COLLATERAL INTERVIEW

Applicant Last_____ First Initial_____

RESPONDENT INFORMATION

Name:_____ Relationship to Applicant:_____

Title (if applicable): _____ Agency (if applicable):_____

Date of Interview: _____ Location of Interview:_____

Hands-on caregiver? ☐ Yes ☐ No, # of days per week _____ for _____ ____months / years

LEGEND

With the exception of behaviors (behaviors using the opposite scale) the following applies:
Always = Applicant can always perform the function without assistance.
Usually = Applicant requires assistance 1-3 days per week.
Usually not = Applicant requires assistance 4 or more days per week.
Never = Applicant can never perform the function without assistance.

I. TRANSFER/ MOBILITY

Rise from a chair independently? ☐ Always ☐ Usually ☐ Usually Not ☐ Never

Get on and off the toilet independently? ☐ Always ☐ Usually ☐ Usually Not ☐ Never

Get in and out of bed independently? ☐ Always ☐ Usually ☐ Usually Not ☐ Never

If this applicant requires physical assistance with transfer, # days per week physical assistance is required:

☐ 1-3 ☐ 4-6 ☐ 7 ☐ N/A

Walk independently without physical assistance from another person ?

☐ Always ☐ Usually ☐ Usually Not ☐ Never ☐ NA

If answered UN or N, can he/she use a wheelchair independently, either manual or electric?

☐ Always ☐ Usually ☐ Usually Not ☐ Never ☐ NA

Usual method of mobility? ☐ Walk ☐ Wheelchair

Assistive devices: ☐ Cane/Quad Cane ☐ Walker ☐ Lift Chair ☐ Wheelchair ☐ Gait belt

☐ Other(specify): _____

Gait Description, if observed(pace, steadiness):

_____

_____

Is this applicant able to walk or operate wheelchair without **physical assistance** from another person? ☐ Yes ☐ No

If no, # days per week assistance required ☐ 1-3 ☐ 4-6 ☐ 7 ☐ NA

What medical condition(s) does he/she have to support the need for physical assistance with Transfer/ Mobility?

_____

Transfer/Mobility Comments:_____

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II. EATING/TOILETING

Is He/She able to:

Eat prepared meals without assistance from others? ☐ Yes ☐ No If no, # days per week: ☐1-3 ☐ 4-6 ☐ 7

Administer tube feeding independently? ☐ Yes ☐ No If no, # days per week: ☐1-3 ☐ 4-6 ☐ 7 ☐ NA

If assistance is indicated, describe the type of assistance provided: _____

_____

What medical condition(s) does he/she have to support the need for physical assistance, constant one-on-one observation and verbal assistance? _____

_____

Toilet Independently?	☐ Yes	☐ No,	If no,# days per week:	☐1-3	☐ 4-6	☐ 7		
Maintain continence of bladder?	☐ Yes	☐ No	If no, # days per week:	☐1-3	☐ 4-6	☐ 7	☐ NA	
Maintain continence of bowel?	☐ Yes	☐ No	If no,# days per week:	☐1-3	☐ 4-6	☐ 7	☐ NA	
Clean self after incontinence episode?	☐ Yes	☐ No	☐ N/A					
Does applicant use a catheter?	☐ Yes	☐ No	☐ N/A					
Does applicant have an ostomy?	☐ Yes	☐ No	☐ N/A					
If yes, how often is assistance required?	☐ Always	☐ Usually	☐ Usually Not	☐ Never				

Eating/Toileting Comments: _____

_____

III. Orientation

Is He/She able to:

Oriented to name?	☐ Always	☐ Usually	☐ Usually Not	☐ Never
Able to identify family members?	☐ Always	☐ Usually	☐ Usually Not	☐ Never
Oriented to place?	☐ Always	☐ Usually	☐ Usually Not	☐ Never
Aware of current circumstances in order to make decisions that prevent risk of harm?	☐ Always	☐ Usually	☐ Usually Not	☐ Never

If any answer other than Always, please provide **specific** examples: _____

_____

Orientation Comments: _____

_____

IV. COMMUNICATION

Follow simple directions?	☐ Always	☐ Usually	☐ Usually Not	☐ Never
Communicate basic needs with or without assistive aid?	☐ Always	☐ Usually	☐ Usually Not	☐ Never

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Communication Comments: _____
_____

V. BEHAVIOR

Does applicant require persistent behavioral intervention/supervision? ☐ Yes ☐ No ☐ NA
Describe the established and persistent behaviors which are not primarily related to a mental health condition or substance abuse disorder:_____
_____
Describe the persistent staff or caregiver intervention/supervision required/provided_____
_____
If behavioral intervention/supervision is indicated, who is presently providing this intervention? _____
_____
Behavior Comments: _____
_____

VI. MEDICATION

Please get this information from person responsible for dispensing medications

Information obtained from?_____

Is He/She able to take pills from a medcup/hand, get them to their mouth, and swallow them (refusal doesn't indicate inability) on the appropriate schedule? ☐ Yes ☐ No
Is He/She receiving any injections (not including sliding scale insulin), topicals, eye drops, or inhalers? ☐ Yes ☐ No
If yes, are they able to self-administer? ☐ Yes ☐ No
If no, # of days per week assistance is required: ☐ 1-3 ☐ 4-6 ☐ 7 ☐ NA
If no, to any of the above, describe intervention(s): _____
_____
Medication Comments: (If unable to self-administer, describe limitations and number of days assistance is needed)
_____

VII. SIGNATURE

BY MY SIGNATURE, I AGREE THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION MAY BE USED TO DETERMINE MEDICAID ELIGIBILITY AND MAY ALSO BE USED BY A JUDGE TO MAKE A HEARING DECISION. I FURTHER UNDERSTAND THAT PEOPLE WHO LIE AND PROVIDE FALSE INFORMATION THAT WOULD POTENTIALLY RESULT IN A PERSON OBTAINING TENNCARE SERVICES TO WHICH HE/SHE IS NOT ENTITLED IS CONSIDERED AN ACT OF FRAUD AND MAY BE FINED OR SENT TO JAIL.

Signature of person providing information:_____ Date:_____

Signature of person providing **medication** information:_____ ____Date: _____

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If by telephone, I _____ certify that I have conducted this interview with _____ and have read back the responses to all questions and have obtained permission to sign this document on their behalf. Signature:_____ Date:_____

Printed Name: _____

Signature: _____ Credentials: _____

Date: _____Assessor Code: _____

VIII: Assessor Recertification of Assessment

BY MY SIGNATURE, I CERTIFY I HAVE MET WITH THE APPLICANT FACE TO FACE, I HAVE THOUROUGHLY REVIEWED THIS DOCUMENTATION WITH THE COLLATERAL INTERVIEWEE, AND THE INTERVIEWEE HAS VERBALIZED THAT THE INFORMATION CONTAINED IN THIS DOCUMENT IS AN ACCURATE REFLECTION OF THE APPLICANTS FUNCTIONAL ABILITIES. I FURTHER CERTIFY THE INFORMATION CONTAINED HEREIN IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE AND THAT THIS RECERTIFICATION IS BEING COMPLETED WITHIN 365 DAYS OF THE ORIGINAL COMPLETION DATE OF THIS ASSESSMENT.

Printed Name: _____

Signature: _____ Credentials: _____

Date: _____Assessor Code :_____