



# Oregon Minor Client Acuity Scale Worksheet

**Optional Form**

Date of Assessment \_\_\_\_\_ Client Name \_\_\_\_\_

Clients are assigned to a Level if they meet one or more of the criteria listed within each Level.

Point values are different for different LIFE AREAS by page.

<b>PSYCHOSOCIAL (Part A) Pages 1-3</b>				
<b>Life Area</b>	<b>Level #1 (1 point)</b>	<b>Level #2 (2 points)</b>	<b>Level #3 (3 points)</b>	<b>Level #4 (4 points)</b>
<p><b>Basic Needs</b></p> <p>Level _____</p> <p>Points _____</p>	<p>___ Food, clothing, and other sustenance items available through client's own means.</p> <p>___ Has ongoing access to assistance programs that maintain basic needs consistently.</p> <p>___ Able to perform activities of daily living (ADL) independently.</p>	<p>___ Sustenance needs met on a regular basis with occasional need for help accessing assistance programs.</p> <p>___ Unable to routinely meet basic needs without emergency assistance.</p> <p>___ Needs assistance to perform some ADL weekly.</p>	<p>___ Routinely needs help accessing assistance programs for basic needs.</p> <p>___ History of difficulties in accessing assistance programs on own.</p> <p>___ Often w/o food, clothing or other basic needs.</p> <p>___ Needs in-home ADL assistance daily.</p>	<p>___ Has no access to food.</p> <p>___ Without most basic needs.</p> <p>___ Unable to perform most ADL.</p> <p>___ No home to receive assistance with ADL.</p>
<p><b>Transportation</b></p> <p>Level _____</p> <p>Points _____</p>	<p>___ Has own or other means of transportation consistently available.</p> <p>___ Can drive self.</p> <p>___ Can afford private or public transportation.</p> <p>___ Has consistent means to transport to school.</p>	<p>___ Has minimal access to private transportation.</p> <p>___ Needs occasional assistance with finances for transportation.</p>	<p>___ No means via self/others.</p> <p>___ In area under or unserved by public transportation.</p> <p>___ Unaware of or needs help accessing transportation services.</p>	<p>___ Lack of transportation is a serious contributing factor to current crisis.</p> <p>___ Lack of transportation is a serious contributing factor to lack of regular medical care.</p>
<p><b>Risk Reduction</b></p> <p>Level _____</p> <p>Points _____</p>	<p>___ Family takes precautions in home and school.</p> <p>___ Client has good understanding of risks.</p> <p>___ Risk reduction is age appropriate.</p>	<p>___ Client is able to comprehend risk to others.</p> <p>___ Client has fair understanding of risks.</p>	<p>___ Client has poor understanding of risks.</p> <p>___ Client with safe behavior.</p>	<p>___ Significant risk behavior.</p> <p>___ Client has little or no understanding of risks.</p> <p>___ Client with significant barriers to safer behavior.</p>

Client Name \_\_\_\_\_

Page Total \_\_\_\_\_



Life Area	Level #1 (1 point)	Level #2 (4 points)	Level #3 (6 points)	Level #4 (8 points)
<p><b>Housing/Living Arrangement</b></p> <p>Level _____</p> <p>Points _____</p>	<p>___ Living in housing of choice: clean, habitable apartment or house.</p> <p>___ Living with biological/ adoptive parent(s).</p> <p>___ Living with stable foster family.</p>	<p>___ Living in stable subsidized housing (public housing, private subsidized housing, or secure Section-8 voucher).</p> <p>___ Safe &amp; secure non-subsidized housing, but choices limited due to moderate income.</p> <p>___ Housing is habitable, but requires limited improvements.</p> <p>___ Housing is in jeopardy due to projected financial strain (&gt;30 days); needs assistance with rent/utilities to maintain housing.</p> <p>___ Living in long-term (&gt;3 mo.) transitional rental housing.</p>	<p>___ Formerly independent person temporarily residing with family or friends.</p> <p>___ Eviction imminent.</p> <p>___ Living in temporary (&lt;3 mo.) transitional shelter.</p> <p>___ Housing is in jeopardy due to immediate projected financial strain (&lt;30 days); needs assistance with rent/utilities to maintain housing.</p> <p>___ No stable family to live with.</p>	<p>___ Needs assisted living facility; unable to live independently.</p> <p>___ Home uninhabitable due to health and/or safety hazards.</p> <p>___ Recently evicted from rental or residential program.</p> <p>___ Homeless, (living in emergency shelter, car, on street/camping, etc.).</p>
<p><b>Mental Health</b></p> <p>Level _____</p> <p>Points _____</p>	<p>___ No history of mental illness, psychological disorders or psychotropic medications.</p> <p>___ No need for counseling referral.</p>	<p>___ History of mental health disorders/treatment in client and/or family.</p> <p>___ Level of client/family stress is high. Needs emotional support to avert crisis.</p> <p>___ Need for counseling referral.</p> <p>___ Need for family counseling.</p> <p>___ Has some trouble getting along with others.</p>	<p>___ Experiencing an acute episode and/or crises.</p> <p>___ Severe stress or family crisis re: HIV; need for mental health assessment.</p> <p>___ Diagnosed ADD.</p> <p>___ Requires significant emotional support.</p> <p>___ Significant trouble getting along with others.</p>	<p>___ Danger to self or others.</p> <p>___ Needs immediate psychiatric assessment/ evaluation.</p> <p>___ Active chaos or problems in family due to violence or abuse.</p> <p>___ Requires therapy, not accessing it.</p>
<p><b>Addictions</b></p> <p>Level _____</p> <p>Points _____</p>	<p>___ No difficulties with addictions including: alcohol, drugs, sex, or gambling.</p> <p>___ Past problems with addiction; &gt;1yr. in recovery.</p> <p>___ No need for treatment referral.</p>	<p>___ Past problems with addiction; &lt;1 year in recovery.</p> <p>___ At high risk for substance abuse.</p>	<p>___ Current addiction but is willing to seek help in overcoming addiction.</p> <p>___ Major addiction impairment of family.</p> <p>___ Currently using substances at a rate which could lead to addiction.</p>	<p>___ Current addiction; not willing to seek or resume treatment.</p> <p>___ Fails to realize impact of addiction on life/indifference regarding consequences of substance use.</p>

