Appendix 29 ▪ Social Work Care Manager Alternate Discipline Visit (ADV) Assessment

Note: This assessment is only required when the Social Work Care Manager is the alternate discipline and the ADV is the site's method for Level of Care (LOC) recertification.

Participant Name: _____ MSSP ID: _____
ADV Date: _____
Staff Name/Title: _____ Staff Signature: _____

The **Nurse** signature below confirms there was a discussion between disciplines regarding any changes in the participant's needs and condition.

Name/Title: _____ Signature: _____ Date: _____

Description of Participant and Home Environment:

Cognitive/Psychological Functioning:
(Note: Include orientation, memory, ability to resolve problems, depression, mental health, response to losses, wandering, suicidal ideation, anxiety, significance of current problems to participant)

Changes in Participant Condition
Please indicate below if there have been any changes since the last assessment.

1. **Diagnoses:** ☐ Yes ☐ No

   If yes, describe:

2. **Medications:** ☐ Yes ☐ No

   If yes, describe:

3. **Health:** ☐ Yes ☐ No
   (Note: Include changes in general health status, health practices, medical compliance, nutrition, physical activity, continence, problematic signs or symptoms, frequency and adequacy of health care)

   If yes, describe*:*

4. **Hospitalizations, SNF admissions, or ER visits:** ☐ Yes ☐ No

   If yes, describe:

5. **Falls:** ☐ Yes ☐ No

   If yes, have all fall incidents been reported on the CIR: ☐ Yes ☐ No

   If yes, describe:

6. **IHSS/Caregiver hours:**

   Indicate if there was a change in the last 12 months ☐ Yes ☐ No

   List current IHSS hours:_____

   Are current hours adequate to meet participant's personal care and chore needs?

   ☐ Yes ☐ No

   If not, describe:

7. **ADL/IADL Functioning Levels:** ☐ Yes ☐ No

   (Note: Complete if FNAG is not completed within 30 days of this assessment. Identify any changes in ambulatory status, functional abilities, assistive devices, areas of unmet need; support for LOC finding)

   If yes, describe:

8. **Social Support:** ☐ Yes ☐ No

   (Note: Include community, threats of social isolation or withdrawal)
   If yes, describe:

9. **Formal Services**: ☐ Yes ☐ No

   (Note: Include changes in services received, i.e., Social Security, CalFresh, Medi-Cal, referrals, etc. as well as financial, legal and others)

   If yes, describe:

10. **Care Plan:** ☐ Yes ☐ No

    (Note: Review the status of any ongoing participant need statements and ensure the

care plan adequately and appropriately addresses the participant's changing needs and personal goals. If the Social Worker ADV assessment replaces the progress note for the month, it is important that all of the participant's need statements are addressed within the assessment or in the section below)

If yes, describe:

Additional Comments: