

**New Jersey Department of Human Services
Division of Aging Services
NEED-BASED CARE ALLOCATION TOOL**

	Date
Name of Participant	SSN
Street Address	Date of Birth
City, State, Zip Code	Telephone Number

The New Jersey Department of Human Services, Division of Aging Services (DHS/DoAS) administers the Global Options (GO) Waiver. The GO Waiver offers Home Based Supportive Care (HBSC) services which can be provided through an agency or through a Participant Employed Provider (PEP). GO in-home supportive services include agency and/or PEP support with personal needs, transportation, chore service, and/or attendant care, among others.

GO is designed to supplement – not replace – the assistance already being provided by family, friends and neighbors. If the PEP resides in the same home as the participant, and the PEP is also attending the functions or providing any other service that a person sharing a home can be reasonably expected to perform, the PEP will not be reimbursed for such tasks as housekeeping, grocery shopping, laundry, meal preparation, taking the participant to religious services, out to dinner, family/special events, etc. By providing a flexible package of services and supports, the program strengthens the ability of caregivers to continue in their vital role as primary support providers.

Personal Care Assistant (PCA) Services are administered by the Department of Human Services, Division of Disability Services (DHS/DDS). PCA hours are determined through a process administered and authorized by DHS/DDS. Care services are provided by a certified PCA under the direction of a registered nurse in accordance with a physician's certification of need for care.

PCA and HBSC, provided by an agency or a PEP, are mutually exclusive of one another. This means that the participant must choose either PCA or HBSC.

ADL or IADL support hours for all state and/or federal publicly-funded services are to be combined and should not exceed the total hours/score computed using this tool. Care Managers must take all publicly-funded ADL or IADL support hours into consideration when constructing the Plan of Care.

This tool shall be completed when developing the initial Plan of Care, the annual Plan of Care or when there has been a significant change in the participant's functional abilities or a significant change in caregiver status requiring a revision to the Plan of Care. This tool shall be used in conjunction with the following documents, as applicable:

- NJ Choice Care Manager Assessment
- Long Term Care Re-evaluation Tool

This tool is a guide to assist Care Managers in determining a participant's care needs. This tool is meant to be a guide only and each individual's needs may vary. A copy of this tool is to be kept in the participant's active case file.

NEED-BASED CARE ALLOCATION TOOL (Continued)

Name of Participant	Date	
CHECK ONLY ONE SCORE PER SECTION		
I. SUPPORTIVE SERVICES / LIVING ENVIRONMENT		
A.	Participant lives alone or with others and is independent.	<input type="checkbox"/> 0
B.	Participant lives alone or with others and receives assistance at least 4-7 days per week from informal supports.	<input type="checkbox"/> 1
C.	Participant lives alone or with others and receives assistance at least 1-3 days per week from informal supports.	<input type="checkbox"/> 2
D.	Participant lives alone and receives no assistance from informal supports -OR- lives with others and receives negligible assistance from informal supports.	<input type="checkbox"/> 3
II. COGNITIVE STATUS		
A.	Participant is consistently alert and oriented and independently initiates, performs and/or self-directs performance of ADL/IADL care.	<input type="checkbox"/> 0
B.	Participant demonstrates minimal cognitive impairment only in new or specific situations and requires cueing/supervision/reminders to initiate, perform and/or self-direct performance of ADL/IADL care.	<input type="checkbox"/> 1
C.	Participant demonstrates moderate cognitive impairment and requires cueing/supervision/reminders repeatedly to initiate, perform and/or self-direct performance of ADL/IADL care.	<input type="checkbox"/> 2
D.	Participant demonstrates severe cognitive impairment and never/rarely makes decisions. Participant is unable to initiate, perform or self-direct performance of ADL/IADL care.	<input type="checkbox"/> 3
III. AMBULATION / BED MOBILITY		
A.	Participant ambulates independently with or without assistive devices or is independently mobile in a wheelchair. Participant is able to independently reposition self in bed.	<input type="checkbox"/> 0
B.	Participant requires cueing, supervision and/or reminders while ambulating with or without assistive devices. Participant is able to independently reposition self in bed.	<input type="checkbox"/> 1
C.	Participant is ambulatory with partial assistance from others with or without assistive devices and is able to independently reposition self in bed.	<input type="checkbox"/> 2
D.	Participant is ambulatory with full assistance from others with or without assistive devices and is able to independently reposition self in bed.	<input type="checkbox"/> 3
E.	Participant requires full assistance from others to propel wheelchair indoors and/or outdoors and is able to independently reposition self in bed.	<input type="checkbox"/> 4
F.	Participant is non-ambulatory and is limited to bed, chair, or wheelchair and requires assistance from others to reposition in bed.	<input type="checkbox"/> 5

**NEED-BASED CARE ALLOCATION TOOL
(Continued)**

Name of Participant		Date
CIRCLE ONLY ONE SCORE PER SECTION		
IV. TRANSFERS (EXCLUDES TRANSFERS FOR TOILETING AND BATHING)		
A.	Participant is able to transfer independently with or without the use of assistive devices.	<input type="checkbox"/> 0
B.	Participant is able to transfer but requires cueing, supervision and/or reminders during transfers.	<input type="checkbox"/> 1
C.	Participant is weight bearing and is able to transfer with the assistance of one person with or without assistive devices.	<input type="checkbox"/> 2
D.	Participant is non-weight bearing and transfers with the assistance of one person.	<input type="checkbox"/> 3
E.	Participant is non-weight bearing and transfers with the assistance of two people -OR- transfers with assistance via a mechanical lift device. (NOTE: Second person transfer assistance provided by an unpaid informal caregiver such as a family member.)	<input type="checkbox"/> 4
V. EATING / MEAL PREPARATION		
A.	Participant is independent with meal preparation and eating -OR- administers own tube feedings.	<input type="checkbox"/> 0
B.	Participant requires assistance with meal preparation and serving/set up.	<input type="checkbox"/> 2
C.	Participant requires assistance with meal preparation and needs cueing, supervision, reminders or partial assistance with eating.	<input type="checkbox"/> 3
D.	Participant cannot feed self and is fully dependent on others for meal preparation and feeding or is fully dependent on others who prepare and administer tube feedings.	<input type="checkbox"/> 4
VI. BATHING (INCLUDES TRANSFERS FOR BATHING)		
A.	Participant is able to bathe self independently.	<input type="checkbox"/> 0
B.	Participant requires setup, cueing, supervision, or reminders while bathing.	<input type="checkbox"/> 2
C.	Participant requires partial assistance with full bath (participant performs more than 50% of activity); includes tub bath, shower, or sponge bath.	<input type="checkbox"/> 4
D.	Participant requires extensive assistance with full bath (caregiver performs more than 50% of activity); includes tub bath, shower, or sponge bath.	<input type="checkbox"/> 5
E.	Participant is fully dependent on others for full bath (full performance of activity by caregiver); includes tub bath, shower, or sponge bath.	<input type="checkbox"/> 6

