Veteran Directed Care (VDC) Program
Mental/Emotional/Behavioral Health Assessment (MEBH)

Referral Date _____ Diagnosis Code: _____

Date Assessed _____ Date Reassessed _____

Respondent (specify relationship) _____

Case Manager _____

Last Name _____ **First Name** _____ **MI** _____

Address 1 _____

Address 2 _____

City _____ Zip Code _____ County _____

Home Phone _____ Other _____ DOB _____

Sex: ☐ Male ☐ Female Primary Language _____

Marital Status: ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed

Social Security # _____

Medicaid # _____

Medicare Number _____ ☐ A ☐ B ☐ C ☐ D

Private/Supplemental _____ Policy # _____

VA Identification #s _____

Main Support:

Name _____

Relationship _____

Phone _____

Alt. Phone _____

Back Up Support:

Name _____

Relationship _____

Phone _____

Alt. Phone _____

Emergency Contact: Check here if same as main support

Name _____

Relationship _____

Address _____

City, State, Zip _____

Phone _____ Alt. Phone _____

Emergency Plan:
Specify who would provide backup support in the event of an emergency, inability of employee to provide care, and/or lack of hired employee(s).

Name _____

Relationship _____

Address _____

City, State, Zip _____

Phone _____ Alt. Phone _____

Comments:

Court Appointed Conservator/Guardian (if applicable):

Name _____

Relationship _____

Address _____

City, State, Zip _____

PHYSICAL HEALTH

Date of last hospitalization _____

Reason for last hospitalization _____

Diagnosis (provide details)

- ☐ CVA _____
- ☐ Myocardial Infarction _____
- ☐ Heart Disease _____
- ☐ Emphysema/COPD _____
- ☐ Other Lung Disease _____
- ☐ Neuromuscular Disease _____
- ☐ Rheumatoid/Ostoe _____

- [ ] Osteoporosis _____
- [ ] Alzheimer's/Dementia _____
- [ ] Chronic Head Aches _____
- [ ] Eating Disorder _____
- [ ] Amputation _____
- [ ] Blood Disorder/Disease _____
- [ ] Diabetes _____
- [ ] Hazardous Exposure _____
- [ ] Infectious Disease _____
- [ ] Cancer _____
- [ ] Digestive Disorder _____
- [ ] UTI _____
- [ ] Agent Orange Exposure _____
- [ ] Spinal Cord Injury _____
- [ ] Mental Illness _____
- [ ] PTSD _____
- [ ] Traumatic Brain Injury _____
- [ ] Fracture/Injury _____
- [ ] Decubitus/Stasis Ulcer _____
- [ ] CHF _____
- [ ] Incontinence _____

Other Diagnosis (please specify):

Alcohol Use:

- [ ] N/A
- [ ] Occasional
- [ ] Almost Every Day
- [ ] Every Day

Recreational Drug Use:

- [ ] N/A
- [ ] Occasional
- [ ] Almost Every Day
- [ ] Every Day

Nutrition --- Special Diet: ☐ Yes ☐ No

If yes, specify: _____

Comments

PHYSICAL ENVIRONMENT

Living Arrangement:

☐ Alone ☐ With Child(ren) ☐ With Spouse
☐ With Relatives ☐ With Non-Relatives

Housing (check all that apply):

☐ Apartment ☐ Low-Income Housing ☐ Boarding House
☐ Home of Relatives ☐ Owns Home ☐ Subsidized
☐ Senior Housing ☐ Condominium ☐ Residential Care
☐ Mobile Home ☐ Other (Please specify: _____)

Check each category	YES	NO	NEEDS REPAIR	COMMENTS
Sound building	☐	☐	☐	
Sound furnishings	☐	☐	☐	
Running water (hot/cold)	☐	☐	☐	
Adequate heating/cooling	☐	☐	☐	
Tub/shower/commode (accessible & useable)	☐	☐	☐	
Stove/microwave	☐	☐	☐	
Refrigerator	☐	☐	☐	
Freezer Space	☐	☐	☐	
Telephone	☐	☐	☐	
TV/Radio	☐	☐	☐	
Washer/Dryer	☐	☐	☐	
Adequate space	☐	☐	☐	

Check each category	YES	NO	NEEDS REPAIR	COMMENTS
Adequate lighting	☐	☐	☐	
Adequate locks	☐	☐	☐	
Neighborhood safe/secure	☐	☐	☐	
Free of insects/rodents	☐	☐	☐	
Smoke Detectors	☐	☐	☐	
Free of architectural barriers	☐	☐	☐	
CO2 detectors	☐	☐	☐	

Additional Comments:

Is there a weapon in the home and where?

Overall review of physical environment

ASSISTIVE DEVICES & SENSORY IMPAIRMENT

	HAS	USES	NEEDS	COMMENTS
Bed Pan	☐	☐	☐	
Bedside Commode	☐	☐	☐	
Elevated Toilet Seat	☐	☐	☐	
Tub Seat	☐	☐	☐	
Grab Bars	☐	☐	☐	
Cane/Crutches	☐	☐	☐	
Walker	☐	☐	☐	
Hospital Bed	☐	☐	☐	
Lift Chair	☐	☐	☐	

	HAS	USES	NEEDS	COMMENTS
Wheelchair	☐	☐	☐	
Prosthesis	☐	☐	☐	

List other assistive devices

Vision

- ☐ Adequate
- ☐ Moderate Loss
- ☐ Severe Loss
- ☐ Total Blindness

Hearing

- ☐ Adequate
- ☐ Moderate Loss
- ☐ Severe Loss
- ☐ Total Deafness

MENTAL/EMOTIONAL/BEHAVIORAL HEALTH

Cognitive Functioning: ☐ 0 – Alert ☐ 1 - Confused ☐ 2 – Forgetful ☐ 3 - Disoriented

Comprehension:

- ☐ 0 – Understands – clear comprehension.
- ☐ 1 – Usually understands – misses some part/intent of message, but comprehends most conversation with little or no prompting.
- ☐ 2 – Often understands – misses some part/intent of message, with prompting can often comprehend conversation.
- ☐ 3 – Rarely/never understands.

Decision Making Ability:

- ☐ 0 - Consumer makes consistent, reasonable decisions.
- ☐ 1 - Consumer makes simple decisions without assistance.
- ☐ 2 - Consumer makes poor decisions and needs cues/supervision.
- ☐ 3 - Consumer is severely impaired and rarely makes his/her decisions.

Short Term Memory Impairment:

- ☐ 0 - N/A
- ☐ 1 - Consumer has short term memory impairment.
- ☐ 2 - Memory lapses resulting in frequently not performing tasks even with reminders.
- ☐ 3 - Memory lapses resulting in inability to perform routine tasks on daily basis.

BEHAVIOR PATTERN	No Problem (0)	Moderate Problem (1) (but not daily)	Serious Problem (2) (nearly every day)
Physically/verbally abusive or assaultive	☐	☐	☐
Angry, threatening behaviors	☐	☐	☐
Threats to health and safety	☐	☐	☐
Wandering	☐	☐	☐
Repetitive Actions	☐	☐	☐
Rummaging, hoarding, hiding, losing items	☐	☐	☐
Suspicious	☐	☐	☐
Sundowners	☐	☐	☐
Inappropriate Behaviors	☐	☐	☐

Mental Health Screening:

☐ 0 – No ☐ 1- Yes During the last six months, have you had a lack of interest in most activities?

☐ 0 – No ☐ 1- Yes During the last six months, have you had problems sleeping?

☐ 0 – No ☐ 1- Yes During the last six months, have you felt down, depressed, hopeless?

☐ 0 – No ☐ 1- Yes During the last six months, have you felt devalued as a person?

Comments

SUBTOTAL MENTAL/EMOTIONAL/BEHAVIOR HEALTH --

☐

ADL/IADL ASSESSMENT

ADLs Help Needed	None (0 pt)	Mild (1)	Severe (2)	Total (3)	Needs Met By	Needs Unmet	Totally Met	Partially Met	Freq.
Feed Self						☐	☐	☐	☐
Transfer						☐	☐	☐	☐
Toileting						☐	☐	☐	☐
Peri Care						☐	☐	☐	☐
Bathing						☐	☐	☐	☐
Grooming						☐	☐	☐	☐
Trim Nails						☐	☐	☐	☐
Dressing						☐	☐	☐	☐
Walking						☐	☐	☐	☐
Balance Problems						☐	☐	☐	☐
TOTAL SCORES									

