Applicant's Name: _____ Date: _____

The Virginia Department of Medical Assistance Services:
Questionnaire To Assess An Applicant's Ability to Independently Manage Consumer-Directed Services

To The Assessor: In addition to reviewing the applicant's ability to answer questions on the Uniform Assessment Instrument (UAI) regarding his or her status and care needs, it is necessary to question the applicant in the following areas and document the response.

I. **Daily Decision-Making**

1. Did you pick out the clothes you are wearing? Please explain how you select what clothing you will wear for the day.

2. How do you plan or arrange for your meals? What kinds of things do you eat for breakfast, lunch, and dinner?

3. How do you manage your finances (pay your bills)?

4. What do you do everyday? Please tell me your daily routine.

II. **Short- and Long-Range Planning**

1. How often do you have to leave the house? If you do leave the house, how do you make appointments or schedule transportation? What transportation do you use?

2. How do you plan for a future event (for example, Christmas, family visits, etc?)

Questionnaire To Assess An Applicant's Ability to Independently Manage Consumer-Directed Services (Continued)

Applicant's Name: _____ Date: _____

III. **Finding a Personal Assistant/Care Aide**

1. How will you find and hire someone to be your personal assistant/aide? What kind of person will you need to take care of your needs?

2. How will you find a replacement if a personal assistant/aide fails to come to work or quits without notice? How will you manage until you can find another aide?

3. What would you do to let someone know you needed assistance if your personal assistant/aide does not show up?

4. What steps would you take if your personal assistant/aide was abusive, or you thought the personal attendant was stealing from you?

IV. **Health Knowledge/Supports**

1. What kind of medical problems do you have? How are you currently taking care of these needs (i.e., are you seeing a doctor?) If you needed to talk to someone about a medical problem, whom would you call?

2. What kind of medications do you take and how often do you take them? What are they for?

3. Who will be providing for your medical needs other than your personal assistant/aide?

Questionnaire To Assess An Applicant's Ability to Independently Manage Consumer-Directed Services (Continued)

V. **Support Network**

1. Do you have additional support available from family, neighbors, friends, school or employers who

Applicant's Name: _____ Date: _____

can contact in case you have an emergency? If so, whom? How would you contact them?

_____

_____

_____

Pre-Admission Screening Team Recommendation:

☐ I recommend the applicant receive Consumer-Directed (CD) Services based on: 1) The applicant's demonstrated ability to supervise a personal assistant/ aide; and/or 2) The applicant has adequate accommodations/support that enables him or her to manage services independently. The applicant will receive personal care aide management training prior to receiving CD services.

Additional Comments: _____

_____

(This section is applicable for applicants, who are knowledgeable about their own care, can communicate their needs to a personal care aide, and understands the rights, risks, and responsibilities of Medicaid-Funded CD services. The applicant's responses to issues related to daily decision-making, short- and long-range planning, finding an aide, health knowledge/supports, and support networks demonstrate that the applicant is capable of handling the responsibilities associated with consumer-directed services. Factors which should not influence this decision include, but are not limited to the inability to read and/or write due to a print impairment, educational level, the inability to communicate verbally, or the lack of previous experience in managing his or her health services.)

☐ I do not recommend the applicant receive CD services in the Medicaid Waiver. The applicant has little or no knowledge of his or her care requirements and could not assume the responsibilities of consumer-directed services at the present time. The applicant will be offered alternative Medicaid-funded long-term care options.

Additional Comments: _____

_____

(This section is applicable if the applicant has little or no knowledge of his or her care requirements or consumer-directed program responsibilities. Responses in the areas of daily decision-making, short- and long-range planning, finding a personal assistant/aide, health knowledge/supports, or support networks given by the applicant do not demonstrate that the recipient would be capable of meeting program requirements of the Waiver and successfully managing CD services.)

Assessor Signature/Title: _____ Date: _____