In-Home Operations Case Report

☐ **Intake** ☒ **Case Management** **IHO Region:** ☒ **North** ☐ **South**

Name: **Bob, Billy** **Visit Date:** **4-21-2011**

CIN: **XXXXXXXX** **NE II:** **R.N.**

Visit Location and Directions (include any specific details)

Go to 16th street and turn Left. Stay straight on CA 160 N-merge onto Capitol City Freeway. Take Marconi Exit. Right on Marconi Ave. Right on Watt Ave. XXXXXXXX

Onsite Visit Summary

Purpose of Visit:	☐ Level of Care assessment ☒ Evaluation of ongoing HCBS waiver program and services ☐ other:
Visit Location:	☒ Home ☐ Facility (type: ☐acute, ☐ rehabilitation, ☐ subacute, ☐ NF B ☐ NF A) ☐ CLHF ☐ school ☐ other:

Persons present*: Billy Bob and NEII

**For ongoing cases, please explain below in the comments if the HCBS Waiver Case Manager is not present.*

Information provided by: Billy Bob

Additional information obtained from the IHO case file, the home/facility chart, and through direct observation of the participant during this on-site review.

Comments: None

Home Safety Review

☐ n/a. Home was not assessed.

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Home Environment	☒ apartment ☐ single family residence ☐ condominium ☐ mobile home ☐ CLHF ☐ rented room ☐ other:			
	☐ single story ☒ multi-level 2 bedrooms, 2 bathrooms			
	☒ own bedroom ☐ shares bedroom with n/a ☐ other: n/a			
	Total # of entrances/exits: 2 How many are wheelchair accessible? 2			
	Lives alone? ☒ Yes ☐No			
	If no, list other residents in the home and their relationship to the participant/applicant:* *If the residence is a CLHF, please state "other CLHF residents"			
	Is there room for the storage of medical equipment and supplies? ☒ Yes ☐ No If no, please explain the comments			
	Are there pets?	☒ Yes ☐No	If yes, please specify:	1 dog

	Yes	No*
Is there a home/safety evaluation for this residence present in the IHO case file?	☒	☐
Is the home environment adequate for the provision of waiver services?	☒	☐
Are the utilities functional?	☒	☐
Is there a fire extinguisher present?	☒	☐
Is there a smoke detector present?	☒	☐
Is the home free from pests?	☒	☐
Is there an emergency evacuation plan?	☒	☐

*Please explain any No answers in the comments

Comments: Billy would exit out the bedroom window in a dire emergency, or be pulled with blankets out the front door if there is no time to get into his wheelchair. 911 would be called.

Plan of Treatment (POT) Review

☐ n/a. No authorized services

The most recent available primary physician signed POT is current to 07-27-2011.

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The current POT is signed by:	Yes	No
primary physician	☒	☐
participant	☒	☐
primary ca□egiver	☒	☐
all HCBS waiver providers	☒	☐
other: n/a	☐	☐

The signed POT reflects **all waiver** and **non-waiver** services being provided.*	☒	☐
The participant is receiving waiver and non-waiver services as specified on the signed POT.*	☒	☐
The participant/primary caregiver verbalizes an understanding of the care and treatment.*	☒	☐
The signed POT includes an identified circle of support trained in meeting the individual's skilled care needs in the event the HCBS provider is unable to provide the authorized services.*	☒	☐

***** If no, please explain the comments.

Comments: The waiver participant and/or AR will hire and train the IHSS & WPCS providers in the waiver participant's personal and medical care needs. The waiver participant and/or AR will direct the IHSS & WPCS providers to assist with all of the waiver participants activities of daily living, medication management, medical care, transfers, mobility, personal needs, house keeping, shopping, laundry & home care needs. The waiver participant and/or AR will instruct the IHSS & WPCS provider to dial 911 and ensure that the waiver participant will be transported immediately should he/she become incapacitated and unable to direct his/her own care.