Client Name \_\_\_\_\_

Page Total \_\_\_\_\_

**RN ASSESSMENT (Part B) Pages 4-5**

Life Area	Level #1 (1 point)	Level #2 (4 points)	Level #3 (6 points)	Level #4 (8 points)
<p><b>Knowledge of HIV Disease</b></p> <p>Level _____</p> <p>Points _____</p>	<p>___ Verbalizes age appropriate understanding about the disease.</p>	<p>___ Some understanding verbalized.</p> <p>___ Needs continuing reinforcement of information.</p>	<p>___ Little understanding.</p> <p>___ Parent is unwilling to communicate about HIV with child.</p>	<p>___ Does not understand HIV progression.</p> <p>___ Does not understand risk to others.</p>
<p><b>Adherence</b></p> <p>Level _____</p> <p>Points _____</p>	<p>___ Adherent to medications as prescribed for more than 6 months without assistance.</p> <p>___ Currently understands medications.</p> <p>___ Able to maintain primary care.</p> <p>___ Keeps medical appointments as scheduled.</p> <p>___ Not currently being prescribed medications.</p>	<p>___ Adherent to medications as prescribed less than 6 months/ more than 3 months with minimal assistance.</p> <p>___ Keeps majority of medical appointments.</p>	<p>___ Adherent to medications and treatment plan with regular, ongoing assistance.</p> <p>___ Doesn't understand medications.</p> <p>___ Misses taking or giving several doses of scheduled meds weekly.</p> <p>___ Misses at least half of scheduled medical appointments.</p> <p>___ Takes long/extended *drug holidays* AMA.</p> <p>___ Takes non-HIV systemic therapies without MD knowledge.</p>	<p>___ Resistance/minimal adherence to medications and treatment plan even with assistance.</p> <p>___ Refuses/declines to take medications against medical advice.</p> <p>___ Medical care sporadic due to many missed appointments.</p> <p>___ Uses ER only for primary care.</p> <p>___ Inability to take/give meds as scheduled; requires professional assistance to take/give meds and keep appointments.</p>
<p><b>*Medical Needs</b></p> <p>*(Level 3 or Level 4 in this <i>Life Area</i> automatically give the client an overall <b>Acuity of "4"</b>)</p> <p>Level _____</p> <p>Points _____</p>	<p>___ Stable health with access to ongoing pediatric HIV medical care.</p> <p>___ Lab work periodically.</p> <p>___ Asymptomatic in medical care.</p>	<p>___ Needs primary care referral.</p> <p>___ HIV care referral needed - stable.</p> <p>___ Short-term acute condition; receiving medical care.</p> <p>___ Chronic non-HIV related condition under control with medication/treatment.</p> <p>___ HIV symptomatic with one or more conditions that impair overall health.</p>	<p>___ Poor health.</p> <p>___ HIV care referral needed - ASAP.</p> <p>___ Needs treatment or medication for non-HIV related condition.</p> <p>___ Debilitating HIV disease symptoms/infections.</p> <p>___ Multiple medical diagnoses.</p> <p>___ Home bound; home health needed.</p>	<p>___ Medical emergency.</p> <p>___ Client is in end-stage of HIV disease.</p> <p>___ Intensive/complicated home care required.</p> <p>___ Hospice services or placement indicated.</p>

Client Name \_\_\_\_\_

Page Total \_\_\_\_\_

Life Area	Level #1 (1 point)	Level #2 (4 points)	Level #3 (6 points)	Level #4 (8 points)
<p><b>Nutrition</b></p> <p>Level _____</p> <p>Points _____</p>	<p>___ No signs of wasting syndrome or obvious physical maladies.</p> <p>___ No abdominal pain reported.</p> <p>___ No significant weight problems.</p> <p>___ No problems with eating.</p> <p>___ No problems with nausea or vomiting or diarrhea.</p> <p>___ No need for nutritional intervention.</p>	<p>___ Unplanned weight loss in the past 6 months.</p> <p>___ Requests assistance in improving nutrition.</p> <p>___ Occasional episodes of nausea, vomiting or diarrhea.</p>	<p>___ Visual assessment shows initial signs of wasting syndrome or other obvious physical maladies &lt; not advanced &gt;.</p> <p>___ Abdominal problems reported.</p> <p>___ Changes in eating habits in the past 3 months.</p> <p>___ Chronic nausea, vomiting and/or diarrhea.</p>	<p>___ Visual assessment shows advanced signs of wasting syndrome or other obvious physical maladies.</p> <p>___ Acute abdominal pain.</p> <p>___ Severe problems eating.</p> <p>___ Acute nausea, vomiting and/or diarrhea.</p> <p>___ Significant weight loss in past 3 months.</p>
<p><b>Oral Health</b></p> <p>Level _____</p> <p>Points _____</p>	<p>___ Is currently in active dental care.</p> <p>___ Has seen dentist in past six months.</p> <p>___ No complaints of mouth, tongue, tooth or gum pain <u>and</u> teeth and gums appear healthy as observed during assessment.</p> <p>___ Client reports practicing daily oral hygiene.</p>	<p>___ Does not have a regular dentist.</p> <p>___ No dental insurance.</p> <p>___ Has not seen a dentist in more than 6 months.</p> <p>___ Client reports not practicing daily oral hygiene.</p> <p>___ Dentures need adjusting, but still able to eat.</p>	<p>___ Reports episodic pain and/or sensitivity in teeth, gums or mouth.</p> <p>___ Missing days from work because of problems with teeth, gums or mouth.</p> <p>___ Client reports difficulty interacting with others because oral health problems negatively impact self-esteem.</p> <p>___ Observed appearance of dark, discolored teeth; missing teeth; bleeding, red gums; other problems with mouth.</p> <p>___ Client reports episodic or moderate difficulty eating.</p>	<p>___ Current tooth, gum or mouth pain and severe discomfort.</p> <p>___ Very few or no teeth.</p> <p>___ Observed appearance or client report of decayed teeth; white, hairy growth or creamy, bump-like patches; oral lesions or bleeding from gums/teeth.</p> <p>___ Client reports significant difficulty eating due to oral health problems.</p> <p>___ Client has difficulty talking because of oral health problems.</p>

**Comments:**

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Client Name \_\_\_\_\_

Page Total \_\_\_\_\_

**Acuity Level Guidelines:**

**Level 1: 12-21 points**

- Initial face-to-face nursing and psychosocial assessments.
- Annual face-to-face nursing and psychosocial reassessments.
- Documentation in progress notes or CAREWare care notes.
- Care planning, goals, activities and outcomes documented on the Care Plan Form (DHS 8400).

**Level 2: 22-42 points**

- Initial face-to-face nursing and psychosocial assessments.
- Annual face-to-face nursing and psychosocial reassessments.
- Minimum contact (telephone or face-to-face) every 6 months to verify address/phone number and to check on client’s current status.
- Care planning, goals, activities and outcomes documented on the Care Plan Form (DHS 8400).

**Level 3: 43-63 points**

- Initial face-to-face nursing and psychosocial assessments.
- Minimum annual face-to-face nursing and psychosocial reassessments.
- Minimum contact (telephone or face-to-face) **every 30 days**.
- Minimum evaluation of goals, activities and outcomes **every 30 days**.
- Nurse is consulted (see Nurse Roles and Responsibilities in Standards) on client’s care planning goals, activities and outcomes (care plan). A nursing note and signature to show consultation must be in the client’s file a minimum of **every 90 days**.
- Nurse signature is required on every updated Acuity Scale Worksheet.
- Care planning, goals, activities and outcomes documented on the Care Plan Form (DHS 8400).

**Level 4: 64-84 points**

- Initial face-to-face nursing and psychosocial assessments.
- Minimum annual face-to-face nursing and psychosocial reassessments.
- Minimum contact (telephone or face-to-face) **every 2 weeks**.
- Minimum evaluation of goals, activities and outcomes **every 2 weeks**.
- Nurse is consulted (see Nurse Roles and Responsibilities in Standards) on client’s care planning goals, activities and outcomes (care plan). A nursing note and signature to show consultation must be in the client’s file a minimum of **every 30 days**.
- Nurse signature is required on every updated Acuity Scale Worksheet.
- Care planning, goals, activities and outcomes documented on the Care Plan Form (DHS 8400).

**Exceptions:** \* At the discretion of the case manager, release from a correctional facility may be a condition warranting an Acuity Level 3 during the first 90 days after release.

\* Medical Life Area activity of “3” or “4” results in automatic overall activity of “4”.

Level Total: _____	Assigned Acuity Level: _____	
Client Name: _____		Date: _____
Case Manager Signature: _____		Date: _____
Nurse Signature (if different than Case Manager): _____		Date: _____