

Client Changes Reporting Form for Case Managers

Client name: _____

Medicaid number: _____

Medicaid program: _____

Home address: _____

Case manager: _____

Case manager contact number: _____

Instructions: Use this form to report any events or changes in the client's condition that could inform the assessment process. **Include events or changes that have occurred in the last 60 days.** After completing the form, email a copy to **dhs.daas.reassessment@arkansas.gov**

1. Has the client been hospitalized in the last 60 days? Yes___ No___

Dates of hospitalization: _____

Explanation and impact on client: _____

2. Has there been a change in informal (unpaid) caregiver support in the last 60 days?

Yes___ No___

Explanation and impact on client: _____

3. Has there been a significant change in the client's environment in the last 60 days?

Yes___ No___

Explanation and impact on client: _____

4. Has there been an **improvement** in the overall medical condition of the client in the last 60 days? Yes___ No___

Explanation and impact on client: _____

5. Has there been a **decline** in the overall medical condition of the client in the last 60 days?

Yes___ No___

Explanation and impact on client: _____

6. Have there been any changes in dementia or cognition in the last 60 days?

Yes___ No___

Explanation and impact on client: _____

7. Have there been any changes in a client's activities of daily living (ADLs) in the last 60 days?

Yes___ No___

Explanation and impact on client: _____
