

Evaluation of RN Semiannual Assessment

Name of Individual				Medicaid No.
Home and Community Support Services Agency (HCSSA) Name	Vendor No.	Region	County Name	Date of Visit

I. EVALUATION

1. What is the individual's condition compared to the last semiannual visit? **A-Stable** **B-Improved** **C-Declining**
2. Is the Community Based Alternatives (CBA) service plan appropriate?..... **A-Yes** **B-No**
3. What was the date of the last physician's visit?..... _____
4. Were new physician's orders received this semiannual period?..... **A-Yes** **B-No**
5. Were there any emergency room visits during this semiannual period?..... **A-Yes** **B-No**
If yes, give dates: _____
6. Were there any hospitalizations during this semiannual period?..... **A-Yes** **B-No**

II. ACTIONS (check all that apply)

1-Completed RN Semiannual Nursing Assessment

- A. Total Time Spent in Home..... _____
- B. Administrative Time Spent Completing Form..... _____

2-Evaluated Health Care Plan

- A-No Changes to Health Care Plan
- B-Modified Health Care Plan

3-Evaluated CBA Service Plan

- A-No Changes to CBA Service Plan
- B-Initiated CBA Service Plan Change (per the following attachment[s]):

<input type="checkbox"/> (1)-Form 3671-B, Therapy Service Authorization	<input type="checkbox"/> (2)-Form 3671-C, Nursing Service Plan	<input type="checkbox"/> (3)-Form 3671-D, Minor Home Modifications	<input type="checkbox"/> (4)-Form 3671-E, Adaptive Aids and Medical Supplies
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4-Attendant Training (refer to protocol/nursing notes)

5-Informal Support Training (refer to protocol/nursing notes)

6-Skilled Interventions as Documented in Nurses Notes (this includes any nursing task)

7-Referral(s) Made To:

- A-Physician
- B-Medicare Provider for Services
- C-Medicaid Provider for Services
- D-Other

Signature—RN	Date
Name of RN (print or type)	HCSSA Telephone No.