IHO Authorized Direct Care and Case Management Services

☐ n/a. No authorized services

n/a ☐	☒ HCBS Waiver Case Management	2 hours per ☒ month ☐ week ☐ other
	Provided by: ☐ HHA R.N. ☒ HCBS R.N. ☐ HCBS M.T. ☐ HCBS LCSW ☐ Licensed Psychologist ☐ Professional Corporation ☐ Non-Profit Agency	100% of the hours are being provided

n/a ☒	☐ Registered Nurse (R.N.) Supervision **(EPSDT only)**	_____ hours per ☐ month ☐ week ☐ other
		_____% of the hours are being provided

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n/a ☐	Services authorized under: ☒ HCBS Waiver ☐ EPSDT	
	☒ Registered Nurse (R.N.) private duty nursing (PDN) ☐ Licensed Vocational Nurse (L.V.N.) PDN ☐ Certified Home Health Aide (CHHA) care ☐ Waiver Personal Care Services (WPCS) ☐ Congregate Living Health Facility	208 hours per ☐ day ☐ week ☒ month 100% of the hours are being provided

n/a ☐	Services authorized under: ☒ HCBS Waiver ☐ EPSDT	
	☐ Registered Nurse (R.N.) private duty nursing (PDN) ☒ Licensed Vocational Nurse (L.V.N.) PDN ☐ Certified Home Health Aide (CHHA) care ☐ Waiver Personal Care Services (WPCS)	490 hours per ☐ day ☐ week ☒ month 100% of the hours are being provided

n/a ☒	Services authorized under: ☐ HCBS Waiver ☐ EPSDT	
	☐ Registered Nurse (R.N.) private duty nursing (PDN) ☐ Licensed Vocational Nurse (L.V.N.) PDN ☐ Certified Home Health Aide (CHHA) care ☐ Waiver Personal Care Services (WPCS)	_____ hours per ☐ day ☐ week ☐ month _____% of the hours are being provided

Comments: None

Medical History

Medical History:	Secondary to a bicycle vs. motor vehicle accident in 1902, Billy is a 30 year old C 2-4 spinal cord injury (SCI); he is an incomplete quadriplegic. He remains dependent on his tracheostomy for respiratory integrity and mechanical ventilation during hours of sleep. Steven requires inhalation therapy for wheezing/congestion as necessary. He has a history of multiple skin integrity impairments; currently his skin is reported as intact. Billy has limited use of his upper extremities and remains dependent on others to meet his activities of daily living (ADL's)as well as his instrumental activities of daily living. (IADL's).
MD visit:	November 2010 with Dr. XXXX for new trach
Last ER visits:	none
Last hospitalization:	none

Allergies: ☐Yes ☒ No If yes, please state:

Immunization(s) current: ☒Yes ☐ No

Comments: Current flu shot givrn by Dr. XXX

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Review of Systems

Height/Length: 5'2" Weight: 135 Date: 11-2010 Is the weight stable? ☒ Yes ☐ No
Has the M.D. been notified of significant changes? ☒ Yes ☐ No

Neurological:

☒ Within normal limits.

Cognitive Functioning:	☒ awake/alert ☐ lethargic ☐ disoriented ☐ comatose/non-responsive ☐ Altered mental status or memory loss requiring supervision ☐ Unable to understand spoken language (not related to a language barrier) ☐ Unable to express needs or ideas (not related to a language barrier)
	Orientation: ☒ person ☒ place ☒ time
	Memory - short-term intact: ☒ Yes ☐ No long-term intact: ☒ Yes ☐ No
	Decision making ability: ☒ independent ☐ impaired
If applicant/participant is a Regional Center consumer: Developmental age as determined by Regional Center: n/a	

Pain n/a ☐	location:	back	frequency:	occasionally
	treatment:	reposition for comfort; on occasion he is medicated with Tylenoll with codiene		
	Date of last PRN medication:	one week ago		

Seizure activity n/a ☒	Are they controlled with medications?	☐ Yes ☐ No		
	Type		Frequency:	
	Description:			
	Medications/Treatment:			
	Date of last PRN medication:			

Vision Impairment n/a ☒	☐ Partially impaired needs or wears corrective lenses
	☐ Severely impaired/legally blind
	☐ Unable to assess

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Hearing Impairment n/a ☒	☐ Partially impaired/hard of hearing
	☐ Uses hearing aides in ☐ left ear ☐ right ear
	☐ Severely impaired/deaf ☐ able to lip read
	☐ Unable to assess

Speech Impairment n/a ☐	☒ Minimal difficulty in speaking due to tracheostomy or in expressing ideas and needs.
	☐ Moderate difficulty, speaks in phrases short sentences
	☐ Severe difficulty in expressing basic ideas or needs. Uses single words or short phrases.
	☐ Aphasic. Unable to express basic needs, but is not comatose or unresponsive
	☐ Nonresponsive or comatose

Language & Communication Impairment ☐ Yes ☒ No	Primary language, if other than English: n/a		
	Requires language interpreter: ☐ Yes ☒ No		
	Uses: ☐ American Sign Language ☐ gestures ☐ sounds ☐ speech generating and/or other communication device		
	Speech Therapy:	☐ Yes ☒ No If yes, frequency:	

please document any other issues in the comments section

Comments: None

DME/Medical Supplies: (please list)
None

DME/Medical Supply Issues:
None

Respiratory:

☐ Within normal limits

Medical Gases n/a ☒	O_2 @ l/min via ☐ continuous or ☐ prn If prn, last used:
	Humidification: If used, frequency:
	Room air mist If used, frequency: RA no O2

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Airway Clearance Issues n/a ☐	Able to cough and expectorate secretions: ☒ Yes ☐ No
	Uses in-exsufflator to stimulate cough: : ☐ Yes ☒ No
	Requires suctioning: ☒ Yes ☐ No If yes, type of suctioning: ☐ oral ☐ nasal ☒ tracheal Frequency: daily 6-10 times Equipment used: ☒ suction machine ☐ bulb syringe
	Secretions (please describe): clear
	Chest PT: If used, frequency: 2-3 times/week

Respiratory Treatments n/a ☒	Medication & frequency:
	Date of last PRN & reason:

Tracheostomy n/a ☐	Type & Size: #8 Shiley Date last changed: 11-2010 and by whom: Dr. Zorba.
	Frequency of tracheostomy care: daily
	How the trach cleaning is done: ☒ sterile or ☐ clean technique
	Is the tracheostomy stoma clean and free from complications? ☒ Yes ☐ No If no, please describe:

Ventilator n/a ☐	Type: LP-10 (primary) LP-10 (back-up) Number of hours on ventilator: 18-20
	Ventilator humidifier: yes
	Able to sprint off ventilator? ☒ Yes ☐ No If yes, how long? up to 6 hours
	Back-up power: batteries for ventilator

Bi-Level Positive Airway Pressure (Bi-PAP) n/a ☒	Frequency of use:
	Individual able to connect self to Bi-PAP? ☐ Yes ☐ No
	Back-up power:

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Continuous Positive Airway Pressure (CPAP) n/a ☒	Frequency of use:
	Individual able to connect self to CPAP? ☐ Yes ☐ No

Pulse oximeter n/a ☒	Frequency of use:
	# of desaturations: 0 in a ☐ day ☐ week.
	Interventions:
	Date of last desaturation & intervention:

Apnea monitor n/a ☒	Frequency of use:
	# of apneic episodes: : in a ☐ day ☐ week.
	Interventions:
	Date of last episode & intervention:

Person who cleans & cares for equipment: LVN caregivers

Date of last upper respiratory infection or pneumonia: none in 2010
Treatment:

Number of upper respiratory infections or pneumonia within the last 6 months: none

please document any other issues in the comments section

Comments: None

DME/Medical Supplies: (please list)
Ventilator X2, suction machine, trach cleaning kits, suction catheters, nebulizer

DME/Medical Supply Issues:
None

Cardiovascular:

☐ Within normal limits

Cardiovascular medications n/a ☒	Cardiovascular medications: (Please list below and state the reason for the medication) none

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Pacemaker n/a ☒	How often is it checked? n/a Date last checked: n/a

Pulse and BP monitored: ☒Yes ☐ No If yes, what is the most recent pulse and BP: 100/70 date taken: few days ago XXX
Intake & Output monitored: ☒Yes ☐ No

Central line n/a ☒	Location: n/a
	Site care: (please describe)
	Person(s) responsible for central line care: n/a
	Is the insertion site clean and free from complications? ☐ Yes ☐ No If no, please describe: n/a
	Is the line used for intravenous or infusion therapy (excluding TPN): ☐ Yes ☐ No
	If yes, what is the frequency? n/a. Who administers the infusion? n/a

please document any other issues in the comments section

Comments: None

DME/Medical Supplies: (please list)
B/P cuff

DME/Medical Supply Issues:
None

Genito-Urinary:

☐ Within normal limits

Incontinent: ☐Yes ☒ No
(If yes, list the supplies and amount used **daily** in the DME/Medical Supplies section below.)

n/a ☒	☐ Indwelling Foley catheter ☐ Suprapubic catheter size: Fr.
	Catheter last changed on (date) by n/a. It is changed n/a.
	Catheter care frequency: n/a
	Drainage bag changes & care: n/a

