Kentucky Department for Medicaid Services
Division of Community Alternatives
1915(c) HCBS Waiver Participant Welfare Checklist
March 2020

Participant Information	
Name: Click here to enter text.	**Date of Birth:** Click here to enter text.
Who did you speak with? Click here to enter text.	**Date and Time of Contact:** Click here to enter text.
Relationship to Participant (if not speaking with the participant): Click here to enter text.	**Reason given for not speaking directly to the participant:** Click here to enter text.

Questions
Are you hungry or thirsty? ☐ Yes ☐ No **Do you have food and drinks to address that?** *Comments:* Click here to enter text.
Are you taking all of the medicines your doctor told you to take? **☐ Yes ☐ No** *Comments:* Click here to enter text.
Are you running low on medications or out of any medications? ☐ Yes ☐ No *Comments:* Click here to enter text.
Are there any household essentials that you do not have like toilet paper or hygiene supplies? ☐ Yes ☐ No *Comments:* Click here to enter text.
Has your health changed or how you are feeling gotten worse since we last talked? **☐ Yes ☐ No** **If the participant is experiencing a significant change his health, the caller should notify the center's nurse.* **What symptoms are you feeling?** Click here to enter text.
Is everything okay with your housing? Are utilities on, can you lock your doors, etc.? **☐ Yes ☐ No** *Comments:* Click here to enter text.

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Do you feel safe? ☐ Yes ☐ No **If not, why?** *Comments:* Click here to enter text.
Are you feeling more sad or anxious than the last time we talked? ☐ Yes ☐ No *Comments:* Click here to enter text.
Are there any additional questions you need to ask me or things you want me to know? Click here to enter text.
Additional Comments: Click here to enter text.

Employee Signature: **Electronic signature is acceptable.* Click here to enter text.	**Print Name:** Click here to enter text.
By signing above, I hereby certify, under the penalty of perjury, that the foregoing information is true and correct. This record will be maintained for at least 5 years from the date of creation and shall immediately be available to the Kentucky Department for Medicaid Services upon request.	