**NEED-BASED CARE ALLOCATION TOOL
(Continued)**

Name of Participant		Date
CIRCLE ONLY ONE SCORE PER SECTION		
VII. TOILETING (INCLUDES TRANSFERS TO/FROM TOILET-COMMODE-BEDPAN, PERINEAL CARE [CONTINENCE AND INCONTINENCE CARE] AND CLOTHING ADJUSTMENTS)		
A.	Participant is continent or incontinent and is independent with toileting and/or incontinence care and/or independent with ostomy or catheter care.	<input type="checkbox"/> 0
B.	Participant is continent but requires assistance with ostomy or catheter care.	<input type="checkbox"/> 1
C.	Participant is continent but requires partial assistance with toileting and related care (participant performs more than 50% of activity).	<input type="checkbox"/> 2
D.	Participant is occasionally incontinent of bowel and/or bladder (incontinent episodes 2 or more times a week but not on a daily basis) and requires assistance with toileting and incontinence care.	<input type="checkbox"/> 3
E.	Participant is frequently incontinent of bowel and/or bladder (incontinent episodes tend to occur daily, some control present) and requires assistance with toileting and incontinence care.	<input type="checkbox"/> 5
F.	Participant is nearly always/always incontinent of bowel and/or bladder (inadequate control, occurs multiple times daily) and requires full assistance with toileting and incontinence care.	<input type="checkbox"/> 6
VIII. GROOMING / DRESSING		
A.	Participant is able to groom and/or dress self independently.	<input type="checkbox"/> 0
B.	Participant requires cueing, supervision and/or reminders to groom.	<input type="checkbox"/> 1
C.	Participant requires cueing, supervision and/or reminders to dress.	<input type="checkbox"/> 2
D.	Participant is able to groom and/or dress self with partial assistance (participant performs more than 50% of activity).	<input type="checkbox"/> 3
E.	Participant is able to groom and/or dress self with extensive assistance (caregiver performs more than 50% of activity) -OR- is totally dependent on others to perform grooming and dressing activities.	<input type="checkbox"/> 4
IX. HOUSEKEEPING / SHOPPING		
A.	Participant is independent with these tasks.	<input type="checkbox"/> 0
B.	Participant is dependent on others for housekeeping and/or shopping.	<input type="checkbox"/> 2
X. LAUNDRY		
A.	Participant is independent with this task.	<input type="checkbox"/> 0
B.	Participant is dependent on others for laundry performed within private residence.	<input type="checkbox"/> 1
C.	Participant is dependent on others for laundry performed outside of housing unit of a multi-unit complex (apartment, condominium, etc.) but laundry facilities are available in building or on grounds of complex.	<input type="checkbox"/> 2
D.	Participant is dependent on others for laundry performed outside of the private residence or housing unit of a multi-unit complex (apartment, condominium, etc.) but laundry facilities are NOT available on premises, in building, or on grounds of complex.	<input type="checkbox"/> 3
TOTAL NEED-BASED SCORE: Individual Hours per Week: []] NEED-BASED SCORE = HOURS OF SERVICE PER WEEK		

NEED-BASED CARE ALLOCATION TOOL (Continued)

Name of Participant	Date
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Current Formal and Informal Supports *(Please complete the following section):*

Service	Service Provider	Units of Service, Frequency and Duration	Provider Type or Payment Source ¹

NOTE: ADL/IADL support hours for all state and/or federal publicly-funded services are to be combined and should not exceed the total hours/score computed using this tool. Concurrent enrollment in some publicly-funded programs is prohibited; eligibility must be verified prior to enrollment in multiple programs. Take all publicly-funded ADL/IADL support hours into consideration when constructing the Plan of Care.

¹Use the following codes to indicate Provider Type or Payment Source:

- | | |
|---|---|
| <ul style="list-style-type: none"> a. Adult Day Health Services (ADHS) b. Informal Support (Unpaid Provider) c. Medicare d. Older American Act/Title III Funds e. Personal Assistance Services Program (PASP) f. Personal Care Assistant Services (PCA) | <ul style="list-style-type: none"> g. Personal Preference Program h. Private Provider (Private Payment) i. Social Services Block Grant j. Traumatic Brain Injury Fund (TBI Fund) k. Other (specify): _____ |
|---|---|

Name (<i>Print</i>): <input type="checkbox"/> Assessor –OR– <input type="checkbox"/> Care Manager	
Signature	Date

Name (<i>Print</i>): <input type="checkbox"/> Participant –OR– <input type="checkbox"/> Participant Authorized Representative	
Signature	Date

It is my belief that based on the needs of the participant and the justification presented to me by the Care Manager, _____ hours are justified to address the health needs of this participant. As the Care Coordinator / Care Manager Supervisor I authorize the increase, not to exceed 40 hours per week or more than \$2841.00 dollars in waiver services, for this GO participant.

Name (<i>Print</i>): <input type="checkbox"/> Care Coordinator –OR– <input type="checkbox"/> Care Manager Supervisor	
Signature	Date