Comments:

IADLs Help Needed	None (0 pt)	Mild (1)	Severe (2)	Total (3)	Needs Met By	Needs Unmet	Totally Met	Partially Met	Freq.
Meal Prep									
Open Jars, Cans, Bottles									
Shopping/ Errands									
Light Housework									
Heavy Housework									
Handling Finances									
Telephone Use									
Med. Mgmt.									
Laundry									
Trans-portation									
TOTAL SCORES									

Comments:

SUBTOTAL OF ADLs & IADLs	

SUMMARY & JUDGEMENT

GRAND TOTAL SCORE	

Provide a copy of MEBH assessment to Veteran after completed fully if requested (may have to mail a copy)

Assessor Signature: _____ Date: _____

Veteran Directed Care (VDC) Program
Agreement between Veteran and Employee / Worker

This agreement is between the veteran / representative (if applicable) _____ (print name), who is the employer of record, and the employee/worker _____ (print name).

The employee (Personal Assistant / in-home worker) agrees to the following:

1. I will perform the tasks on the attached task list and other duties as directed by the veteran / employer of record or authorized representative.
2. I am authorized to work for the veteran who is the employer of record for _____ hours per week and I understand that I will not be compensated for any time worked beyond the authorized hours stated in this Agreement.
3. I will be on time, and if I am late or unable to work at a scheduled time, I will call the veteran / employer of record or authorized representative.
4. I will tell the veteran / employer of record two weeks in advance when I need time off.
5. I will complete the approved time sheet on a semi-monthly basis in a manner that accurately reflects the number of hours of service delivered to the veteran / employer of record.
6. I will submit my time sheets to the veteran / employer of record or authorized representative for his/her signature.
7. If I submit my time sheet late to the veteran / employer of record or authorized representative, I understand that my time sheet will be processed in the next payroll cycle.
8. I understand that Pennyrile Area Development District is the Financial Management organization for the veteran / employer of record and that the Pennyrile Area Development District is responsible for processing my payroll.
9. I will communicate with the veteran / employer of record or authorized representative openly about all work related issues.
10. I will give the veteran / employer of record two weeks' notice if I decide to terminate my employment agreement.
11. I understand that I am neither an employee nor an agent of the Pennyrile Area Development District or Pennyrile Area Agency on Aging & Independent living.
12. I release Pennyrile Area Development District and Pennyrile Area Agency on Aging & Independent living which includes the Case Manager from all responsibility and liability for any injury incurred or loss of property resulting from the delivery of service to the veteran / employer of record.
13. I understand that failure to perform agreed upon expectations or violate any terms as described in the "Program Manual for Veterans" under the "Terminating an Employee Agreement" can and will be grounds for termination.
14. I understand that employment is contingent on providing all information required to successfully be enrolled in the VF/EA FMS entity's payroll system.

_____
Printed Name of Employee

_____ _____
Signature of Employee Date

The veteran or authorized representative agrees to the following:

1. I will pay the employee /worker an hourly rate of _____ (or closest to, depending on taxes-may fluctuate year to year) for services delivered under this contract.

2. I will ensure a safe work environment for the employee / worker.

3. I will assign clear duties and job responsibilities.

4. I will submit timesheets to the Pennyrile Area Development District in a timely manner to ensure that the employee / worker can be paid promptly.

5. I will communicate with the employee / worker openly about all work related issues.

I have been fully informed of the results of the employee / worker's background check prior to making the decision to hire the employee / worker.

_____
Printed Name of Veteran / Employer of Record

_____ _____
Signature of Veteran / Employer of Record Date

Kentucky Veterans Directed Care Program (KY VDC) Satisfaction Survey (Annually)

The Kentucky Veterans Directed Care Program (KY VDC Program) is a program that helps our disabled veterans remain in their own home while receiving assistance. We value your opinion and are open to any comments, questions, or suggestions about your experience in this program. To better serve you, please answer the questions below. Thank you for your participation in this survey. This is completed at 60 days from veteran going active, at six months in the first year of service as well as at the twelve-month reassessment, and twelve months thereafter.

Program

1. How satisfied are you with the amount of time it took for you and your worker(s) to enroll in the KY VDC Program?

- ☐ Very satisfied
- ☐ Mostly satisfied
- ☐ Indifferent or mildly dissatisfied
- ☐ Quite dissatisfied
- ☐ Unknown

2. How satisfied are you with the amount of your involvement in the planning and managing of your services?

- ☐ Very satisfied
- ☐ Mostly satisfied
- ☐ Indifferent or mildly dissatisfied
- ☐ Quite dissatisfied
- ☐ Unknown

3. Have you received all of the information you need about the program and in a way that you understand?

- ☐ Yes, definitely
- ☐ Yes, generally
- ☐ No, not really
- ☐ No, definitely not
- ☐ Unknown

4. Do you feel that you understand your rights and responsibilities?

- ☐ Very satisfied
- ☐ Mostly satisfied
- ☐ Indifferent or mildly dissatisfied
- ☐ Quite dissatisfied
- ☐ Unknown

5. Do you understand your monthly budget and the services or goods you may purchase?

- ☐ Yes, definitely
- ☐ Yes, generally
- ☐ No, not really
- ☐ No, definitely not
- ☐ Unknown

6. Has KY VDC Program allowed you to receive in-home services or goods that you need most in order to stay in your home?

- ☐ Yes, definitely
- ☐ Yes, generally
- ☐ No, not really
- ☐ No, definitely not
- ☐ Unknown

Support

7. **Does your Veterans Case Manager listen to your needs?**

- ☐ Yes, definitely
- ☐ Yes, generally
- ☐ No, not really
- ☐ No, definitely not
- ☐ Unknown

8. **How satisfied are you with the Veterans Case Managers response to your calls and requests for assistance?**

- ☐ Very satisfied
- ☐ Mostly satisfied
- ☐ Indifferent or mildly dissatisfied
- ☐ Quite dissatisfied
- ☐ Unknown

9. **How satisfied are you with the way and timeliness that your KY VDC Program bills are paid?**

- ☐ Very satisfied
- ☐ Mostly satisfied
- ☐ Indifferent or mildly dissatisfied
- ☐ Quite dissatisfied
- ☐ Unknown

10. **Do you know whom to contact if you have a problem or if you feel that you need more help?**

- ☐ Yes
- ☐ No
- ☐ Unknown

Services

11. **Does the KY VDC Program achieve its goal of providing services that help keep you in your home?**

- ☐ Yes, definitely
- ☐ Yes, generally
- ☐ No, not really
- ☐ No, definitely not
- ☐ Unknown

12. **Was it easy to find a worker or workers?**

- ☐ Yes, definitely
- ☐ Yes, generally
- ☐ No, not really
- ☐ No, definitely not
- ☐ Unknown

13. **Do your workers provide you with help at times that work best for you?**

- ☐ Yes, definitely
- ☐ Yes, generally
- ☐ No, not really
- ☐ No, definitely not
- ☐ Unknown

Quality

14. **How would you rate the quality of the services you receive?**

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

15. **Overall, do you feel that the KY VDC Program services…**

- ☐ Helped a lot
- ☐ Helped a little
- ☐ Did not help
- ☐ Made things worse
- ☐ Unknown

16. **What is the likelihood that you would have gone into a nursing home without KY VDC Program services?**

- ☐ Very likely
- ☐ Somewhat likely
- ☐ Almost certain
- ☐ Not at all likely
- ☐ Unknown

17. **Have the services you received improved your life?**

- ☐ Yes, definitely
- ☐ Yes, generally
- ☐ No, not really
- ☐ No, definitely not
- ☐ Unknown

18. **If a fellow veteran was in need of similar help, would you refer him or her to the KY VDC Program?**

- ☐ Yes, definitely
- ☐ Yes, generally
- ☐ No, not really
- ☐ No, definitely not
- ☐ Unknown

19. **Do you have any comments, questions, or suggestions about your experience in the KY VDC Program?**

- ☐ Yes, if so explain
- ☐ No

Your feedback is important to us and we value your opinion. In the section below please explain your experience and satisfaction/dissatisfaction with the KY VDC Program within the past year. Please also list any changes or recommendations (if any) that you think would be beneficial in improving the KY VDC Program.