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n/a ☒	☐ Intermittent catheterizations Frequency: n/a Performed by: n/a
	Catheter size: n/a Fr
	Technique used ☐ clean ☐ sterile

n/a ☐	Other urinary diversion or collection device (please specify below): condom catheters
	Care/treatment ordered for urinary diversion/collection device: n/a

n/a ☒	Bladder irrigation: Frequency: n/a Irrigating solution: n/a Performed by: n/a

Dialysis n/a ☒	☐ Peritoneal Dialysis ☐ Hemodialysis	Frequency: n/a	
	Dialysis performed at: n/a		by: n/a

Date of last urinary tract infection: None
Treatment: n/a

Does the participant have menses? ☐Yes ☐ No ☒ n/a

please document any other issues in the comments section

Comments: Billy uses the urinal while awake and condom caths while up in the chair and at night.

DME/Medical Supplies: (please list)
None

DME/Medical Supply Issues:
None

Gastrointestinal:

☐ Within normal limits

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Oral Nutritional Intake n/a ☐	☒ Regular diet ☐ Other (specify): n/a
	☐ Able to independently feed self ☒ Requires meal set-up, intermittent assistance or supervision from another person ☐ Unable to feed self
	☐ Receives supplemental nutrients through a nasogastric tube or gastrostomy tube in addition to oral feedings

Enteral Nutrition n/a ☒	Feeding formula, frequency & rate:	
	☐ feeding pump ☐ bolus feeding	
	Residual checked: ☐ Yes ☐ No If yes, amount:	
	☐ Gastrostomy tube size: n/a Fr ☐ MIC-KEY button size: n/a Fr ☐ Jejunostomy tube size: n/a Fr ☐ Nasogastric tube size: n/a Fr	
	Button/Tube last changed on (date) by n/a. ☐ It is changed (frequency). ☐ There is no regular schedule for changing the tube.	
	Site Care:	(please describe)
	Frequency:	n/a
	Is the button/tube insertion site clean and free from complications? ☐ Yes ☐ No If no, please describe: n/a	

Parenteral Nutrition n/a ☒	☐ TPN ☐ Lipids Infusion rate: n/a cc/hr over n/a hours via CADD.
	Administered by: n/a

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Elimination	Bowel pattern: ☐ normal ☒ constipation ☐ diarrhea
	Frequency: every 3 days
	Bowel incontinence: ☒ Yes ☐ No
	Bowel program: ☒ Yes ☐ No
	if yes, bowel program using: digital stimulation
	if digital stimulation/disimpaction is ordered: frequency per Billy's choice every 2-3 days by the nurse of his choice. performed by n/a
	Ostomy: ☐ Yes ☒ No If yes, what type: n/a
	Ostomy care: please describe

Endocrine Disorders n/a ☒	Diabetes Mellitus treated with: ☐ Insulin ☐ Oral antidiabetic agents ☐ Diet only
	Medication: n/a
	Blood Glucose monitoring: ☐ Yes ☐ No If yes, frequency:
	If yes, blood glucose range within the last month: n/a
	Sliding scale coverage: ☐ Yes ☐ No
	Thyroid issues: ☐ Yes ☐ No medication: n/a

please document any other issues in the comments section

Comments: None

DME/Medical Supplies: (please list)
None

DME/Medical Supply Issues:
None

Integumentary:

☒ Within normal limits. Skin is intact.

please document any issues in the comments section

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Decubitus Ulcers n/a ☒	Stages:	Description: # of ulcers, location, size, healing status*			
		# of ulcers 1	# of ulcers 2	# of ulcers 3	# of ulcers 4 or more
	I	None	None	None	None
	II	None	None	None	None
	III	None	None	None	None
	IV	None	None	None	None
	Wound care and treatment ordered:				
	Frequency of care:				
	Care performed by:				
	Therapeutic Anti-Decubitus Mattresses and Bed Products used:				
	Number of available turning surfaces:	n/a			
	*Healing status: fully granulating, early/partial granulation, not healing				

Skin lesions, stasis ulcers, wounds, or other skin integrity issues n/a ☒	Location:	n/a
	Description: (include location, size, healing status)	n/a
	Wound care/treatment: (include frequency)	n/a
	Care performed by:	n/a

please document any other issues in the comments section

Comments: Billy has had decubitus in the past; currently his skin is intact as bony prominences are protected by duo derm

DME/Medical Supplies: (please list)
None

DME/Medical Supply Issues:
None

Musculoskeletal:

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☐ Within normal limits

Motor function impairment n/a ☐	Able to move all extremities: ☐ Yes ☒ No If *No*, limitations: Billy is an incomplete quadriplegic; he has minimal function to his right hand and arm and limited function to the left. He is prompted and encouraged to maintain mobility and he can eat with his hand once his food is prepared and set-up fpr him.
	Able to turn and position self in bed: ☐ Yes ☒ No
	Weakness: general
	Contractures: lower extremities
	Spasticity: yes, lower extremities
	Flaccid: yes, lower extremities

Ambulation	☐ Independent ☐ Requires use of an assistive device (☐ cane ☐ walker) ☒ Non-ambulatory	
	Gait steady: ☐ Yes ☒ No	
	Requires supervision or assistance of another person assistance to negotiate stairs, steps or uneven surfaces: ☒ Yes ☐ No	
	Requires supervision or assistance of another person at all times: ☒ Yes ☐ No	
	Ambulation issues:	quadriplegic

Mobility n/a ☐	manual wheelchair: ☐ Yes ☒ No able to wheel self independently: ☐ Yes ☒ No	
	power wheelchair: ☒ Yes ☐ No able to use power chair independently: ☒ Yes ☐ No	
	wheelchair usage (frequency and duration)	Out of bed into wheelchair about 3X/week
	wheelchair issues:	no

Transfer issues n/a ☐	Transfers with minimal assistance or with use of an assistive device: ☒ Yes ☐ No.
	Assistive device: Hoyer lift
	Able to bear weight and pivot: ☐ Yes ☒ No
	Must be physically lifted by nurse/primary caregiver: ☒ one person ☐ two person.
	Hydraulic lift: ☒ Yes ☐ No

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Orthotics and/or prosthetics n/a ☒	type:	n/a
	frequency:	n/a
	compliance:	n/a

Therapies n/a ☒	Physical Therapy: ☐ Yes ☐ No frequency: n/a Is there a home treatment plan? ☐ Yes ☐ No Last reviewed by therapist: (date)	
	Progress towards treatment goals:	please explain
	Occupational Therapy: ☐ Yes ☐ No frequency: n/a Is there a home treatment plan? ☐ Yes ☐ No Last reviewed by therapist: (date)	
	Progress towards treatment goals:	please explain

Restraints n/a ☒	type:	n/a
	frequency:	n/a
	reason:	n/a

please document any other issues in the comments section

Comments: None

DME/Medical Supplies: (please list)
Hospital bed, Hoyer lift, power wheelchair

DME/Medical Supply Issues:
None

Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL)

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Function	Independent	Requires assistance	Dependent	Comments
Bathing	☐	☐	☒	None
Dressing	☐	☐	☒	None
Grooming	☐	☐	☒	None
Oral Care	☐	☒	☐	None
Toileting	☐	☐	☒	None
Telephone usage	☒	☐	☐	None
Shopping	☐	☐	☒	None
Meal Preparation	☐	☐	☒	None
Housekeeping (cooking, cleaning, laundry)	☐	☐	☒	None
Medication Administration and Management	☐	☐	☒	None
Equipment/Supply Management:	☐	☐	☒	None

Transportation:	☐ Independent uses public transportation (bus, van service, etc.) or drives own car ☐ Travels using private auto driven by another ☒ Needs to be accompanied by another ☐ Requires Non-emergency medical transportation ☐ Other:

please document any other issues in the comments section

Comments: Billy uses para transit for his appointments.

DME/Medical Supplies: (please list)
None

DME/Medical Supply Issues:
None

Psychosocial

Primary Caregiver: Bobby Joe Relationship to applicant/participant: caregiver

Back-up Caregiver: Mary Jane Relationship to applicant/participant: mother

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	Yes	No*	n/a
Is there a back-up plan if there is no primary or backup caregiver?	☒	☐	☐
Does the back-up plan adequately address the health and safety needs?	☒	☐	☐
Is the participant, family and/or legal guardian coping well with waiver/non-waiver services?	☒	☐	☐
Is the participant, family, and/or legal guardian satisfied with how the participant's care is delivered?	☒	☐	☐
Are the participant's preferences for care considered?	☒	☐	☐

