Department of Medical Assistance Services
Division of Long Term Care

TECHNOLOGY ASSISTED WAIVER SUPERVISORY MONTHLY SUMMARY

Agency: _____ Date of Supervisor visit: _____

Primary Caregiver: _____ Month of service reported: _____

Tech Waiver Participant: _____ Medicaid #: _____

Orders renewed date: _____ Primary Diagnosis: _____

Participant attends school with a TW nurse? Yes No

Health, safety and welfare needs met? Yes No
(If no, see note in problem section below)

Nursing hours authorized/day: _____ Respite hours provided: _____ Total Respite hours used to date: _____

CLINICAL STATUS THIS MONTH (illnesses, MD order changes, scheduled procedures, etc.) _____
_____
_____
_____

PROBLEMS / CHANGES NOTED WITH DME (too much, too little, improper usage, agency): _____
_____

TECHNOLOGY / NURSING NEEDS: (Circle Answer) Ventilator CPAP BIPAP – continuous intermittent

Oxygen: continuous intermittent back up only

Enteral feedings: continuous q2hrs. q3hrs. Q4hrs+

IV/Hyperal: continuous 8-16hrs. 4-7hrs. <4hrs.

Oral Supplements: _____
(type, frequency, amount)

Trach Care: QD BID TID Trach Change: weekly <weekly Suctioning: qhr. Q1-4hrs. q4hrs+

Other dressings: _____ q8hrs or less >q8hrs
(Specify type and location)

Medication changes:_____
_____

Peritoneal dialysis (frequency and length) _____

Catheterization: q4hrs q8hrs q12hrs QD PRN Special TX: _____ QID TID BID QD

Specialized monitor I/O (reason): _____frequency _____

Other skilled nursing (specify): _____

Has any technology been discontinued for this participant? Yes No **(If yes, notify the DMAS Health Care Coordinator)**

HOSPITALIZATIONS / REASONS: _____

THERAPIES (name of provider, frequency, location, progress): _____

CURRENT MD PLAN OF TREATMENT IN THE HOME CHART? Yes No **COPY SENT TO DMAS**? Yes No

CAREGIVER /PARTICIPANT'S RESPONSE TO NURSING SERVICES: _____

DATE OF CONTACT WITH FAMILY / CAREGIVER: _____During Home Visit ❒ and / or Via Phone ❒

NURSES STAFFING CASE THIS MONTH: **(If no nursing for 30 days or more notify the DMAS Health Care Coordinator)**
_____

PROBLEMS IDENTIFIED _____

PARTICIPANT'S / FAMILY'S / CAREGIVER'S SIGNATURE (If available)_____

_____	_____	_____
RN SUPERVISOR'S SIGNATURE	AGENCY PHONE #	DATE