

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 the client _____

2. Has there been a change in informal (unpaid) caregiver support in the last 60 days? Yes ___ No ___
Explanation and impact on the 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 the 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 the client _____

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

Yes ___ No___

Explanation and impact on the 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 the client _____