*****Please explain any No answers in the comments

Comments: None

Ask the applicant/participant/primary caregiver (as *appropriate*):	Yes	No
Are there issues or concerns regarding neglect, exploitation or abuse?*	☐	☒
Is the applicant/participant/primary caregiver aware of how and to whom they should report issues or concerns regarding neglect, exploitation or abuse?	☒	☐
If such events occurred, were the appropriate authorities notified? *	☐	☐

*****If *Yes*, please explain in the comments

Comments: Abuse and abuse reporting was discussed at the home visit. Billy reports he understands the different types of abuse; physical, emotional, financial and he denies any of this or neglect/exploitation. Should abuse occur, he will call 911, APS, IHSS to report it.

Employed: ☐ Yes ☒ No If yes, type of work: n/a # of hours worked: n/a
School: ☐ Yes ☒ No name of school: n/a # of hours attended: n/a
Does the HCBS caregiver accompany them to school? ☐ Yes ☐ No ☒ n/a

Comments: None

Other Services

IHSS n/a ☐	Hours:	70.6	County:	Sacramento
	Comments:	Domestic hours; no direct care hours		

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Regional Center n/a ☒	RC:	None				
	Consumer Service Coordinator:	None			Telephone:	None
	Respite hours:	None	other services:	None		

CCS n/a ☒	County:	None		
	CCS Contact:	None	Telephone:	None
	Services:	None		

OHC n/a ☒	Plan:	None
	Services:	None

Other programs n/a ☒	List other programs and services that the individual is receiving. *Include the program name, location services provided, the services received, telephone number, and program contact person.*
	None

Is the applicant/participant enrolled in another waiver? ☐ Yes ☒ No
If yes, what is the name of the waiver:

Comments: Billy is receiving 24 hour care through shift nursing via waiver program. Domestic and other services via IHSS.

Menu of Health Services (MOHS) Review

☐ n/a waiver applicant.

In-Home Operations Case Report

☐ **Intake** ☒ **Case Management** **IHO Region:** ☒ **North** ☐ **South**

Name: **Bob, Billy** **Visit Date:** **4-21-2011**

CIN: **XXXXXXXX** **NE II:** **R.N.**

	Yes	No*
Was the current MOHS reviewed with the waiver participant/primary caregiver?	☒	☐
Does the current MOHS document the approved waiver program cost?	☒	☐
Does the current MOHS reflect all authorized Waiver and State plan services?	☒	☐
Is the current MOHS cost neutral to the identified program cost?	☒	☐
Is the participant receiving all services, waiver and non-waiver services, needed to remain safely in the home?	☒	☐

**Please explain any No answers in the comments*

Comments: None

Is there a request for a change in authorized services? ☐ Yes ☒ No

Requested change: None

Comments: Case Manager to oversee the TAR have same end-date for all care-providers

Issues/Plan of Resolution

Issues identified during **this visit** and the plan for resolution:
None, participant is satisfied with the program

Issues identified during **prior visit(s)** and the current status:
None

Comments: None

Justification for Program Level of Care and Level of Case Management

Based upon the information contained in this report, Billy Bob meets the criteria for the IHO Waiver. Level of Care (LOC) determination: Adult Subacute

LOC justification:	Billy is dependent on his tracheostomy and ventilator for respiratory integrity support during the hours of sleep. He requires suctioning every 4-6 hours and inhalation therapy via nebulizer for congestion and wheezing. He needs his medication administrated to him, (routine and prn), skin integrity assessment and intervention to prevent pressure sores. Billy is dependent on others for his ADL and IADL care, bowel and bladder care.
Recommendation:	Continue to evaluate Mr. Bob on the IHO-Waiver Sub-Acute level-providing ongoing support towards continuing cost-neutrality.

In-Home Operations Case Report

☐ **Intake** ☒ **Case Management** **IHO Region:** ☒ **North** ☐ **South**

Name: **Bob, Billy** **Visit Date:** **4-21-2011**

CIN: **XXXXXXXX** **NE II:** **R.N.**

n/a waiver applicant ☐	Level of Case Management:	2	Justification:	No staffing or eligibility issues. No hospitalizations this past 6 months.

NE II completing the review: _____ signature NEII printed name

Date report completed: 04-28-2011

Second Opinion/Reviewer: _____ signature printed name and title

Date report reviewed:

Second Opinion/Reviewer comments: *(optional)*	☐ No comments