

List alternative bathrooms in the member's home and the member's ability to utilize the alternative bathrooms.

Describe how member's bathing and toileting needs are currently being met.

JUSTIFICATION OF ENVIRONMENTAL MODIFICATIONS.

Describe how the proposed EM would enable the member to function with greater independence.

Describe how the proposed EM would assist in assuring the health, welfare, and safety of the member.

Describe how the proposed EM would reduce the member's risk for premature institutionalization.

Enter additional comments if needed.

The physical or occupational therapist signs and dates the form, and enters the name of the agency.

Routing

The case manager keeps the original for the case file and forwards a copy to:

AD*vantage* Administration Unit, PO Box 50550, Tulsa, OK 74150-0550

A copy of the completed form is placed and scanned into the member file in the AD*vantage* Administration Unit (AAU).