

Supplemental Assessment

As part of the care planning process, Medicaid Managed Care Organizations (MCOs) are required to complete a written Supplemental Assessment. (A sample form is attached.) In addition to including the amount of time the enrollee can be safely left alone, the assessment must include the following with regard to “natural supports” (this refers to unpaid support that is **voluntarily** provided):

- The role of each natural support in the enrollee’s day-to-day life;
- Each natural support’s day-to-day responsibilities, including an evaluation of the support’s work, school, and other schedules and responsibilities in addition to caring for the enrollee;
- Each natural support’s stress and well-being, including any medical limitation or disability the natural support may have that would limit their ability to participate in the care of an enrollee (e.g. lifting restrictions, developmental disorder, bed rest for pregnancy, etc.)
- The willingness of the natural support to participate in the enrollee’s care.

Tip:

If there is any concern about the sufficiency of services being authorized, a copy of the Supplemental Assessment should be requested from the case manager or the Plan’s grievance and appeals coordinator.

A sample of a Supplemental Assessment Form is on the following two pages.

Supplemental Assessment Sample Form



Caregiver Assessment					
<i>*Please complete the Caregiver Assessment with the member's natural support who are providing care to the member. This excludes paid caregivers. Assessor should conduct one assessment per caregiver.</i>					
Caregiver Demographics					
Caregiver Full Name:					
Caregiver Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Caregiver Date of Birth:		
Caregiver Relationship to individual:	<input type="checkbox"/> Wife <input type="checkbox"/> Son / In-law	<input type="checkbox"/> Husband <input type="checkbox"/> Daughter / In-law	<input type="checkbox"/> Partner <input type="checkbox"/> Other relative	<input type="checkbox"/> Parent <input type="checkbox"/> Other Non-relative	
Caregiver Address:					
City:		State:		Zip:	
Caregiver Primary Phone Number:		Alternative Phone Number:			
Do you currently have anyone to assist you with providing care?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Caregiver Questionnaire					
Do you work outside the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:	Schedule:		
Do you go to school outside the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:	Schedule:		
Do you have other responsibilities outside the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:	Please describe other responsibilities: Schedule:		
Do you currently provide care for this client?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, describe the care you are providing and the number of hours for each service provided:					
How many hours per week do you currently spend providing care for the client?					
How long have you been providing care for this client?	<input type="checkbox"/> Less than 6 months <input type="checkbox"/> 1 to 2 years	<input type="checkbox"/> 6 to 12 months <input type="checkbox"/> 2 or more years	<input type="checkbox"/> NA		
Do you need training or assistance in performing caregiving tasks?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
In your opinion, how long can the client be left alone safely?					
Do you experience mental or emotional strain as a result of your responsibility to provide care for the client?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, please describe the emotion strain you experience:					
<i>Considering other aspects of your life, please rate the level of difficulty in your:</i>					
Relationship with individual:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty
Relationship with family:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty
Relationships with friends:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty
Physical Health	<input type="checkbox"/> No	<input type="checkbox"/> Little	<input type="checkbox"/> Some	<input type="checkbox"/> Moderate	<input type="checkbox"/> A lot

Member Name: _____

Member ID Number: _____

	Difficulty	Difficulty	Difficulty	Difficulty	Difficulty	
Finances:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty	
Functional Abilities:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty	
Employment:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty	
Time for yourself to do the things you enjoy:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty	
Other responsibilities such as caring for children / other family members, going to school, religious or social activities, etc.:	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Little Difficulty	<input type="checkbox"/> Some Difficulty	<input type="checkbox"/> Moderate Difficulty	<input type="checkbox"/> A lot Difficulty	
Are you willing to provide or continue to provide care or services to the client?	<input type="checkbox"/> Willing to provide More Care	<input type="checkbox"/> Willing to provide Same Care	<input type="checkbox"/> Willing to provide Less Care	<input type="checkbox"/> Unable to provide any care		
How confident are you that you will have the ability to provide or continue to provide care?	<input type="checkbox"/> Very confident		<input type="checkbox"/> Somewhat confident	<input type="checkbox"/> Not very confident		
If not confident, what is the main reason you may be unable to continue to provide care?						
How many hours per week do you think you could reasonable provide going forward?						
Assessor Information						
Is the caregiver in crisis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, check all that apply:	<input type="checkbox"/> Financial	<input type="checkbox"/> Emotional	<input type="checkbox"/> Physical
Assessor Name:				Date of Caregiver Assessment:		