Appendix 27 ▪ MSSP Reassessment

Instructions: Inquire about each area as appropriate and enter a response or indicate if not applicable in the comments. Focus on new information and significant changes since the last assessment and address the current status of participant need statements. It is not necessary to include information in more than one section of the reassessment. Place it where it has the most relevance.

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

Are the following documents completed with the reassessment?

Functional Needs Assessment Grid	☐ Yes	☐ No, Completed with ADV
Medication List	☐ Yes	☐ No, Completed with ADV
Cognitive Screening Tool	☐ Yes	☐ No, Completed with ADV

Comments: _____

1. **Participant and Home Environment Description**: (Age, living arrangement, changes in adequacy of home; safety and accessibility considerations, physical appearance, and presentation).

Changes in adequacy of home/safety and accessibility considerations:

☐ Loose rugs ☐ Electrical cords ☐ Unsafe stairs ☐ History of falls
☐ Cluttered house ☐ Unclean house ☐ Concerning odors
☐ Pest issues ☐ Inadequate lighting
☐ Inadequate kitchen facilities ☐ Inadequate bathroom facilities
☐ Inadequate heating ☐ Inadequate cooling
☐ Phone/Internet accessibility issues
☐ Weapons ☐ Other:

Comments/Describe:

Safety and Special Equipment Checklist:	Does Participant Have?	Does Participant Use? (Optional)	Does Participant Need?
Tub	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Shower	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Hand-held shower	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Bath bench/chair	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Bathmats, shower/tub	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Non-slip floor mats	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Grab bars, toilet	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Grab bars, shower	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Grab bars, tub	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Raised toilet seat	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Bed cane/rail	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Bedside commode	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Incontinence supplies	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Ambulation aids, cane	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Ambulation aids, walker	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Ambulation aids, wheelchair	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Ambulation aids, scooter	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Ambulation aids, other	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Ramp	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Emergency response system	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Smoke alarm	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Carbon monoxide alarm	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No
Other (Explain)	◯Yes ◯ No	◯Yes ◯ No	◯Yes ◯ No

Comments:

2. **Health:** (Include changes in general health status, health practices, diagnoses, medical compliance, nutrition, physical activity, continence, problematic signs or symptoms, frequency and adequacy of health care, use of alcohol and/or drug use).
   Hospitalizations, SNF admissions, or ER visits in past year: ☐Yes ☐No
   Comments/Describe:

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

4. **Medications**:

Pharmacy used: _____

Changes in medication use? ☐ Yes ☐ No

☐ New allergies to medications ☐ Forgets medications ☐ Problem with cost

☐ Has prescription medications which are no longer prescribed and/or expired

☐ Primary physician knows about all of the participant's medications

Does the participant need help with medications? ☐ Yes ☐ No

What kind of help? _____

If yes, who helps? _____

☐ Needs more help (please explain in comments)

Does the participant understand their medications or have concerns?

☐ Yes ☐ No

Comments:

5. **ADL/IADL Functioning Levels**: (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).

6. **Caregiver**: (Changes in formal and informal support, reliability and skill level of caregiver, need for education/resources, degree of caregiver stress/need for respite, evidence of caregiver health or financial problems impacting or potentially impacting ability to provide care).

IHSS/Caregiver Hours: _____

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

☐ Yes ☐ No

If not, please explain:

7. **Social Support**: (Include changes in family, friends, quality of relationships, losses, leisure activities, threats of social isolation or withdrawal).

8. **Critical Incidents**: (Evidence of abuse, neglect, or exploitation since last assessment, recent falls, etc.).
   Were all incidents reported on the Critical Incident Report? ☐Yes ☐No ☐N/A

9. **Finances**: (Changes in benefits, source of income, ability to manage own affairs, problematic expenses, indication of mismanagement).
   Does the participant have? ☐Conservator ☐Power of Attorney
   Name of Conservator/POA:_____

10. **Formal Services**: (Include changes in services received, referrals, services refused, i.e. Social Security, CalFresh, Medi-Cal, as well as financial, legal and others).

11. **Participant Concerns**: (Changes in what the participant and family want from MSSP).

12. **Care Plan**: (Ensure the care plan is adequate and appropriate to address the participant's changing needs and personal goals. List any changes to the care plan. Review the status of any ongoing participant need statements not already addressed above. NOTE: This section is intended to replace the progress note for the month of reassessment, so it is important that all participant need statements are addressed within the reassessment. If there are no changes and all participant needs statements have been covered (in either the assessment or progress notes), it is acceptable to write N/A).

Updated Participant Needs List: