SUA Resource Library:

State Care Recipient Assessments

Foreword

In 2012, the Administration for Community Living (ACL), an operating division of the US Department of Health and Human Services, began a comprehensive evaluation of its National Family Caregiver Support Program (NFCSP). This was the first comprehensive federal evaluation of the NFCSP, which serves over 800,000 family caregivers annually. The NFCSP evaluation has three broad goals to benefit policy and program decision-making:

1. Collect and analyze information on program processes and site operations;
2. Evaluate program efficiency and cost issues for approaches best suited to specific contexts; and
3. Evaluate effectiveness of the program's contribution to family caregivers in terms of maintaining their health and well-being, improving their caregiving skills, and avoiding or delaying institutional care of the care recipient.

As part of the evaluation survey, State Units on Aging (SUAs) were asked to submit relevant documents if they answered 'yes' to any of the following five questions:

- Do you have a statewide task force, commission or coalition specifically to examine family caregiver issues?
- Have community needs assessments for caregiver support services been conducted?
- Does your state have a standardized caregiver assessment?
- Does your SUA conduct routine programmatic monitoring of the NFCSP program?
- Do you use a uniform caregiver satisfaction survey across all AAAs?

ACL received assessment tools and grouped them into the following categories:

1. Community Assessment Materials
2. General Customer Satisfaction Survey Materials
3. Grandparent Assessment Materials
4. High-Level Administrative Materials
5. Program Monitoring Materials
6. State Caregiver Assessments
7. State Care Recipient Assessments
8. Task Force Materials
9. Uniform Satisfaction Materials
10. Other Materials

While ACL does not specifically endorse these tools, we are sharing them because they may be helpful to other programs. For more information on the NFCSP please go to: http://www.aoa.acl.gov/. For more information on the evaluation of the NFCSP please go to: http://www.aoa.acl.gov/Program_Results/Program_Evaluation.aspx

State Care Recipient Assessments

2015 Consumer Assessment

Updated February 6, 2015

I.A. Consumer Demographics				
Last Name, First Name, Middle Initial:				
Gender: ☐ Male ☐ Female		Birth Date: / /		Age:
Soc. Sec. Number (last 4 digits): XXX - XX - _ _ _ _		Are you Hispanic or Latino? ☐ Yes ☐ No		What is your race?
What is your monthly income range?	☐ $ 981 or less ☐ $ 982 to $1,226 ☐ $1,227 to $1,815 ☐ $1,816 or more	What is you and your spouse's monthly married income range?	☐ $1,328 or less ☐ $1,329 to $1,660 ☐ $1,661 to $2,457 ☐ $2,458 or more	
Marital Status:	☐ Married ☐ Single	☐ Divorced	☐ Widowed	☐ Other
Employment:	☐ Full-time ☐ Part time	☐ Temporary jobs	☐ Not employed	
Are you willing to volunteer?	☐ Yes ☐ No	☐ Currently volunteering	☐ Don't know	
Are you a veteran?	☐ Yes ☐ No	What is your primary language?		
Do you have vision problems?	☐ Yes ☐ No	Do you wear eye glasses?	☐ Yes	☐ No
Do you have hearing problems?	☐ Yes ☐ No	Do you use a hearing aid?	☐ Yes	☐ No
I. B. Address				
Residential Street Address				
Residential City or Town		State, Residential Zip Code		
County of Residence		Telephone Number (including area code):		
Mailing Address - Street/P.O. Box				
Mailing City or Town		State, Mailing Zip Code		
I.C. Living Situation Information				
What is your living arrangement?	☐ Live Alone ☐ Live with spouse/partner	☐ Live with extended family	☐ Live with non-relatives	
Where do you live?	☐ Own home ☐ Rent home/apartment/room	☐ Family member's residence	☐ Long-term care facility	
	☐ Homeless ☐ Other			
What is the name of your spouse (optional if applicable)?				
I.D. Consumer Contacts				
Name of friend or relative (**other than spouse/partner**) to contact in case of an emergency:				
Relationship to emergency contact (**other than spouse/partner**):				
Telephone number (including area code) of friend or relative to contact in case of an emergency:				
Name of your primary care physician:				
Telephone number (including area code) of your primary care physician:				

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights.

Signature_____ Date_____

II.A. Nutrition Checklist (If answer "yes," circle the score. Add the scores to determine your total nutritional score.)	**Yes**	**No**	**Yes Score**
I have an illness or condition that made me change the kind and/or amount of food I eat.			2
I eat fewer than 2 meals per day.			3
I eat few fruits or vegetables or milk products.			2
I have 3 or more drinks of beer, liquor, or wine almost every day.			2
I have tooth or mouth problems that make it hard for me to eat.			2
I don't always have enough money to buy the food I need.			4
I eat alone most of the time.			1
I take 3 or more different prescribed or over the counter drugs a day.			1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.			2
I am not always physically able to shop, cook and/or feed myself.			2
What is the consumer's nutritional risk score? (0-2 = No Risk 3-5 = Moderate Risk 6 or more = High Risk)			**Total 'Yes' Score:** _____

III.A. ADLs (Activities of Daily Living)	**Yes**	**No**	**III.B. IADLs (Instrumental Activities of Daily Living)**	**Yes**	**No**
I can eat without help.			I can manage money without help.		
I can dress myself without help.			I can take care of shopping without help.		
I can bathe myself without help.			I can take my medication without help.		
I can use the toilet without help.			I can prepare meals without help.		
I can get in and out of bed/chairs without help.			I can do ordinary housework without help.		
I can get around inside my home without help.			I can use the telephone without help.		
			I can use transportation without help.		
			Are you currently receiving assistance with ADLs or IADLs from anyone?		
			From whom are you receiving assistance with ADLs and or IADLs?		
What is the consumer's ADL count? **Total 'No' Score:** _____			What is the consumer's IADL count? **Total 'No' Score:** _____		

III.C. Other Eligibility Criteria - *For assessor's use only*	**Yes**	**No**
Does the consumer require Home Health Aide based on orders from a physician?		
Does the consumer reside in a rural area (to justify home delivered meals)?		
Can the consumer perform chore activities without help?		
Is the consumer homebound?		
Is the consumer homebound because he/she lives in a remote geographic location?		
Reason consumer is homebound (**other than graphic location**):		
Comment on the consumer's inability to perform chore services:		
Describe how to get to the consumer's home:		
Consumer's current level of cognitive functioning: ☐ Alert/oriented ☐ Requires assistance in routine situations due to lack of cognitive functioning		

Division of Services for Aging and Adults with Physical Disabilities

CAREDelaware
Caregiver Assistance-Respite-Education

Care Recipient Assessment

Date of Assessment: _____ **Agency Name:** _____

CareGIVER Name: _____ **Person reporting:** _____

Program: ☐ Case Mgmt ☐ Respite ☐ CRC ☐ Other

Last Name: _____ **First:** _____ ☐ Male ☐ Female

Address: _____ **Apt #:** _____ **County:** ☐ NCC ☐ Kent ☐ Sussex

Address 2: _____ (apt. complex or development name)

City: _____ **St** _____ **Zip:** _____ **Rural?:** ☐ YES ☐ NO

Telephone1: _____ **Telephone 2:** _____

Care Recipient's Date of Birth:

Client's Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino

Race:
☐ White - Non-Hispanic
☐ White - Hispanic
☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Other Race

Reporting 2 or more races ☐ YES

Race Data Missing ☐ YES

If DOB is unable to be collected, please check appropriate date range:
☐ <50 ☐ 55-59 ☐ 75-84
☐ 50-54 ☐ 60-74 ☐ 85+

If the client is under age 60, is he/she diagnosed with early-onset dementia? ☐ Yes ☐ NO

Does the client live alone? ☐ Yes ☐ No

If you answered "no" - How many in the household? _____

Is the client's income level below Federal Poverty? ☐ Yes ☐ No

Income level - Not Reported ☐

1 person household	< $851/mth
2 person household	<$1,141/mth
3 person household	<$1,431/mth
4 person household	<$1,721/mth

How many of the following six ADL's is the client **unable** to perform without personal assistance, stand-by assistance, supervision or cues:

☐ Dressing ☐ Bathing ☐ Toileting ☐ Transferring in/out of bed/chair
☐ Eating ☐ Walking Total Client ADL's: ☐ 0 ☐ 1 ☐ 2 ☐ 3+

How many of the following eight IADL's is the client **unable** to perform without personal assistance, stand-by assistance, supervision or cues:

☐ Preparing Meals ☐ Medication Management ☐ Money Management
☐ Using the Telephone ☐ Doing Heavy Housework ☐ Doing Light Housework
☐ Access Transportation Without Assistance ☐ Shopping for Personal Items

Total Client IADL's: ☐ 0 ☐ 1 ☐ 2 ☐ 3+

Services recommended to the Care Recipient Include:

☐ Personal Care ☐ Housekeeping ☐ Adult Day Program ☐ Companionship ☐ Meals
☐ E & D Waiver Program ☐ Transportation ☐ Legal Services

Notes: _____

Client's Suggested Donation Amount **$** _____ per **week / month** (circle one)

Care Recipient Assessment Form Rev 8-2011

NAT 1-9-15

1. INTRODUCTION

1.A. INDIVIDUAL'S IDENTIFICATION

1. Date of the face to face interview for Needs Assessment Tool (NAT)

_____/_____/_____

2. Individual's Last Name

_____

3. Individual's First Name

_____

4. Individual's Middle Initial

_____

5. Individual's Name Suffix (If applicable)

_____

6. Individual's Nickname/ Alias

_____

_____

_____

_____

7. Individual's Date of Birth (DOB)

_____/_____/_____

8. Individual's Gender

- ☐ Female
- ☐ Male

9. Individual's Ethnicity (Check only one.)

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

10. Individual's Race

- ☐ American Indian/ Native Alaskan
- ☐ Asian
- ☐ Black/ African American
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Non-Minority (White, non-Hispanic)
- ☐ White-Hispanic
- ☐ Unknown/ Unavailable
- ☐ Other-Document Details in Notes

11. Individual's Social Security Number (SSN)

_____-_____-_____

12a. Does the individual have a Medicaid number?

- ☐ No
- ☐ Yes
- ☐ Pending

12b. Indicate Medicaid recipient number

_____

13a. Does the individual have Medicare?

- ☐ No
- ☐ Yes

13b. Indicate Medicare recipient number

_____

14a. Does the individual have any other insurance?

- ☐ No
- ☐ Yes
- ☐ Don't know

14b. Indicate other health insurance information

_____

1.B. ASSESSMENT INFORMATION

1. PSA number conducting assessment:

- ☐ 01
- ☐ 02
- ☐ 03
- ☐ 04
- ☐ 05
- ☐ 06
- ☐ 07
- ☐ 08
- ☐ 09
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
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- ☐ 36
- ☐ 37
- ☐ 38
- ☐ 39
- ☐ 40
- ☐ 41
- ☐ 42
- ☐ 43
- ☐ 44
- ☐ 45
- ☐ 46
- ☐ 47
- ☐ 48
- ☐ 49
- ☐ 50
- ☐ 51
- ☐ 52

2. Indicate type of Needs Assessment Tool (NAT)

- ☐ Annual Care Plan
- ☐ DC-Domiciliary Care Annual
- ☐ Initial
- ☐ Significant Change in Needs
- ☐ Other-Document Details in Notes

3. Where was the individual interviewed?

- ☐ AL-Assisted Living
- ☐ DC-Domiciliary Care
- ☐ Home
- ☐ Home of Relative/ Caregiver
- ☐ Hospital
- ☐ PCH-Personal Care Home
- ☐ Other-Document Details in Notes

4. Did the individual participate in the assessment?

- ☐ No-Must complete 1.B.5
- ☐ Yes

5. If anyone else participated during the time of the needs assessment, please document the name and relationship in Notes.

- ☐ 1 - Spouse/ Domestic Partner
- ☐ 2 - Family-Other than Spouse
- ☐ 3 - Legal Guardian
- ☐ 4 - Durable Power of Attorney (POA)
- ☐ 5 - Friend
- ☐ 6 - Other-Document Name and Relationship in Notes

1.C. POWER OF ATTORNEY (POA) / LEGAL GUARDIANSHIP

1a. Does the individual have a legal guardian?

- ☐ No-Skip to 1.C.2a
- ☐ Yes

1b. Was proof of legal guardianship provided?

- ☐ No
- ☐ Yes

1c. Name of legal guardian

_____

1d. Complete address of legal guardian

_____

1e. Primary phone number of legal guardian

1f. Secondary phone number of legal guardian

1g. E-mail address of legal guardian

2a. Does the individual have a Power of Attorney (POA)?

- [ ] No-Skip to 1.D.1a
- [ ] Yes

2b. Proof of POA provided?

- [ ] No
- [ ] Yes

2c. Type of POA

- [ ] Durable
- [ ] Financial
- [ ] Health
- [ ] Other-Document Details in Notes

2d. Name of POA

2e. Complete address of POA

2f. Primary phone number of POA

2g. Secondary phone number of POA

2h. E-mail address of POA

1.D. INDIVIDUAL'S DEMOGRAPHICS

1a. Is the individual homeless?

- [ ] No-Skip to 1.D.2
- [ ] Yes

1b. Does the individual have a place to stay tonight?

- [ ] No-Document Details in Notes
- [ ] Yes

1c. Does the individual have a place to stay long-term?

- [ ] No-Document Details in Notes
- [ ] Yes

1d. Explain homeless situation:

- [ ] Cannot afford housing
- [ ] Evicted
- [ ] Housing not available
- [ ] Voluntary
- [ ] Other-Document Details in Notes

2. Type of PERMANENT residence in which the individual resides

- [ ] AL-Assisted Living
- [ ] Apartment
- [ ] DC-Domiciliary Care
- [ ] Group Home
- [ ] Nursing Home
- [ ] Own Home
- [ ] PCH-Personal Care Home
- [ ] Relative's Home
- [ ] Specialized Rehab/ Rehab Facility
- [ ] State Institution
- [ ] Other-Document Details in Notes

3. What is the individual's PERMANENT living arrangement? (Include in the "Lives Alone" category individuals who live in an AL, DC or PCH, pay rent and have NO ROOMMATE.)

- [ ] Lives Alone
- [ ] Lives with Spouse Only
- [ ] Lives with Child(ren) but not Spouse
- [ ] Lives with other Family Member(s)
- [ ] Unknown
- [ ] Other-Document Details in Notes

4. Individual's marital status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Legally Separated
- [ ] Widowed
- [ ] Other-Document Details in Notes

5a. Is the individual a Veteran?

- [ ] No
- [ ] Yes
- [ ] Unable to Determine

5b. Is the individual the spouse/ widow or dependent child of a Veteran?

- [ ] No
- [ ] Yes
- [ ] Unable to Determine

5c. Is the individual receiving Veteran's benefits?

- [ ] No
- [ ] Yes
- [ ] Unable to Determine

6a. Does the individual require communication assistance?

- [ ] No-Skip to 1.D.7a
- [ ] Yes
- [ ] Unable to Determine

6b. What type of communication assistance is required?

- [ ] Assistive Technology
- [ ] Interpreter
- [ ] Large Print
- [ ] Picture Book
- [ ] Unable to Communicate
- [ ] Unknown
- [ ] Other-Document Details in Notes

7a. Does the individual use sign language as their PRIMARY language?

- [ ] No-Skip to 1.D.8
- [ ] Yes

7b. What type of sign language is used?

- [ ] American Sign Language
- [ ] International Sign Language
- [ ] Makaton
- [ ] Manually Coded Language-English
- [ ] Manually Coded Language-Non-English
- [ ] Tactile Signing
- [ ] Other-Document Details in Notes

8. What is the individual's PRIMARY language?

- [ ] English
- [ ] Russian
- [ ] Spanish
- [ ] Other-Document Details in Notes

1.E. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED

1. Is the individual's postal/ mailing address exactly the same as the residential address?

- [ ] No-Complete Section 1.E & F
- [ ] Yes

2a. Residential County

- [ ] Adams
- [ ] Allegheny
- [ ] Armstrong
- [ ] Beaver
- [ ] Bedford
- [ ] Berks
- [ ] Blair
- [ ] Bradford
- [ ] Bucks
- [ ] Butler
- [ ] Cambria
- [ ] Cameron
- [ ] Carbon
- [ ] Centre
- [ ] Chester
- [ ] Clarion
- [ ] Clearfield
- [ ] Clinton
- [ ] Columbia
- [ ] Crawford
- [ ] Cumberland
- [ ] Dauphin
- [ ] Delaware
- [ ] Elk
- [ ] Erie
- [ ] Fayette
- [ ] Forest
- [ ] Franklin
- [ ] Fulton
- [ ] Greene
- [ ] Huntingdon
- [ ] Indiana
- [ ] Jefferson
- [ ] Juniata
- [ ] Lackawanna
- [ ] Lancaster
- [ ] Lawrence
- [ ] Lebanon
- [ ] Lehigh
- [ ] Luzerne
- [ ] Lycoming
- [ ] McKean
- [ ] Mercer
- [ ] Mifflin
- [ ] Monroe
- [ ] Montgomery
- [ ] Montour
- [ ] Northampton
- [ ] Northumberland
- [ ] Perry
- [ ] Philadelphia
- [ ] Pike
- [ ] Potter
- [ ] Schuylkill
- [ ] Snyder
- [ ] Somerset
- [ ] Sullivan
- [ ] Susquehanna
- [ ] Tioga
- [ ] Union
- [ ] Venango
- [ ] Warren
- [ ] Washington
- [ ] Wayne
- [ ] Westmoreland
- [ ] Wyoming
- [ ] York
- [ ] Out of State

2b. Residential Street Address

_____

2c. Residential Address Second Line (Apt or Room #, Building or Complex Name, etc.)

_____

2d. Residential Municipality - REQUIRED (usually a Township or Boro where individual votes, pays taxes)

_____

2e. Residential City/ Town

_____

2f. Residential State

_____

2g. Residential Zip Code

_____

3. Directions to the individual's home

_____

_____

_____

_____

4. Does individual reside in a rural area?

- ☐ No
- ☐ Yes

5a. Primary Phone Number

5b. Mobile Phone Number

5c. Other Phone Number (Enter number where individual can be reached.)

5d. E-mail Address

6. What was the outcome when the individual was offered a voter registration form? REQUIRED

- ☐ AAA will submit completed voter registration
- ☐ Does not meet voter requirements (i.e. citizenship, etc.).
- ☐ Individual declined application
- ☐ Individual declined-already registered
- ☐ Individual will submit completed voter registration
- ☐ No Response

1.F. INDIVIDUAL'S POSTAL/MAILING ADDRESS INFORMATION

1a. Postal Street Address

1b. Postal Address Line 2 (optional)

1c. Postal City/ Town

1d. Postal State

1e. Postal Zip Code

1.G. EMERGENCY CONTACT

1. Name of Emergency Contact

2. Relationship of Emergency Contact

3. Telephone Number of Emergency Contact

4. Work Telephone Number of Emergency Contact

2. USE OF MEDICAL SERVICES

2.A. HOSPITAL, NURSING FACILITY, ER, INPATIENT PSYCHIATRIC VISITS/STAYS

1. Has the individual stayed in the HOSPITAL in the LAST 12 MONTHS?

- ☐ No-Skip to 2.A.3
- ☐ Yes-Complete 2.A.2
- ☐ Unable to Determine-Document Details in Notes

2. The approximate number of times the individual has stayed overnight in the HOSPITAL in the LAST 12 MONTHS. Document Details in Notes

3. The approximate number of times the individual has visited the ER in the LAST 12 MONTHS and was NOT admitted.

4. The approximate number of times the individual was admitted to a NURSING FACILITY in the LAST 12 MONTHS. Document Details in Notes

5. The approximate number of times the individual was an inpatient in a PSYCHIATRIC Facility in the LAST 24 MONTHS. Document Details in Notes

6. The number of times the individual has had outpatient surgery in the LAST 12 MONTHS:

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ Other-Document Details in Notes

2.B. PRIMARY PHYSICIAN INFORMATION

1. Does the individual have a PRIMARY care physician?

- ☐ No
- ☐ Yes

2. PRIMARY Physician's Name

3. PRIMARY Physician's Street Address

4. PRIMARY Physician's City or Town

5. PRIMARY Physician's State

6. PRIMARY Physician's Zip Code

7. PRIMARY Physician's Business Phone Number (Requires 10 digits to transfer to SAMS, optional 1-5 digit extension.)

8. PRIMARY Physician's FAX Number

9. PRIMARY Physician's E-MAIL ADDRESS

10. Additional Physicians

11. Does the individual receive alternative medical care from a practitioner?

- ☐ No-Skip to 3.A.1
- ☐ Yes-Complete 2.B.12

12. Select the type of alternative medical care-Document Details in Notes

- ☐ Acupuncturist
- ☐ Chiropractor
- ☐ Herbalist
- ☐ Homoeopathist
- ☐ Masseur
- ☐ Other-Document Details in Notes

3. SAINT LOUIS UNIVERSITY MENTAL STATUS (SLUMS)

3.A. SLUMS PREPARATION

1. Determine if the individual is alert. Alert indicates that the individual is fully awake and able to focus.

- ☐ Alert
- ☐ Confused
- ☐ Distractible
- ☐ Drowsy
- ☐ Inattentive
- ☐ Preoccupied

2. Do you have trouble with your memory?

- ☐ No
- ☐ Yes

3. SLUMS is being completed as which of the following?

- ☐ SLUMS is a new screening
- ☐ SLUMS is a copy from the LCD

4. May I ask you some questions about your memory?

- ☐ No
- ☐ Yes
- ☐ Other-Document Details in Notes

5. Is the individual able to complete the SLUMS Exam?

- ☐ No-Document Details in Notes & Skip to 3.D.1a
- ☐ Yes

3.B. SLUMS QUESTIONNAIRE (Each score is beside the response.)

1. What DAY of the week is it?

- ☐ 1 - Correct (1)
- ☐ 2 - Incorrect (0)

2. What is the YEAR?

- ☐ 1 - Correct (1)
- ☐ 2 - Incorrect (0)

3. What is the name of the STATE we are in?

- ☐ 1 - Correct (1)
- ☐ 2 - Incorrect (0)

4. Please remember these five objects. I will ask you what they are later. Apple, Pen, Tie, House, Car

_____

5a. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20. How much did you spend?

- ☐ 1 - Correct ($23) (1)
- ☐ 2 - Incorrect (0)
- ☐ 3 - Unanswered (0)

5b. How much do you have left?

- ☐ 1 - Correct ($77) (2)
- ☐ 2 - Incorrect (0)
- ☐ 3 - Unanswered (0)

6. Please name as many animals as you can in one minute.

- ☐ 0-4 (0)
- ☐ 5-9 (1)
- ☐ 10-14 (2)
- ☐ 15+ (3)
- ☐ Unanswered (0)

7. What were the five objects I asked you to remember? (1 point for each one correct.)

- ☐ Apple (1);
- ☐ Pen (1);
- ☐ Tie (1);
- ☐ House (1);
- ☐ Car (1);
- ☐ Unanswered/ None Correct (0)

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say four-two, you would say two-four.

- ☐ 8-7 (78) (0);
- ☐ 6-4-9 (946) (1);
- ☐ 8-5-3-7 (7358) (1);
- ☐ Unanswered/ None correct (0)

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.

- ☐ Hour markers correct (2);
- ☐ Time correct (2);
- ☐ Unanswered/ None Correct (0)

10a. Place an X in the triangle

- ☐ 1 - Correct (Triangle) (1)
- ☐ 2 - Incorrect (0)

10b. Which of the figures is the largest?

- ☐ 1 - Correct (Square) (1)
- ☐ 2 - Incorrect (0)

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

- ☐ What was the female's name? (Jill) (2);
- ☐ What state did she live in? (Illinois) (2);
- ☐ What work did she do? (Stockbroker) (2);
- ☐ When did she go back to work? (Kids were teenagers) (2)
- ☐ Unanswered/ None Correct (0)

3.C. SLUMS RESULTS

1. SLUMS Consumers Total Score

2. Record the highest grade (1-12) the individual completed in school.

3. Identify the highest educational degree that the individual obtained.

- ☐ High School Graduate/ or GED
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Graduate's Degree
- ☐ Doctoral's Degree
- ☐ Other-Document Details in Notes

4. Care Manager's conclusion after completion of the individual's SLUMS Exam:

- ☐ Normal (HS 27+, Non HS 25+)
- ☐ MNCD-Mild Neurocognitive Disorder (HS 21-26, Non HS 20-24)
- ☐ Mild Dementia (HS 16-20, Non HS 15-19)
- ☐ Moderate Dementia (HS 11-15, Non HS 11-14)
- ☐ Severe Dementia (Any 10 or Less)

3.D. COGNITIVE FUNCTION

1a. Does the individual exhibit any cognitive impairments?

- ☐ No-Skip to 4.A.1
- ☐ Yes-Complete 3.D

1b. Does this impairment interfere with the individual's ability to function daily?

- ☐ No-Skip to 4.A.1
- ☐ Yes-Document Details in Notes

1c. Is the individual able to direct/ supervise his own care with the impairment?

- ☐ No-Complete 3.D.1d
- ☐ Yes

1d. Does the individual have a representative who is able and willing to direct the individual's care because of the impairment?

- ☐ No
- ☐ Yes-Complete 3.D.1e

1e. Document contact information (Name, Relationship, Phone Number, etc.) of the individual who is willing to supervise care. Additional space in Notes

4. DIAGNOSES

4.A. RESPIRATORY

1. Select all RESPIRATORY diagnoses:

- ☐ None-Skip to 4.B.1
- ☐ Asthma
- ☐ COPD-Chronic Obstructive Pulmonary Disease
- ☐ Emphysema
- ☐ Pulmonary Edema
- ☐ Respiratory Failure
- ☐ Other-Document Details in Notes

2. Signs and symptoms of RESPIRATORY diagnoses:

- ☐ None
- ☐ Chest Tightness
- ☐ Cough
- ☐ Frequent Respiratory Infections
- ☐ Respiratory Failure
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Other-Document Details in Notes

3. Current treatments for RESPIRATORY diagnoses:

- ☐ None
- ☐ Medications-List in 9.D
- ☐ Oxygen
- ☐ Respiratory Treatments (Nebulizers, Inhalants, etc.)
- ☐ Suctioning
- ☐ Tracheostomy/ Trach Care
- ☐ Ventilator/ Vent Care
- ☐ Other-Document Details in Notes

4. Do the RESPIRATORY diagnoses affect the individual's ability to function?

- ☐ No
- ☐ Yes-Document Details in Notes

5. Who manages care of the RESPIRATORY condition(s)?

- ☐ Formal Support
- ☐ Informal Support
- ☐ Primary Care Physician
- ☐ Self
- ☐ Specialty Physician
- ☐ Other-Document Details in Notes

6. Does the individual need additional assistance in managing the care of the RESPIRATORY condition(s)?

- ☐ No
- ☐ Yes-Document Details in Notes

4.B. HEART/ CIRCULATORY SYSTEMS

1. Select all HEART/ CIRCULATORY systems diagnoses:

- ☐ None-Skip to 4.C.1
- ☐ A-Fib and other Dysrhythmia, Bradycardia, Tachycardia
- ☐ Anemia
- ☐ Ascites
- ☐ CAD-Coronary Artery Disease: including Angina, Myocardial Infarction, ASHD
- ☐ DVT-Deep Vein Thrombosis
- ☐ Heart Failure: including CHF, Pulmonary Edema
- ☐ Hypertension
- ☐ PE-Pulmonary Embolus
- ☐ PVD/PAD (Peripheral Vascular or Artery Disease)
- ☐ Other-Document Details in Notes

2. Signs and symptoms of the HEART/ CIRCULATORY systems diagnoses:

- ☐ None
- ☐ Activity Intolerance
- ☐ Chest Pains
- ☐ Edema in Extremities
- ☐ Fainting (Syncope)
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Skin Discoloration
- ☐ Weakness
- ☐ Other-Document Details in Notes

3. Current treatments for HEART/ CIRCULATORY systems diagnoses:

- ☐ None
- ☐ Cardiac Rehabilitation
- ☐ Compression Device, TED Hose, Ace Bandage Wrap(s)
- ☐ Medications-List in 9.D
- ☐ Pacemaker
- ☐ Special Diet
- ☐ Other-Document Details in Notes

4. Do the HEART/ CIRCULATORY systems diagnoses affect the individual's ability to function?

- ☐ No
- ☐ Yes-Document Details in Notes

5. Who manages care of the HEART/ CIRCULATORY systems condition(s)?

- ☐ Formal Support
- ☐ Informal Support
- ☐ Primary Care Physician
- ☐ Self
- ☐ Specialty Physician
- ☐ Other-Document Details in Notes

6. Does the individual need additional assistance in managing the care of the HEART/ CIRCULATORY systems condition(s)?

- [ ] No
- [ ] Yes-Document Details in Notes

4.C. GASTROINTESTINAL

1. Select all GASTROINTESTINAL diagnoses:

- [ ] None-Skip to 4.D.1
- [ ] Barrett's Esophagus
- [ ] Crohn's Disease
- [ ] Diverticulitis
- [ ] GERD
- [ ] Hernia
- [ ] IBS-Irritable Bowel Syndrome
- [ ] Laryngeal Reflux Disease
- [ ] Other-Document Details in Notes

2. Signs and symptoms of GASTROINTESTIONAL diagnoses:

- [ ] None
- [ ] Abdominal Pain
- [ ] Bloated
- [ ] Constipation
- [ ] Diarrhea
- [ ] Flatulence
- [ ] Heartburn
- [ ] Rectal Bleeding
- [ ] Other-Document Details in Notes

3. Current treatments for GASTROINTESTINAL diagnoses:

- [ ] None
- [ ] Aspiration Precautions
- [ ] Feeding Tube-Document Type in Notes
- [ ] Medications-List in 9.D
- [ ] Ostomy-Document Type in Notes
- [ ] Speech Therapy
- [ ] TPN-Total Parenteral Nutrition
- [ ] Other-Document Details in Notes

4. Do the GASTROINTESTINAL diagnoses affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

5. Who manages care of the GASTROINTESTINAL condition(s)?

- [ ] Formal Support
- [ ] Informal Support
- [ ] Primary Care Physician
- [ ] Self
- [ ] Specialty Physician
- [ ] Other-Document Details in Notes

6. Does the individual need additional assistance in managing the care of the GASTROINTESTINAL condition(s)?

- [ ] No
- [ ] Yes-Document Details in Notes

4.D. MUSCULOSKELETAL

1. MUSCULOSKELETAL diagnoses and/ or signs and symptoms of MUSCULOSKELETAL diagnoses:

- [ ] None-Skip to 4.E.1
- [ ] Ambulatory Dysfunction
- [ ] Amputation-Document Details in Notes
- [ ] Arthritis-Document Type of Arthritis in Notes
- [ ] Contracture(s)
- [ ] Fractures-Document Details in Notes
- [ ] Joint Deformity
- [ ] Limited Range of Motion
- [ ] Muscular Dystrophy
- [ ] Osteoporosis
- [ ] Paraplegia
- [ ] Poor Balance
- [ ] Quadriplegia
- [ ] Spinal Stenosis
- [ ] Spasms
- [ ] Weakness
- [ ] Other-Document Details in Notes

2. Current treatments for MUSCULOSKELETAL diagnoses::

- [ ] None
- [ ] Assistive Devices-Document Details in Notes
- [ ] Brace(s)
- [ ] Cast
- [ ] Elevate Legs
- [ ] Medication(s)-List in 9.D
- [ ] Physical/ Occupational therapy
- [ ] Prosthesis(es)
- [ ] Splint
- [ ] Traction
- [ ] Other-Document Details in Notes

3. Do the MUSCULOSKELETAL diagnoses affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

4. Who manages care of the MUSCULOSKELETAL condition(s)?

- [ ] Formal Support
- [ ] Informal Support
- [ ] Primary Care Physician
- [ ] Self
- [ ] Specialty Physician
- [ ] Other-Document Details in Notes

5. Does the individual need additional assistance in managing the care of the MUSCULOSKELETAL condition(s)?

- [ ] No
- [ ] Yes-Document Details in Notes

4.E. SKIN

1. Select all SKIN diagnoses:

- [ ] None-Skip to 4.F.1
- [ ] Dry Skin
- [ ] Incision (surgical)
- [ ] Psoriasis
- [ ] Rash
- [ ] Ulcer
- [ ] Wound
- [ ] Other-Document Details in Notes

2. Check ALL affected SKIN location(s):

- [ ] Abdomen
- [ ] Ankle(s)
- [ ] Arm(s)
- [ ] Back of Knee(s)
- [ ] Buttock(s)
- [ ] Chest
- [ ] Face
- [ ] Foot/ Feet
- [ ] Hip(s)
- [ ] Leg(s)
- [ ] Lower Back
- [ ] Shoulder Blade(s)
- [ ] Spine
- [ ] Tailbone
- [ ] Other-Document Details in Notes

3. Identify the highest known ULCER STAGE.

- [ ] 0 - Unstageable
- [ ] 1 - Stage 1 - Redness
- [ ] 2 - Stage 2 - Partial Skin Loss
- [ ] 3 - Stage 3 - Full Thickness
- [ ] 4 - Stage 4 - Muscle and/or Bone Exposed
- [ ] 5 - Unknown

4. Signs and symptoms of the SKIN diagnoses:

- [ ] None
- [ ] Edema/ Swelling
- [ ] Excoriation
- [ ] Odor/ Drainage
- [ ] Pain
- [ ] Redness/ Discoloration
- [ ] Skin Tears
- [ ] Other-Document Details in Notes

5. Current treatments for SKIN diagnoses:

- [ ] None
- [ ] Debridement
- [ ] Medications-List in 9.D
- [ ] Pressure Relieving Devices
- [ ] Surgery
- [ ] Unna Boot(s)
- [ ] Wound Dressing
- [ ] Wound Therapy
- [ ] Wound VAC
- [ ] Other-Document Details in Notes

6. Do the SKIN diagnoses affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

7. Who manages care of the SKIN condition(s)?

- [ ] Formal Support
- [ ] Informal Support
- [ ] Primary Care Physician
- [ ] Self
- [ ] Specialty Physician
- [ ] Other-Document Details in Notes

8. Does the individual need additional assistance in managing the care of the SKIN condition(s)?

- [ ] No
- [ ] Yes-Document Details in Notes

4.F. ENDOCRINE/ METABOLIC SYSTEMS

1. Select all ENDOCRINE/ METABOLIC systems diagnoses:

- [ ] None-Skip to 4.G.1
- [ ] Ascites
- [ ] Cirrhosis
- [ ] Diabetes Mellitus (DM)-Insulin Dependent
- [ ] Diabetes Mellitus (DM)-Non-Insulin Dependent
- [ ] Diabetic Neuropathy
- [ ] Hypoglycemia
- [ ] Thyroid Disorder
- [ ] Other-Document Details in Notes

2. Signs and symptoms of the ENDOCRINE/ METABOLIC systems diagnoses:

- [ ] None
- [ ] Agitation
- [ ] Anxiety
- [ ] Blurred Vision
- [ ] Confusion
- [ ] Frequent Urination
- [ ] Increased Thirst
- [ ] Lethargy
- [ ] Slow Healing Sores
- [ ] Sweating
- [ ] Other-Document Details in Notes

3. Current treatments for ENDOCRINE/ METABOLIC systems diagnoses:

- [ ] None
- [ ] Blood Sugar Monitoring
- [ ] Blood Transfusions
- [ ] Medications-List in 9.D
- [ ] Special Diet
- [ ] Other-Document Details in Notes

4. Do the ENDOCRINE/ METABOLIC systems diagnoses affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

5. Who manages care of the ENDOCRINE/ METABOLIC systems condition(s)?

- [ ] Formal Support
- [ ] Informal Support
- [ ] Primary Care Physician
- [ ] Self
- [ ] Specialty Physician
- [ ] Other-Document Details in Notes

6. Does the individual need additional assistance in managing the care of the ENDOCRINE/ METABOLIC systems condition(s)?

- [ ] No
- [ ] Yes-Document Details in Notes

4.G. GENITOURINARY

1. Select all GENITOURINARY diagnoses:

- [ ] None-Skip to 4.H.1
- [ ] Ascites
- [ ] Benign Prostatic Hypertrophy (BPH)
- [ ] Bladder Disorders, including neurogenic or overactive bladder, urinary retention
- [ ] Frequent Urinary Tract Infections (UTI)
- [ ] Renal Insufficiency/ Failure (ESRD)
- [ ] Other-Document Details in Notes

2. Signs and symptoms of the GENITOURINARY diagnoses:

- [ ] None
- [ ] Abdominal Distention/ Bloated
- [ ] Bladder Spasms
- [ ] Frequent Urination
- [ ] Incontinence
- [ ] Low/ No Urine Output
- [ ] Painful/ Burning Urination
- [ ] Urinary Retention
- [ ] Other-Document Details in Notes

3. Current treatments for GENITOURINARY diagnoses:

- [ ] None
- [ ] Catheter-Complete 4.G.4
- [ ] Dialysis
- [ ] Fluid Restrictions
- [ ] Medications-List in 9.D
- [ ] Ostomy
- [ ] Other-Document Details in Notes

4. If the individual has a catheter, indicate the type.

- [ ] External/ Condom
- [ ] Indwelling
- [ ] Straight Catheterization
- [ ] Suprapubic
- [ ] Other-Document Details in Notes

5. Do the GENITOURINARY diagnoses affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

6. Who manages care of the GENITOURINARY condition(s)?

- [ ] Formal Support
- [ ] Informal Support
- [ ] Primary Care Physician
- [ ] Self
- [ ] Specialty Physician
- [ ] Other-Document Details in Notes

7. Does the individual need additional assistance in managing the care of the GENITOURINARY condition(s)?

- [ ] No
- [ ] Yes-Document Details in Notes

4.H. GYNECOLOGICAL

1. Select all GYNECOLOGICAL diagnoses:

- [ ] None-Skip to 4.I.1
- [ ] Abnormal Pap
- [ ] Breast Lumps
- [ ] Diseases of the Uterus/ Cervix-Document Details in Notes
- [ ] Prolapsed Uterus
- [ ] Other-Document Details in Notes

2. Signs and symptoms of GYNECOLOGICAL diagnoses:

- [ ] None
- [ ] Bleeding
- [ ] Bulging
- [ ] Discharge
- [ ] Infection(s)
- [ ] Itching
- [ ] Odor
- [ ] Other-Document Details in Notes

3. Current treatments for GYNECOLOGICAL diagnoses:

- [ ] None
- [ ] Medications-List in 9.D
- [ ] Sitz Bath
- [ ] Other-Document Details in Notes

4. Do the GYNECOLOGICAL diagnoses affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

5. Who manages care of the GYNECOLOGICAL condition(s)?

- [ ] Formal Support
- [ ] Informal Support
- [ ] Primary Care Physician
- [ ] Self
- [ ] Specialty Physician
- [ ] Other-Document Details in Notes

6. Does the individual need additional assistance in managing the care of the GYNECOLOGICAL condition(s)?

- [ ] No
- [ ] Yes-Document Details in Notes

4.I. INFECTIONS/ IMMUNE SYSTEMS

1. Select all INFECTION/ IMMUNE system diagnoses:

- [ ] Abscesses
- [ ] None-Skip to 4.J.1
- [ ] AIDS Asymptomatic
- [ ] AIDS Symptomatic
- [ ] Hepatitis
- [ ] HIV
- [ ] MRSA/ VRE/ C-Dif
- [ ] Sepsis
- [ ] TB-Tuberculosis
- [ ] Other-Document Details in Notes

2. If HIV or AIDS is indicated in 4.I.1, has the individual ever had lab results of CD4 count under 400?

- [ ] No
- [ ] Yes
- [ ] Unknown

3. Signs and symptoms of the INFECTION/ IMMUNE system conditions. Use Notes for additional text.

_____

_____

_____

_____

4. Current treatments for INFECTION/ IMMUNE system diagnoses:

- [ ] None
- [ ] Intravenous Therapy
- [ ] Isolation
- [ ] Laboratory result monitoring
- [ ] Medication(s)-List in 9.D
- [ ] Transfusion(s)
- [ ] Wound Therapy
- [ ] Other-Document Details in Notes

5. Do the INFECTIONS/ IMMUNE system diagnoses affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

6. Who manages care of the INFECTION/ IMMUNE system condition(s)?

- [ ] Formal Support
- [ ] Informal Support
- [ ] Primary Care Physician
- [ ] Self
- [ ] Specialty Physician
- [ ] Other-Document Details in Notes

7. Does the individual need additional assistance in managing the care of the INFECTIONS/ IMMUNE system condition(s)?

- [ ] No
- [ ] Yes-Document Details in Notes

4.J. CANCER

1. Does the individual have any current CANCER diagnoses?

- [ ] No-Skip to 4.K.1
- [ ] Yes

2. If Yes, identify the STAGE of CANCER:

- [ ] 0 - Unstageable
- [ ] 1 - Stage 1
- [ ] 2 - Stage 2
- [ ] 3 - Stage 3
- [ ] 4 - Stage 4
- [ ] 5 - Unknown

3. Select all current CANCER diagnoses:

- [ ] Basal Cell
- [ ] Bile Duct
- [ ] Bladder
- [ ] Bone
- [ ] Brain
- [ ] Breast
- [ ] Cervical
- [ ] Colon
- [ ] Colorectal
- [ ] Endometrial
- [ ] Esophageal
- [ ] Gallbladder
- [ ] Gastric
- [ ] Hodgkin's Disease
- [ ] Kidney
- [ ] Leukemia
- [ ] Liver
- [ ] Lung
- [ ] Lymphatic
- [ ] Multiple Myeloma
- [ ] Non-Hodgkin's Lymphoma
- [ ] Oral
- [ ] Ovarian
- [ ] Pancreatic
- [ ] Prostate
- [ ] Sarcoma
- [ ] Skin
- [ ] Testicular
- [ ] Throat
- [ ] Thyroid
- [ ] Uterine
- [ ] Vaginal
- [ ] Other-Document Details in Notes

4. Signs and symptoms of the CANCER diagnoses:

- [ ] None
- [ ] Abdominal distention
- [ ] Anemia
- [ ] Anorexia
- [ ] Anxiety
- [ ] Ascites
- [ ] Cachexia
- [ ] Confusion
- [ ] Constipation
- [ ] Cough
- [ ] Diaphoresis
- [ ] Diarrhea
- [ ] Disorientation
- [ ] Dysphagia (choking)
- [ ] Dyspnea at rest
- [ ] Dyspnea upon exertion
- [ ] Edema
- [ ] Fatigue
- [ ] Hallucinations
- [ ] Hematuria
- [ ] Insomnia
- [ ] Jaundice
- [ ] Loss of appetite
- [ ] Lymphedema
- [ ] Mental status changes
- [ ] Nausea
- [ ] Oral thrush
- [ ] Pain
- [ ] Special diet
- [ ] Terminal/ end stage dx
- [ ] Vomiting
- [ ] Weakness
- [ ] Weight loss
- [ ] Other-Document Details in Notes

5. Current treatments for CANCER diagnoses:

- [ ] None
- [ ] Aspiration Precautions
- [ ] Bone Marrow Transplant
- [ ] Chemo/ Radiation Combination
- [ ] Chemotherapy
- [ ] Hospice Care
- [ ] Indwelling Catheter/ Services
- [ ] Maintenance/ Preventative Skin Care
- [ ] Medications-List in 9.D
- [ ] Occupational Therapy
- [ ] Ostomy/ Related Services
- [ ] Oxygen
- [ ] Palliative Care
- [ ] Physical Therapy
- [ ] Radiation
- [ ] Respiratory Therapy
- [ ] Restorative Care
- [ ] Speech Therapy
- [ ] Suctioning
- [ ] Surgery
- [ ] Transfusion(s)
- [ ] Tube Feedings/ TPN
- [ ] Other-Document Details in Notes

6. Do the CANCER diagnoses affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

7. Who manages care of the CANCER condition(s)?

- [ ] Formal Support
- [ ] Informal Support
- [ ] Primary Care Physician
- [ ] Self
- [ ] Specialty Physician
- [ ] Other-Document Details in Notes

8. Does the individual need additional assistance in managing the care of the CANCER condition(s)?

- [ ] No
- [ ] Yes-Document Details in Notes

4.K. EARS, NOSE & THROAT (ENT)

1. Select all ENT diagnoses:

- [ ] None-Skip to 4.L.1
- [ ] Deafness
- [ ] Deviated Septum
- [ ] Rhinitis
- [ ] Sinusitis
- [ ] Tinnitus
- [ ] Other-Document Details in Notes

2. Signs and symptoms of the ENT diagnoses:

- [ ] None
- [ ] Choking
- [ ] Congestion
- [ ] Difficulty Breathing
- [ ] Difficulty Swallowing
- [ ] Dizziness
- [ ] Fullness/ Pressure in Head/ Sinuses
- [ ] Headaches
- [ ] Hearing Loss
- [ ] Hoarseness
- [ ] Persistent Cough
- [ ] Other-Document Details in Notes

3. Current treatments for ENT diagnoses:

- [ ] None
- [ ] Esophageal Dilatation
- [ ] Feeding Tube
- [ ] Hearing Aid
- [ ] Implants
- [ ] Medications-List in 9.D
- [ ] Tracheostomy
- [ ] Other-Document Details in Notes

4. Do the ENT diagnoses affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Details in Notes

5. Who manages care of the ENT condition(s)?

- [ ] Formal Support
- [ ] Informal Support
- [ ] Primary Care Physician
- [ ] Self
- [ ] Specialty Physician
- [ ] Other

6. Does the individual need additional assistance in managing the care of the ENT condition(s)?

- [ ] No
- [ ] Yes-Document Details in Notes

4.L. EYES

1. What EYE diagnoses/ disorders have been confirmed and documented by health/ medical professionals?

- [ ] None-Skip to 4.M.1
- [ ] Blindness
- [ ] Cataracts
- [ ] Glaucoma
- [ ] Legally Blind
- [ ] Macular Degeneration
- [ ] Partially Sighted/ Low Vision
- [ ] Retinal Detachment
- [ ] Other Visual Impairments-Document Details in Notes

2. Signs and symptoms for EYE conditions and/ or diagnoses:

- [ ] None
- [ ] Double /Blurred Vision
- [ ] Dry Eye
- [ ] Itching
- [ ] Redness
- [ ] Other-Document Details in Notes

3. Current treatments for EYE conditions and/ or diagnoses:

- [ ] None
- [ ] Corrective Lenses
- [ ] Corrective Surgery
- [ ] Medications-List in 9.D
- [ ] Other-Document Details in Notes

4. Do the EYE diagnoses affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Detail in Notes

5. Who manages care of the EYE condition(s)?

- [ ] Formal Support
- [ ] Informal Support
- [ ] Primary Care Physician
- [ ] Self
- [ ] Specialty Physician
- [ ] Other-Document Detail in Notes

6. Does the individual need additional assistance in managing the care of the EYE condition(s)?

- [ ] No
- [ ] Yes-Document Details in Notes

4.M. MOUTH

1. Select all MOUTH conditions and/ or diagnoses:

- [ ] None-Skip to 5.A.1
- [ ] Dry Mouth
- [ ] Edentulous/ Toothless
- [ ] Gingivitis
- [ ] Thrush
- [ ] Ulcer(s)
- [ ] Other-Document Details in Notes

2. Current treatments for MOUTH conditions and/ or diagnoses:

- [ ] None
- [ ] Dental Hygiene
- [ ] Medications-List in 9.D
- [ ] Other-Document Details in Notes

3. Signs and symptoms of MOUTH conditions and/ or diagnoses:

- [ ] None
- [ ] Halitosis
- [ ] Pain
- [ ] Swelling
- [ ] Thrush
- [ ] Other-Document Details in Notes

4. Do the MOUTH diagnoses affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Detail in Notes

5. Who manages care of the MOUTH condition(s)?

- [ ] Formal Support
- [ ] Informal Support
- [ ] Primary Care Physician
- [ ] Self
- [ ] Specialty Physician
- [ ] Other-Document Detail in Notes

6. Does the individual need additional assistance in managing the care of the MOUTH conditions?

- [ ] No
- [ ] Yes-Document Details in Notes

5. NEUROLOGICAL (MANDATORY completion of Section 8 if Neurological diagnosis)

5.A. NEUROLOGICAL

1. If there are NEUROLOGICAL diagnoses, select all types & completion of Section 8 (Behaviors) is MANDATORY.

- ☐ None-Skip to 6.A.1
- ☐ ALS
- ☐ Alzheimer's Disease
- ☐ Autism
- ☐ Cerebral Palsy
- ☐ CVA/ TIA/ Stroke
- ☐ Dementia (Include all Non-Alzheimer's Dementia)
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Neuropathy
- ☐ Seizure Disorder
- ☐ TBI-Traumatic Brain Injury
- ☐ Other-Document Details in Notes

2. What characteristics describe the individual's COGNITIVE state?

- ☐ Appears to be cognitively intact
- ☐ Executive functioning impaired-Document Details in Notes
- ☐ Inability to adapt to changes in routine or location
- ☐ Inability to follow commands
- ☐ Non-communicative
- ☐ Poor long term memory
- ☐ Poor short term memory
- ☐ Slow response to questions
- ☐ Other-Document Details in Notes

3. Signs and symptoms of NEUROLOGICAL diagnoses:

- ☐ None
- ☐ Ambulation Dysfunction
- ☐ Aphasia
- ☐ Fatigue
- ☐ Muscle Spasticity/ Stiffness
- ☐ Pain
- ☐ Poor Balance
- ☐ Rigidity
- ☐ Shuffling Gait
- ☐ Spasms
- ☐ Tremors/ Twitches
- ☐ Other-Document Details in Notes

4. Current treatments for NEUROLOGICAL diagnoses:

- ☐ None
- ☐ No Treatment Available
- ☐ Braces
- ☐ Cervical Collar
- ☐ Cognitive/ Behavioral Therapy
- ☐ Electrical Stimulation Device
- ☐ Medications-List in 9.D
- ☐ Seizure Precautions
- ☐ Therapy-Document Details in Notes
- ☐ Traction
- ☐ Other-Document Details in Notes

5. Do the NEUROLOGICAL diagnoses affect the individual's ability to function?

- ☐ No
- ☐ Yes-Document Detail in Notes

6. Who manages care of the NEUROLOGICAL condition(s)?

- ☐ Formal Support
- ☐ Informal Support
- ☐ Primary Care Physician
- ☐ Self
- ☐ Specialty Physician
- ☐ Other-Document Detail in Notes

7. Does the individual need additional assistance in managing the care of the NEUROLOGICAL condition(s)?

- ☐ No
- ☐ Yes-Document Details in Notes

6. INTELLECTUAL/ DEVELOPMENTAL DISABILITY (I/DD) (MANDATORY completion of Section 8 if I/DD diagnosis)

6.A. INTELLECTUAL/ DEVELOPMENTAL DISABILITY (I/DD)

1. Does the individual have a diagnosis of Intellectual/ Developmental Disability (I/DD) from birth to 22nd birthday or known to the ID system?

- ☐ No-Skip to 7.A.1
- ☐ Yes-Completion of Section 8 (Behaviors) is MANDATORY.

2. Is the individual able to self-manage care of the I/DD condition?

- ☐ No
- ☐ Yes
- ☐ Unable to Determine

3. Does the I/DD diagnosis affect the individual's ability to function?

- ☐ No
- ☐ Yes
- ☐ Unable to Determine

7. MENTAL HEALTH (MANDATORY completion of Section 8 if Psychiatric diagnosis)

7.A. PSYCHIATRIC

1. If there are PSYCHIATRIC diagnoses, select all types & completion of Section 8 (Behaviors) is MANDATORY.

- ☐ None-Skip to 7.B.1
- ☐ Anxiety Disorders
- ☐ Bipolar Disorders
- ☐ Depressive Disorders
- ☐ Disruptive Impulse Control/ Conduct Disorders
- ☐ Eating Disorders
- ☐ Obsessive Compulsive Disorders
- ☐ Personality Disorders
- ☐ Schizophrenia/ Other Psychotic Disorders
- ☐ Sleep/ Wake disorders
- ☐ Somatic Symptom/ Related Disorders
- ☐ Trauma/ Stress/ Related Disorders
- ☐ Other-Document Details in Notes

2. Signs and Symptoms of PSYCHIATRIC conditions:

- ☐ None
- ☐ Exhibits Other Unusual Behavior-Document Details in Notes
- ☐ Experiences Sleep Disturbances
- ☐ Experiencing Hallucinations/ Delusions
- ☐ Fearful/ Suspicious
- ☐ Feels Depressed, Sad or Hopeless
- ☐ Feels Lonely
- ☐ Irritable/ Easily Upset
- ☐ Physically/ Verbally Abusive
- ☐ Withdrawn/ Lethargic
- ☐ Worried/ Anxious
- ☐ Other-Document Details in Notes

3. Current treatments for PSYCHIATRIC diagnoses:

- ☐ None
- ☐ No Treatment Available
- ☐ ECT-Electroconvulsive Therapy
- ☐ Medications-List in 9.D
- ☐ Outpatient Psychiatric Care
- ☐ Other-Document Details in Notes

4. Do the PSYCHIATRIC diagnoses affect the individual's ability to function?

- ☐ No
- ☐ Yes-Document Detail in Notes

5. Who manages care of the PSYCHIATRIC condition(s)?

- ☐ Formal Support
- ☐ Informal Support
- ☐ Primary Care Physician
- ☐ Self
- ☐ Specialty Physician
- ☐ Other-Document Detail in Notes

6. Does the individual need additional assistance in managing the care of the PSYCHIATRIC condition(s)?

- ☐ No
- ☐ Yes-Document Details in Notes

7.B. SUICIDE SCREENING

1. Have you thought about hurting yourself or taking your life in the PAST 30 DAYS?

- ☐ No
- ☐ Yes-Complete Aging Suicide Risk Assessment
- ☐ Individual Refused to Answer

2. When did you have these thoughts, and do you have a plan to take your life?

- ☐ No
- ☐ Yes-Document Details in Notes
- ☐ Individual Refused to Answer

3. Have you ever had a suicide attempt?

- ☐ No
- ☐ Yes-Document Details in Notes
- ☐ Individual Refused to Answer

8. BEHAVIORS - MANDATORY if Neurological, I/DD or Psychiatric Diagnosis

8.A. BEHAVIORS

1. Does the individual present with any BEHAVIORAL signs/ symptoms? This Section is REQUIRED if any Neurologic, IDD or Psychiatric Diagnoses were noted in Section 5, 6 or 7.

- ☐ No-Skip to 8.B.1
- ☐ Yes-Completion of Section 8-Behaviors is MANDATORY.
- ☐ Unable to Determine-Completion of Section 8-Behaviors is MANDATORY.

2a. Does the individual exhibit PHYSICAL behavioral symptoms toward OTHERS?

- ☐ No-Skip to 8.A.3a
- ☐ Yes-Complete 8.A.2b-c

2b. Specify ALL types of aggressive PHYSICAL behavior toward OTHERS (If not listed, document in Notes.)

- ☐ Biting
- ☐ Hair pulling
- ☐ Hitting
- ☐ Kicking
- ☐ Picking
- ☐ Scratching
- ☐ Sexual acting out/ behavior
- ☐ Spitting
- ☐ Other-Document Details in Notes

2c. Does the aggressive PHYSICAL behavior toward OTHERS interfere with the individual's ability to function daily?

- ☐ No-Document in Notes why the behavior does NOT interfere.
- ☐ Yes-Document in Notes how it interferes.

3a. Does the individual exhibit aggressive PHYSICAL behavioral symptoms towards SELF?

- ☐ No-Skip to 8.A.4a
- ☐ Yes-Complete 8.A.3b-c

3b. Specify ALL types of aggressive PHYSICAL behavior towards SELF (If not listed, document in Notes.)

- ☐ Biting
- ☐ Hair pulling
- ☐ Hitting
- ☐ Kicking
- ☐ Picking
- ☐ Scratching
- ☐ Spitting
- ☐ Other-Document Details in Notes

3c. Does the aggressive PHYSICAL behavior toward SELF interfere with the individual's ability to function daily?

- ☐ No-Document in Notes why the behavior does NOT interfere.
- ☐ Yes-Document in Notes how it interferes.

4a. Does the individual exhibit aggressive VERBAL behavior symptoms toward OTHERS?

- ☐ No-Skip to 8.A.5a
- ☐ Yes-Complete 8.A.4b-c

4b. Specify ALL types of aggressive VERBAL behavior towards OTHERS (If not listed, document in Notes.)

- ☐ Cursing
- ☐ Screaming
- ☐ Threatening
- ☐ Other-Document Details in Notes

4c. Does the aggressive VERBAL behavior toward OTHERS interfere with the individual's ability to function daily?

- ☐ No-Document in Notes why the behavior does NOT interfere.
- ☐ Yes-Document in Notes how it interferes.

5a. Does the individual exhibit any GENERAL aggressive VERBAL behavior symptoms not specifically directed toward self or others?

- ☐ No-Skip to 8.A.6a
- ☐ Yes-Complete 8.A.5b-c

5b. Select ALL GENERAL aggressive VERBAL behaviors (If not listed, document in Notes.)

- ☐ Disruptive sounds
- ☐ Yelling out
- ☐ Other-Document Details in Notes

5c. Does the GENERAL aggressive VERBAL behavior interfere with the individual's ability to function daily?

- ☐ No-Document in Notes why the behavior does NOT interfere.
- ☐ Yes-Document in Notes how it interferes.

6a. Does the individual exhibit any OTHER behavioral symptoms?

- ☐ No-Skip to 8.B.1
- ☐ Yes-Complete 8.A.6b-c

6b. Specify ALL OTHER types of behaviors reported (If not listed, document in Notes.)

- ☐ Fecal Smearing
- ☐ Hoarding
- ☐ Pacing
- ☐ Public Disrobing
- ☐ Rummaging
- ☐ Sundowner's Syndrome
- ☐ Other-Document Details in Notes

6c. Do the OTHER types of behaviors interfere with the individual's ability to function daily?

- ☐ No-Document in Notes why the behavior does NOT interfere.
- ☐ Yes-Document in Notes how it interferes.

8.B. ADDICTIVE BEHAVIORS

1. Has anyone ever expressed concern about your use of alcohol or drugs?

- ☐ No- Skip to Section 9.A.1
- ☐ Yes-Document Details in Notes and Complete Section 8.B

2. Do you find yourself missing work, family events, activities that you once participated in due to over use of a substance?

- ☐ No
- ☐ Yes-Document Details in Notes

3. Is drinking or use of other substances making your home life unhappy?

- ☐ No
- ☐ Yes-Document Details in Notes

4. Do you find yourself reaching for an alcoholic drink or other substance to get you through an event or interaction with certain people?

- ☐ No
- ☐ Yes-Document Details in Notes

5. Do you drink or use other substances alone? (Do you live alone? Feel lonely?)

- ☐ No
- ☐ Yes-Document Details in Notes

6. Have you ever felt remorse (regret) after you've drank or used other substance?

- ☐ No
- ☐ Yes-Document Details in Notes

7. Do you believe that your drinking or use of other substances is causing a financial burden or decline?

- ☐ No
- ☐ Yes-Document Details in Notes

8. Do you find your ambition (effort to get up and do things each day) has declined since drinking or using other substances?

- ☐ No
- ☐ Yes-Document Details in Notes

9. Do you find yourself replacing meals with either an alcoholic drink or another substance?

- ☐ No
- ☐ Yes-Document Details in Notes

10. Does drinking or use of other substances cause you to have difficulty sleeping?

- ☐ No
- ☐ Yes-Document Details in Notes

11. Do you drink to escape (getaway from) worries or troubles?

- ☐ No
- ☐ Yes-Document Details in Notes

12. Do you find yourself more depressed since drinking or using other substances?

- ☐ No
- ☐ Yes-Document Details in Notes

13. Are you having memory problems due to drinking or use of other substances?

- ☐ No
- ☐ Yes-Document Details in Notes

14. Have you spoken to your doctor about drinking or use of other substances?

- ☐ No
- ☐ Yes-Document Details in Notes

15. Have you ever been treated in a hospital, rehabilitation center or by a doctor for drinking or other substance use?

- ☐ No
- ☐ Yes-Document Details in Notes

9. OTHER MEDICAL INFORMATION

9.A. INFORMATION

1. Has the individual exhibited ELOPEMENT behavior in the LAST 6 MONTHS? If so, indicate the FREQUENCY.

- ☐ Never
- ☐ Less than once a month
- ☐ Once a month
- ☐ Several times a month
- ☐ Several times a week
- ☐ Daily
- ☐ Other-Document Details in Notes

2. Does the individual require supervision?

- ☐ No-Skip to 9.A.4
- ☐ Yes-Complete 9.A

2a. How long can the individual be routinely left alone? Document Details in Notes

- ☐ Indefinitely
- ☐ Entire day and overnight
- ☐ Eight (8) hours or more - day or night
- ☐ Eight (8) hours or more - daytime only
- ☐ Four (4) hours or more - day or night
- ☐ Four (4) hours or more - daytime only
- ☐ Less than four (4) hours
- ☐ Cannot be left alone

3. Why does the individual require supervision?

- ☐ Cognitive diagnosis
- ☐ Environmental issue
- ☐ General physical condition
- ☐ Other-Document Details in Notes

4. Can the individual evacuate their home in the event of a fire?

- ☐ No-See Section 17 Emergency Information
- ☐ Yes

9.B. FRAILTY SCORE

1. Are you tired?

- ☐ No
- ☐ Yes

2. Can you walk up a flight of stairs?

- ☐ No
- ☐ Yes

3. Can you walk a city block (250-350 feet)?

- ☐ No
- ☐ Yes

4. Do you have more than 5 illnesses?

- ☐ No
- ☐ Yes

5. Have you lost more than 5% of your weight in the last year?

- ☐ No
- ☐ Yes

6. Individual shows symptoms of being frail?

9.C. DEPRESSION /LIFE SATISFACTION

1. Are you basically satisfied with your life?

- ☐ No
- ☐ Yes

2. Do you often get bored?

- ☐ No
- ☐ Yes

3. Do you often feel hopeless?

- ☐ No
- ☐ Yes

4. Do you prefer to stay at home, rather than going out and doing new things?

- ☐ No
- ☐ Yes

5. Do you ever have feelings of worthlessness?

- ☐ No
- ☐ Yes

6. Individual shows symptoms of being depressed?

9.D. MEDICATION MANAGEMENT

1. Does the individual take any PRESCRIBED Medications?

- ☐ No-Skip to 9.D.6
- ☐ Yes

2. Does the individual have a central venous line?

- ☐ No
- ☐ Yes-Document Type & Details in Notes

3. List all PRESCRIBED medications taken by the individual:

Name and Dose: Record the name of the medication and dose ordered.

Unit type: gtts (Drops) mEq (Milli-equivalent)
Puffs
gm (Gram) mg (Milligram) %
(Percentage)

Form: Code the route of administration using the following list:

1 = by mounth (PO)	7 = topical
2 = sub lingual (SL)	8 = inhalation
3 = intramuscular (IM)	9 = enteral tube
4 = intravenous (IV)	10 = other
5 = subcutaneous (SQ)	11 = eye drop
6 = rectal (R)	12 = transdermal

Frequency: Code the number of times per period the med is administered using the following list:

PR = (PRN) as necessary	OO = every other day
1H = (QH) every hour	1W = (Q week) once each week
2H = (Q2H) every 2 hours	2W = 2 times every week
3H = (Q3H) every 3 hours	3W = 3 times every week
4H = (Q4H) every 4 hours	4W = 4 times each week
6H = (Q6H) every 6 hours	5W = 5 times each week
8H = (Q8H) every eight hours	6W = 6 times each week
1D = (QD or HS) once daily	1M = (Q month) once/mo.
2D = (BID) two times daily *(includes every 12 hours)*	2M = twice every month
3D = (TID) 3 times daily	C = Continuous
4D = (QID) four times daily	O = Other
5D = 5 times daily	

Name	Dose	Form	Freq.	PRN	# Taken	Drug Code	Comments

4. Does the individual take all medications as prescribed?

- ☐ No-Document Details in Notes
- ☐ Yes

5. Does the individual know what medication they take and why? Document Details in Notes

- ☐ No
- ☐ Yes
- ☐ Unable to Determine

6. List all OVER THE COUNTER (OTC) medications taken by the individual:

Name and Dose: Record the name of the medication and dose ordered.

Unit type: gtts (Drops) mEq (Milli-equivalent)
Puffs
gm (Gram) mg (Milligram) %
(Percentage)

Form: Code the route of administration using the following list:

1 = by mounth (PO)	7 = topical
2 = sub lingual (SL)	8 = inhalation
3 = intramuscular (IM)	9 = enteral tube
4 = intravenous (IV)	10 = other
5 = subcutaneous (SQ)	11 = eye drop
6 = rectal (R)	12 = transdermal

Frequency: Code the number of times per period the med is administered using the following list:

PR = (PRN) as necessary	OO = every other day
1H = (QH) every hour	1W = (Q week) once each week
2H = (Q2H) every 2 hours	2W = 2 times every week
3H = (Q3H) every 3 hours	3W = 3 times every week
4H = (Q4H) every 4 hours	4W = 4 times each week
6H = (Q6H) every 6 hours	5W = 5 times each week
8H = (Q8H) every eight hours	6W = 6 times each week
1D = (QD or HS) once daily	1M = (Q month) once/mo.
2D = (BID) two times daily *(includes every 12 hours)*	2M = twice every month
3D = (TID) 3 times daily	C = Continuous
4D = (QID) four times daily	O = Other
5D = 5 times daily	

Name	Dose	Form	Freq.	PRN	# Taken	Drug Code	Comments

7. Does the individual have any allergies or adverse reactions to any medication?

- ☐ No
- ☐ Yes-Document Details in Notes

8. What is the individual's ability level to manage medication?

- ☐ 1 - Independent-Skip to 9.D.11
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

9. If Limited Assistance, indicate ALL types needed for MEDICATION MANAGEMENT:

- ☐ Assistance with Self-Injections/ Independent with Oral Medications
- ☐ Coaxing
- ☐ Medication Dispenser
- ☐ Set-up/ Prepackaged
- ☐ Verbal Reminders
- ☐ Other-Document Details in Notes

10. Who assists the individual with medication administration?

- ☐ Formal Support-Document Details in Notes
- ☐ Informal Support-Document Details in Notes
- ☐ Other-Document Details in Notes

11. Does the individual use herbs or other remedies?

- ☐ No
- ☐ Yes-Document Details in Notes.

12. Pharmacy Information (Name, Phone, etc.)

_____

_____

_____

_____

9.E. HEIGHT/WEIGHT

1. What is the individual's height?

_____

2. What is the individual's weight?

_____

3. Document the reason(s) for weight gain or loss (See 13.B.10)

- ☐ Diet/ Intentional
- ☐ Fluid Loss
- ☐ Fluid Retention
- ☐ Increased Appetite
- ☐ Poor Appetite
- ☐ Unable to Determine
- ☐ Other

4. Is physician aware of the weight change?

- ☐ No
- ☐ Yes

5. What is the individual's weight type?

- ☐ Normal-height/ weight appropriate
- ☐ Morbidly Obese
- ☐ Obese
- ☐ Overweight
- ☐ Underweight

9.F. PAIN

1. Does the individual report PAIN?

- ☐ No-Skip to 10.A.1a
- ☐ Yes
- ☐ Unable to determine-Skip to 10.A.1a

2. Location(s) of PAIN site(s)

- ☐ Back
- ☐ Bone
- ☐ Chest
- ☐ Head
- ☐ Hip
- ☐ Incision site
- ☐ Knee
- ☐ Soft tissue (muscle)
- ☐ Stomach
- ☐ Other Joint-Document Details in Notes
- ☐ Other-Document Details in Notes

3. Indicate the level of PAIN the individual reports using a scale from 0-10 (0=no pain, 10=severe pain)

- ☐ 0=No pain
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10=Severe pain

4. Indicate the frequency the individual reports the PAIN

- ☐ Less than Daily
- ☐ Daily-One Episode
- ☐ Daily-Multiple Episodes
- ☐ Continuous
- ☐ Other-Document Details in Notes

5. Select all the current treatments for PAIN diagnoses:

- [ ] None
- [ ] Acupuncture
- [ ] Chiropractic Care/ Services
- [ ] Exercises
- [ ] Heat/ Cold Applications
- [ ] Massage
- [ ] Medications-List in 9.D
- [ ] Pain Management Center
- [ ] Physical Therapy
- [ ] Other-Document Details in Notes

6. PAIN Management

- [ ] No pain treatment
- [ ] Treated, full relief
- [ ] Treated, partial relief
- [ ] Treated, no or minimal relief

7. Does PAIN affect the individual's ability to function?

- [ ] No
- [ ] Yes-Document Detail in Notes

8. Who manages care of the PAIN condition(s)?

- [ ] Formal Support
- [ ] Informal Support
- [ ] Primary Care Physician
- [ ] Self
- [ ] Specialty Physician
- [ ] Other-Document Detail in Notes

9. Does the Individual need additional assistance in managing PAIN?

- [ ] No
- [ ] Yes-Document Details in Notes

10. ACTIVITIES OF DAILY LIVING (ADLs)

10.A. ADLs

1a. BATHING: Ability to prepare a bath and wash oneself, including turning on the water, regulating temperature, etc.

- [ ] 1 - Independent-Skip to 10.A.2a
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

1b. If Limited Assistance, indicate ALL types needed for BATHING:

- [ ] Assistance with the use of equipment/ assistive devices
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs (includes hands on assistance)
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

1c. BATHING: Assistance currently provided by what INFORMAL supports? Document Details in Notes

- [ ] None
- [ ] Family
- [ ] Friend
- [ ] Neighbor
- [ ] Other-Document Details in Notes

1d. BATHING: Assistance currently provided by what FORMAL supports? Document Details in Notes

- [ ] None
- [ ] Aging Programs
- [ ] Medicaid
- [ ] Medicare
- [ ] Hospice
- [ ] Private Pay Insurance
- [ ] Other-Document Details in Notes

1e. How often is BATHING support available? Document Details in Notes

- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] Other-Document Details in Notes

1f. Type of BATHING? Document Details in Notes

- [ ] Partial
- [ ] Shower
- [ ] Sponge bath
- [ ] Tub
- [ ] Other-Document Details in Notes

1g. Assistive devices/ adaptive equipment used for BATHING? Document Details in Notes

- [ ] None
- [ ] Bathtub bench
- [ ] Grab bar/ tub rail
- [ ] Handheld shower
- [ ] Hydraulic lift
- [ ] Shower bench
- [ ] Transfer bench
- [ ] Other

1h. Does the individual need additional assistance in BATHING?

- [ ] No
- [ ] Yes-Document Details in Notes

2a. DRESSING: Ability to remove clothes from a closet/ drawer; application of clothing, including shoes/ socks (regular/ TEDS); orthotics; prostheses; removal/ storage of items; managing fasteners; and to use any needed assistive devices.

- [ ] 1 - Independent-Skip to 10.A.3a
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

2b. If Limited Assistance, indicate ALL types needed for DRESSING:

- [ ] Assistance with the use of equipment/ assistive device
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs (includes hands on assistance)
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

2c. DRESSING: Assistance currently provided by what INFORMAL supports? Document Details in Notes

- [ ] None
- [ ] Family
- [ ] Friend
- [ ] Neighbor
- [ ] Other-Document Details in Notes

2d. DRESSING: Assistance currently provided by what FORMAL supports? Document Details in Notes

- [ ] None
- [ ] Aging Programs
- [ ] Medicaid
- [ ] Medicare
- [ ] Hospice
- [ ] Private Pay Insurance
- [ ] Other-Document Details in Notes

2e. How often is DRESSING support available? Document Details in Notes

- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] Other-Document Details in Notes

2f. Assistive devices/ adaptive equipment used for DRESSING? Document Details in Notes

- [ ] None
- [ ] Buttonhole helper
- [ ] Shoe horn
- [ ] Sock cup
- [ ] Other-Document Details in Notes

2g. Does the individual need additional assistance in managing DRESSING?

- [ ] No
- [ ] Yes-Document Details in Notes

3a. GROOMING/ PERSONAL HYGIENE: Ability to comb/ brush hair; brush teeth; care for/ inset dentures; shave; apply make-up (if worn); apply deodorant, etc.

- [ ] 1 - Independent-Skip to 10.A.4a
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

3b. If Limited Assistance, indicate ALL types needed for GROOMING/ PERSONAL HYGIENE:

- [ ] Assistance with the use of equipment/ assistive devices
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs (includes hands on assistance)
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

3c. GROOMING/ PERSONAL HYGIENE: Assistance currently provided by what INFORMAL supports? Document Details in Notes

- [ ] None
- [ ] Family
- [ ] Friend
- [ ] Neighbor
- [ ] Other-Document Details in Notes

3d. GROOMING/ PERSONAL HYGIENE: Assistance currently provided by what FORMAL supports?

- [ ] None
- [ ] Aging Programs
- [ ] Medicaid
- [ ] Medicare
- [ ] Hospice
- [ ] Private Pay Insurance
- [ ] Other-Document Details in Notes

3e. How often is GROOMING/ PERSONAL HYGIENE support available? Document Details in Notes

- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] Other-Document Details in Notes

3f. Are assistive devices/ adaptive equipment used for GROOMING/ PERSONAL HYGIENE? Document Details in Notes

- [ ] No
- [ ] Yes

3g. Does the individual need additional assistance in GROOMING/ PERSONAL HYGIENE?

- [ ] No
- [ ] Yes-Document Details in Notes

4a. EATING: Ability to eat/ drink; cut, chew, swallow food; and to use any needed assistive devices

- [ ] 1 - Independent-Skip to 10.A.5a
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance
- [ ] 4 - Does not eat-Skip to 10.A.4c

4b. If Limited Assistance, indicate ALL types needed for EATING:

- [ ] Assistance with the use of equipment/ assistive devices
- [ ] Encouragement, cueing or coaxing
- [ ] Guided maneuvering of limbs (includes hands on assistance)
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document in Notes

4c. If response to 10.A.4a is "4-Does not eat", indicate type of nutritional intake. Check ALL that apply:

- [ ] IV Fluids
- [ ] NPO (nothing by mouth)
- [ ] Parenteral Nutrition
- [ ] Tube Feeding
- [ ] Other-Document Details in Notes

4d. EATING: Assistance currently provided by what INFORMAL supports? Document Details in Notes

- [ ] None
- [ ] Family
- [ ] Friend
- [ ] Neighbor
- [ ] Other-Document Details in Notes

4e. EATING: Assistance currently provided by what FORMAL supports?

- [ ] None
- [ ] Aging Programs
- [ ] Medicaid
- [ ] Medicare
- [ ] Hospice
- [ ] Private Pay Insurance
- [ ] Other-Document Details in Notes

4f. How often is EATING support available? Document Details in Notes

- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] Other-Document Details in Notes

4g. Assistive devices/ adaptive equipment used for EATING? Document Details in Notes

- [ ] Adaptive cup
- [ ] Adaptive plate
- [ ] Adaptive utensils
- [ ] Dentures
- [ ] Hand split/ braces
- [ ] Infusion pump
- [ ] Special utensil/ plate
- [ ] Other-Document Details in Notes

4h. Does the individual need additional assistance in managing EATING?

- [ ] No
- [ ] Yes-Document Details in Notes

5a. TRANSFER: Ability to move between surfaces, including to/ from bed, chair, wheelchair, or to a standing position; onto or off a commode; and to manage/ use any needed assistive devices.

- [ ] 1 - Independent-Skip to 10.A.6a
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

5b. If Limited Assistance, indicate ALL types needed for TRANSFER:

- [ ] Assistance with the use of equipment/ assistive devices
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs (includes hands on assistance)
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

5c. TRANSFER: Assistance currently provided by what INFORMAL supports? Document Details in Notes

- [ ] None
- [ ] Family
- [ ] Friend
- [ ] Neighbor
- [ ] Other-Document Details in Notes

5d. TRANSFER: Assistance currently provided by what FORMAL supports?

- [ ] None
- [ ] Aging Programs
- [ ] Medicaid
- [ ] Medicare
- [ ] Hospice
- [ ] Private Pay Insurance
- [ ] Other-Document Details in Notes

5e. How often is support available for TRANSFER? Document Details in Notes

- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] Other-Document Details in Notes

5f. Assistive devices/ adaptive equipment used for TRANSFER? Document Details in Notes

- [ ] None
- [ ] Bed rails
- [ ] Bedfast all or most of time
- [ ] Cane
- [ ] Electric lift chair
- [ ] Hospital bed
- [ ] Lifted manually
- [ ] Lifted mechanically
- [ ] Slide board
- [ ] Trapeze
- [ ] Walker
- [ ] Other-Document Details in Notes

5g. Does the individual need additional assistance in managing TRANSFERS?

- [ ] No
- [ ] Yes-Document Details in Notes

6a. TOILETING: Ability to manage bowel and bladder elimination.

- [ ] 1 - Independent-Skip to 10.A.7a
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance
- [ ] 4 - Self management of indwelling catheter/ ostomy

6b. If Limited Assistance, indicate ALL types needed for TOILETING:

- [ ] Assistance on or off bed pan
- [ ] Assistance with incontinent products
- [ ] Assistance with the use of equipment/ assistive devices
- [ ] Clothing maneuvers/ adjustment
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs (includes hands on assistance)
- [ ] Personal hygiene post toileting
- [ ] Setup
- [ ] Supervision
- [ ] Transfer to toilet
- [ ] Other-Document Details in Notes

6c. TOILETING: Assistance currently provided by what INFORMAL supports? Document Details in Notes

- [ ] None
- [ ] Family
- [ ] Friend
- [ ] Neighbor
- [ ] Other-Document Details in Notes

6d. TOILETING: Assistance currently provided by what FORMAL supports?

- [ ] None
- [ ] Aging Programs
- [ ] Medicaid
- [ ] Medicare
- [ ] Hospice
- [ ] Private Pay Insurance
- [ ] Other-Document Details in Notes

6e. How often is support available for TOILETING? Document Details in Notes

- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] Other-Document Details in Notes

6f. Assistive devices/ adaptive equipment used for TOILETING? Document Details in Notes

- [ ] None
- [ ] Bed pan/ urinal
- [ ] Catheter
- [ ] Commode
- [ ] Grab bars
- [ ] Ostomy
- [ ] Pads for incontinence
- [ ] Raised toilet seat
- [ ] Other-Document Details in Notes

6g. Does the individual need additional assistance in managing TOILETING?

- [ ] No
- [ ] Yes-Document Details in Notes

7a. BLADDER CONTINENCE: Indicate the description that best describes the individual's BLADDER function.

- [ ] 1 - Continent - Complete control, no type of catheter or urinary collection device
- [ ] 2 - Usually Continent - Incontinence episodes once a week or less
- [ ] 3 - Incontinent - Inadequate control, multiple daily episodes
- [ ] 4 - Self management of indwelling catheter or ostomy

7b. Does the individual need additional assistance in managing BLADDER CONTINENCE?

- [ ] No
- [ ] Yes-Document Details in Notes

7c. BOWEL CONTINENCE: Indicate the description that best describes the individual's BOWEL function.

- [ ] 1 - Continent - Complete control, no ostomy device
- [ ] 2 - Usually Continent - Incontinence episodes once a week or less
- [ ] 3 - Incontinent - Inadequate control, multiple daily episodes
- [ ] 4 - Continent - with ostomy

7d. Does the individual need additional assistance in managing BOWEL CONTINENCE?

- [ ] No
- [ ] Yes-Document Details in Notes

7e. Does the individual use incontinency products?

- [ ] No
- [ ] Yes-Document Details in Notes

8a. WALKING: Ability to safely walk to/ from one area to another; manage/ use any needed ambulation devices.

- [ ] 1 - Independent-Skip to 11.A.1
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

8b. If Limited Assistance, indicate ALL types needed for WALKING:

- [ ] Hands on assistance with the use of equipment/ assistive devices
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs (includes hands on assistance)
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

8c. Does the individual need additional assistance in managing WALKING?

- [ ] No
- [ ] Yes-Document Details in Notes

11. MOBILITY

11.A. INDIVIDUAL'S MOBILITY

1. BEDBOUND: Is the individual bedbound? Indicate in Notes any comments or relevant information.

- [ ] No
- [ ] Yes-Skip to 12.A.1
- [ ] Unable to Determine

2a. INDOOR MOBILITY: Ability of movement within INTERIOR environment:

- [ ] 1 - Independent-Skip to 11.A.3a
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

2b. If Limited Assistance, indicate ALL types needed for INDOOR MOBILITY:

- [ ] Assistance with the use of equipment/ assistive devices
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs (includes hands on assistance)
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

2c. Assistive devices needed for INDOOR MOBILITY. Document Details in Notes

- [ ] None
- [ ] Cane
- [ ] Hand rails
- [ ] Hold furniture/ walls
- [ ] Prosthesis-Document Type in Notes
- [ ] Quad cane
- [ ] Scooter
- [ ] Stair glide
- [ ] Walker
- [ ] Wheelchair (manual)
- [ ] Wheelchair (motorized)
- [ ] Other-Document Details in Notes

2d. Does the individual need additional assistance in managing INDOOR MOBILITY?

- [ ] No
- [ ] Yes-Document Details in Notes

3a. OUTDOOR MOBILITY: Ability of movement OUTSIDE living arrangement:

- [ ] 1 - Independent-Skip to 11.A.4a
- [ ] 2 - Limited Assistance
- [ ] 3 - Extensive/ Total Assistance

3b. If Limited Assistance, indicate ALL types needed for OUTDOOR MOBILITY:

- [ ] Assistance with the use of equipment/ assistive devices
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs (includes hands on assistance)
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

3c. Assistive devices needed for OUTDOOR MOBILITY. Document Details in Notes

- [ ] None
- [ ] Cane
- [ ] Hand rails
- [ ] Holds onto walls
- [ ] Prosthesis-Document Type in Notes
- [ ] Quad cane
- [ ] Scooter
- [ ] Stair glide
- [ ] Walker
- [ ] Wheelchair (manual)
- [ ] Wheelchair (motorized)
- [ ] Other-Document Details in Notes

3d. Does the individual need additional assistance in managing OUTDOOR MOBILITY?

- [ ] No
- [ ] Yes-Document Details in Notes

4a. STAIR MOBILITY: Movement safely up and down STEPS:

- [ ] 1 - Independent-Skip to 11.A.5
- [ ] 2 - Limited Assistance
- [ ] 3 - Extensive/ Total Assistance

4b. If Limited Assistance, indicate ALL types needed for STAIR MOBILITY:

- [ ] Assistance with the use of equipment/ assistive devices
- [ ] Encouragement, cueing, or coaxing
- [ ] Guided maneuvering of limbs (includes hands on assistance)
- [ ] Independent
- [ ] Set-up
- [ ] Supervision
- [ ] Other-Document Details in Notes

4c. Does the individual need additional assistance in managing STAIR MOBILITY?

- [ ] No
- [ ] Yes-Document Details in Notes

5. What is the individual's weight bearing status?

- [ ] Full weight bearing
- [ ] Partial weight bearing
- [ ] Toe touch weight bearing
- [ ] Non-weight bearing
- [ ] Unable to Determine

6. Select all that affect the individual's MOBILITY:

- [ ] None
- [ ] Ambulation Dysfunction
- [ ] Aphasia
- [ ] Fatigues Easily
- [ ] Muscle Stiffness
- [ ] Pain
- [ ] Poor Balance
- [ ] Rigidity
- [ ] Shuffling Gait
- [ ] Spasms
- [ ] Tremors/ Twitches
- [ ] Other-Document Details in Notes

11.B. FALLS

1. Is the individual at risk of falling?

- [ ] No
- [ ] Yes
- [ ] Unable to Determine

2. Select the number of times the individual has fallen in the LAST 6 MONTHS.

- [ ] None-Skip to 12.A.1
- [ ] 1
- [ ] 2
- [ ] 3 or More

3. Reasons for falls-Document Details in Notes

- [ ] Accidental
- [ ] Environmental
- [ ] Medical
- [ ] Other-Document Details in Notes

12. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

12.A. IADLs

1. MEAL PREPARATION: Ability to plan/ prepare meals, use of kitchen appliances, heat meals. List any needed adaptive equipment/ assistive devices in Notes.

- ☐ 1 - Independent-Skip to 12.A.2
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

1a. MEAL PREPARATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes

- ☐ None
- ☐ Family
- ☐ Friend
- ☐ Neighbor
- ☐ Other-Document Details in Notes

1b. MEAL PREPARATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes

- ☐ None
- ☐ Medicaid
- ☐ Medicare
- ☐ Hospice
- ☐ Private Pay Insurance
- ☐ Other-Document Details in Notes

1c. How often is support available for MEAL PREPARATION? Document Details in Notes

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Other-Document Details in Notes

2. HOUSEWORK: Ability to maintain living space, includes tasks such as dishwashing, making the bed, dusting, running the vacuum or sweeping an area. List any needed adaptive equipment/ assistive devices in Notes.

- ☐ 1 - Independent-Skip to 12.A.3
- ☐ 2 - Limited assistance
- ☐ 3 - Total Assistance

2a. HOUSEWORK: Assistance is currently provided by what INFORMAL supports? Document Details in Notes

- ☐ None
- ☐ Family
- ☐ Friend
- ☐ Neighbor
- ☐ Other-Document Details in Notes

2b. HOUSEWORK: Assistance is currently provided by what FORMAL supports? Document Details in Notes

- ☐ None
- ☐ Medicaid
- ☐ Medicare
- ☐ Hospice
- ☐ Private Pay Insurance
- ☐ Other-Document Details in Notes

2c. How often is support available for HOUSEWORK? Document Details in Notes

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Other-Document Details in Notes

3. LAUNDRY: Ability to gather clothes, place clothes in washing machine, turn on appliance, remove clothes and place in dryer, or hand wash items and hang to dry. List any needed adaptive equipment/ assistive devices in Notes.

- ☐ 1 - Independent-Skip to 12.A.4
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance

3a. LAUNDRY: Assistance is currently provided by what INFORMAL supports? Document Details in Notes

- ☐ None
- ☐ Family
- ☐ Friend
- ☐ Neighbor
- ☐ Other-Document Details in Notes

3b. LAUNDRY: Assistance is currently provided by what FORMAL supports? Document Details in Notes

- ☐ None
- ☐ Medicaid
- ☐ Medicare
- ☐ Hospice
- ☐ Private Pay Insurance
- ☐ Other-Document Details in Notes

3c. How often is support available for LAUNDRY? Document Details in Notes

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Other-Document Details in Notes

4. SHOPPING: Ability to go to the store and purchase needed items, including groceries and other items. List any needed adaptive equipment/ assistive devices in Notes.

- ☐ 1 - Independent-Skip to 12.A.5
- ☐ 2 - Limited assistance
- ☐ 3 - Total Assistance

4a. SHOPPING: Assistance is currently provided by what INFORMAL supports? Document Details in Notes

- [ ] None
- [ ] Family
- [ ] Friend
- [ ] Neighbor
- [ ] Other-Document Details in Notes

4b. SHOPPING: Assistance is currently provided by what FORMAL supports? Document Details in Notes

- [ ] None
- [ ] Medicaid
- [ ] Medicare
- [ ] Hospice
- [ ] Private Pay Insurance
- [ ] Other-Document Details in Notes

4c. How often is support available for SHOPPING? Document Details in Notes

- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] Other-Document Details in Notes

5. TRANSPORTATION: Ability to travel on public transportation or drive a car. List any needed adaptive equipment/ assistive devices in Notes.

- [ ] 1 - Independent-Skip to 12.A.6
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

5a. TRANSPORTATION: Assistance is currently provided by what INFORMAL supports? Document Details in Notes

- [ ] None
- [ ] Family
- [ ] Friend
- [ ] Neighbor
- [ ] Other-Document Details in Notes

5b. TRANSPORTATION: Assistance is currently provided by what FORMAL supports? Document Details in Notes

- [ ] None
- [ ] Medicaid
- [ ] Medicare
- [ ] Hospice
- [ ] Private Pay Insurance
- [ ] Other-Document Details in Notes

5c. How often is support available for TRANSPORTATION? Document Details in Notes

- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] Other-Document Details in Notes

6. MONEY MANAGEMENT: Ability to manage financial matters, writing checks, paying bills, going to the bank. List any needed adaptive equipment/ assistive devices in Notes.

- [ ] 1 - Independent-Skip to 12.A.7
- [ ] 2 - Limited assistance
- [ ] 3 - Total Assistance

6a. MONEY MANAGEMENT: Assistance is currently provided by what INFORMAL supports? Document Details in Notes

- [ ] None
- [ ] Family
- [ ] Friend
- [ ] Neighbor
- [ ] Other-Document Details in Notes

6b. MONEY MANAGEMENT: Assistance is currently provided by what FORMAL supports? Document Details in Notes

- [ ] None
- [ ] Medicaid
- [ ] Medicare
- [ ] Hospice
- [ ] Private Pay Insurance
- [ ] Other-Document Details in Notes

6c. How often is support available for MONEY MANAGEMENT? Document Details in Notes

- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] Other-Document Details in Notes

7. TELEPHONE: Ability to obtain phone numbers, dial the telephone and communicate with person on the other end. List any needed adaptive equipment/ assistive devices in Notes.

- [ ] 1 - Independent-Skip to 12.A.8
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

7a. TELEPHONE: Assistance is currently provided by what INFORMAL supports? Document Details in Notes

- [ ] None
- [ ] Family
- [ ] Friend
- [ ] Neighbor
- [ ] Other-Document Details in Notes

7b. TELEPHONE: Assistance is currently provided by what FORMAL supports? Document Details in Notes

- [ ] None
- [ ] Medicaid
- [ ] Medicare
- [ ] Hospice
- [ ] Private Pay Insurance
- [ ] Other-Document Details in Notes

7c. How often is support available for TELEPHONE? Document Details in Notes

- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] Other-Document Details in Notes

8. HOME MANAGEMENT: Ability to perform heavier household tasks such as taking out the trash, completing minor repairs around the living space, yard work and/ or snow removal. List any needed adaptive equipment/ assistive devices in Notes.

- [ ] 1 - Independent-Skip to 13.A.1
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance

8a. HOME MANAGEMENT: Assistance is currently provided by what INFORMAL supports? Document Details in Notes

- [ ] None
- [ ] Family
- [ ] Friend
- [ ] Neighbor
- [ ] Other-Document Details in Notes

8b. HOME MANAGEMENT: Assistance is currently provided by what FORMAL supports? Document Details in Notes

- [ ] None
- [ ] Medicaid
- [ ] Medicare
- [ ] Hospice
- [ ] Private Pay Insurance
- [ ] Other-Document Details in Notes

8c. How often is support available for HOME MANAGEMENT? Document Details in Notes

- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] Other-Document Details in Notes

13. NUTRITION

13.A. DIETARY ISSUES

1. Does the individual generally have a good appetite?

- ☐ No-Document Details in Notes
- ☐ Yes
- ☐ Other-Document Details in Notes

2. Does the individual use a dietary supplement?

- ☐ No
- ☐ Yes-Document Details in Notes

3. Does the individual have any food allergies?

- ☐ No
- ☐ Yes-Document Details in Notes

4. Does the individual have a special diet for medical reasons?

- ☐ No
- ☐ Yes-Document Details in Notes

5. Does the individual have a special diet for religious/ cultural reasons?

- ☐ No
- ☐ Yes-Document Details in Notes

13.B. NUTRITIONAL RISK ASSESSMENT

1. Has there been a change in lifelong eating habits because of health problems?

- ☐ No
- ☐ Yes-Document Details in Notes

2. Does the individual eat fewer than 2 meals per day?

- ☐ No
- ☐ Yes-Document Details in Notes

3. Does the individual eat fewer than 2 servings of dairy products (such as milk, yogurt, or cheese) every day?

- ☐ No
- ☐ Yes-Document Details in Notes

4. Does the individual eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day?

- ☐ No
- ☐ Yes-Document Details in Notes

5. Does the individual have 3 or more drinks of beer, liquor or wine almost every day?

- ☐ No
- ☐ Yes-Document Details in Notes

6. Does the individual have trouble eating due to problems with chewing/ swallowing?

- ☐ No
- ☐ Yes-Document Details in Notes

7. Individual does not have enough money to buy food needed?

- ☐ No
- ☐ Yes-Document Details in Notes

8. Does the individual eat alone most of the time?

- ☐ No
- ☐ Yes-Document Details in Notes

9. Does the individual take 3 or more prescribed or over-the-counter drugs (OTC) per day?

- ☐ No
- ☐ Yes-Document Details in Notes

10. Has the individual lost or gained at least 10 pounds or more in the LAST 6 MONTHS? Document Details in Notes (See 9.E.3)

- ☐ No
- ☐ Yes, gained 10 pounds or more
- ☐ Yes, lost 10 pounds or more
- ☐ Don't know

11. Individual is not always physically able to shop, cook and/or feed themselves (or find someone to do it for them).

- ☐ No
- ☐ Yes-Document Details in Notes

12. Calculates the consumer's Nutritional Risk Score based upon the responses to 2.A. 1-11.

14. INFORMAL SUPPORTS

14.A. INFORMAL HELPER(S) INFORMATION

1. Does the individual have any NON-PAID helpers that provide care or assistance on a regular basis?

- ☐ No-Skip to 14.C.1
- ☐ Yes-Complete Section 14

2. List names, phone numbers and email addresses of the non-paid helpers. Use the Note section if more room is needed.

_____

_____

_____

_____

3. Do any of the non-paid helpers reside in the individual's home?

- ☐ No
- ☐ Yes-Document Details in Notes

4. Select the relationships of the individual's non-paid helpers:

- ☐ Child/ Child-in-Law
- ☐ Friend
- ☐ Neighbor
- ☐ Parent
- ☐ Spouse/ Domestic Partner
- ☐ Other-Document Details in Notes

14.B. CONCERNS ABOUT THE HELPING RELATIONSHIPS

1. What concerns does the individual have about any of the non-paid helpers? Document Details in Notes

- ☐ None
- ☐ Cognition
- ☐ Doesn't feel safe
- ☐ Drug/ alcohol abuse
- ☐ Mental health
- ☐ Physical health
- ☐ Regrets actions toward helper when upset
- ☐ Strained relationship
- ☐ Stressed/ overwhelmed
- ☐ Theft of belongings/ money/ assets
- ☐ Understanding and managing the behavior of the care recipient
- ☐ Understanding and managing the care recipient's health needs.
- ☐ Other-Document Details in Notes

2. Care Manager's observations or concerns about the non-paid helpers-Document Details in Notes

- ☐ None
- ☐ Cares for others
- ☐ Displays behaviors that pose a risk to the individual's well-being
- ☐ Family or other responsibilities
- ☐ Not reliable/ unwilling to provide care
- ☐ Not Trustworthy
- ☐ Poor physical health, disabled or frail
- ☐ Poor relationship/ communication
- ☐ Possible alcohol/ drug abuse
- ☐ Possible mental health issues
- ☐ Other-Document Details in Notes

14.C. ADDITIONAL INFORMAL SUPPORTS

1. Is the individual involved with any informal supports in the community that are or may be willing to provide help and support (i.e., church, social or community organizations)?

- ☐ No-Skip to 15.A.1
- ☐ Yes-Complete 14.C.2

2. Document the name of the community support(s), type of help and frequency of help that could be or is provided.

_____

_____

_____

_____

15. PROTECTIVE SERVICES (PS)

15.A. PROTECTIVE SERVICES (PS) Questions 1-3 are MANDATORY

1. Does the individual feel afraid in his/ her current living situation?

- ☐ No
- ☐ Yes-Completion of Section 15 is required

2. Is the individual safe to stay in his/ her home environment?

- ☐ No-Completion of Section 15 is required
- ☐ Yes

3. Does the individual need a safe place to stay?

- ☐ No
- ☐ Yes-Completion of Section 15 is required

4. Note any dangers - Document Details in Notes.

- ☐ None/ Not Reported
- ☐ Gang Activity
- ☐ History of Violent Behavior in Home
- ☐ Known Drug Activity
- ☐ Neighborhood Dangers
- ☐ Pets
- ☐ Weapons
- ☐ Unknown
- ☐ Other-Document Details in Notes

5. Is a referral to protective services indicated?

- ☐ No
- ☐ Yes-Document Details in Notes

15.B. ACCESS TO SERVICES

1. Does the individual have an issue with access to needed services or supports?

- ☐ No
- ☐ Yes-Document Details in Notes

2. If the individual does not have access to the needed services or supports, what assistance is needed?

_____

_____

_____

_____

16. PHYSICAL ENVIRONMENT

16.A. CURRENT DWELLING UNIT

1. Does the individual own his/ her current residence?

- [ ] No-Document Details in Notes
- [ ] Yes

2. Is the individual able to remain in his/ her current residence?

- [ ] No-Document Details in Notes
- [ ] Yes
- [ ] Uncertain-Document Details in Notes

3. What conditions of the home environment cause health and safety risks to the individual? Document in notes what and where are the problems.

- [ ] None
- [ ] Appliances
- [ ] Clutter
- [ ] Cooling system
- [ ] Environmental pests
- [ ] Furnishings
- [ ] Hallways
- [ ] Heating system
- [ ] Lack of electricity
- [ ] Lack of fire safety devices
- [ ] Lack of refrigeration
- [ ] Lack of toilet
- [ ] Lack of water
- [ ] Lighting
- [ ] Pets
- [ ] Poor flooring
- [ ] Shower
- [ ] Stairs
- [ ] Structural issues
- [ ] Other-Document Details in Notes

4. What areas of the home environment impact accessibility? Document in Notes, what and where problems exist.

- [ ] Bathroom
- [ ] Bedroom
- [ ] Hallways
- [ ] Home entryways
- [ ] Kitchen
- [ ] Laundry
- [ ] Stairs
- [ ] Other-Document Details in Notes

17. EMERGENCY INFORMATION

17.A. EMERGENCY INFORMATION

1. What are the individual's physical limitations that would prevent individual leaving the home alone in an emergency?

- [ ] None
- [ ] Bed bound/ immobile
- [ ] Dementia (May be reluctant to leave.)
- [ ] Hearing impaired (May need special warnings.)
- [ ] Intellectual disabilities (Supervision needed.)
- [ ] Lives alone (May be reluctant to leave.)
- [ ] Morbid Obesity
- [ ] Visually impaired (Guide dogs may become disoriented in a disaster.)
- [ ] Wheelchair bound (Special transportation needed.)
- [ ] Other-Document Details in Notes

2. Does the individual have any of the following special medical needs during a public emergency?

- [ ] None
- [ ] Dialysis
- [ ] Insulin
- [ ] Life sustaining equipment or treatment
- [ ] Nasal/ gastrointestinal tubes/ suctioning
- [ ] Oxygen
- [ ] Respirator
- [ ] Special medications & management needs
- [ ] Specialized transportation
- [ ] Supervision
- [ ] Other-Document Details in Notes

3. Select ALL types of Personal Emergency Response Systems (PERS) with which the individual is currently utilizing:

- [ ] None
- [ ] PERS/ w 24 hour family/ designated contact notification
- [ ] PERS/ w 24 hour response for elopement (GPS)
- [ ] Other-Document Details in Notes

4. Is the consumer enrolled in a community response program?

- [ ] No
- [ ] Yes-Document Details in Notes

18. INDIVIDUAL/ SPOUSE/ HOUSEHOLD FINANCIAL DATA

18.A. INDIVIDUAL'S INCOME

1. Refused to provide financial information?

- ☐ No
- ☐ Yes

2. Does the individual have direct deposit?

- ☐ No
- ☐ Yes-Document Details in Notes

3. Individual's monthly Social Security (SS) income:

$

4. Individual's monthly Supplemental Social Security Income (SSI):

$

5. Individual's monthly retirement/ pension income:

$

6. Individual's interest/ dividends income:

$

7. Individual's monthly public assistance:

$

8. Individual's monthly VA benefit income:

$

9. Individual's monthly black lung income: Do not consider this as income for CSP determination.

$

10. Individual's monthly wage/ salary/ earnings income:

$

11. Individual's monthly rental income:

$

12. Individual's railroad retirement benefit income:

$

13. Individual's annuity, trust, estate income:

$

14. Reverse mortgage monthly income:

$

15. Individual's other monthly income-Document the source of income in Notes.

$

16. Individual's Total Monthly Income indicator WILL go here. (Until then, manually enter total.)

$

18.B. INDIVIDUAL'S ASSETS

1. Individual's primary savings account balance:

$

2. Individual's primary checking account balance:

$

3. Individual's certificates/ other retirement accounts:

$

4. Individual's NON-residential real estate assets value:

$

5. Cash surrender value of the individual's primary life insurance policy:

$

6. Individual's stocks and bonds account balances:

$

7. Individual's other account(s) balance(s)-Document type of account(s) in Notes.

$

8. Individual's Total ASSETS Value indicator WILL go here. (Until then, manually enter total.)

$

18.C. SPOUSE'S INCOME (RESIDING with Individual)

1. Monthly Social Security (SS) income of spouse RESIDING with the individual:

$

2. Monthly SSI of spouse RESIDING with the individual:

$

3. Monthly retirement/ pension income of spouse RESIDING with the individual:

$

4. Monthly interest/ dividend income of spouse RESIDING with the individual:

$

5. Monthly public assistance income of spouse RESIDING with the individual:

$

6. Monthly VA benefits income of spouse RESIDING with the individual:

$

7. Monthly Black Lung income of spouse RESIDING with the individual:

$

8. Monthly wage/ salary/ earnings income of spouse RESIDING with the individual:

$

9. Monthly NON-residential rental income of spouse RESIDING with the individual:

$

10. Other monthly income of spouse RESIDING with the individual-Document the source of income in Notes.

$

11. RESIDING Spouse's Total monthly income INDICATOR WILL go here. (Until then, manually enter total.)

$

18.D. HOUSEHOLD INCOME

1. Financial Resources Score - Only required for individuals served in community.

- ☐ Individual Alone Annual $34,470 and Above; W/ Spouse $46,530 and Above
- ☐ Individual Alone Annual $33,033-$34,469; W/ Spouse $44,591-$46,529
- ☐ Individual Alone Annual $31,596-$33,032; W/ Spouse $42,652-$44,590
- ☐ Individual Alone Annual $30,160-$31,595; W/ Spouse $40,713-$42,651
- ☐ Individual Alone Annual $28,724-$30,159; W/ Spouse $38,774-$40,712
- ☐ Individual Alone Annual $27,288-$28,723; W/ Spouse $36,835-$38,773
- ☐ Individual Alone Annual $25,852-$27,287; W/ Spouse $34,896-$36,834
- ☐ Individual Alone Annual $24,416-$25,851; W/Spouse $32,957-$34,895
- ☐ Individual Alone Annual $22,980-$24,415; W/ Spouse $31,018-$32,956
- ☐ Individual Alone Annual $21,544-$22,979; W/ Spouse $29,079-$31,017
- ☐ Individual Alone Annual $20,108-$21,543; W/ Spouse $27,141-$29,078
- ☐ Individual Alone Annual $18,672-$20,107; W/ Spouse $25,203-$27,140
- ☐ Individual Alone Annual $17,236-$18,671; W/ Spouse $23,265-$25,202
- ☐ Consumer Alone Annual $14,364-$15,799; W/ Spouse $19,389-$21,326
- ☐ Consumer Alone Annual $15,800-$17,235; W/ Spouse $21,327-$23,264
- ☐ Consumer Alone Annual $0-$14,363; W/ Spouse $0-$19,388

18.E. BENEFIT PROGRAMS

1. Check all benefits the individual is currently RECEIVING:

- ☐ Food Stamps
- ☐ LIHEAP
- ☐ Medicaid
- ☐ PACE
- ☐ Section 8
- ☐ Subsidized Transit
- ☐ Tax and Rent Rebates
- ☐ Weatherization
- ☐ Other-Document Details in Notes

19. NEEDS ASSESSMENT SUMMARY

19.A. LCD & NAT OUTCOME

1. What is the most recent Level of Care Determination (LCD) for this individual?

- ☐ NFCE-Nursing Facility Clinically Eligible
- ☐ NFCE-No physician document
- ☐ NFI-Nursing Facility Ineligible

2. Has the individual had a change in condition that warrants a new LOC determination?

- ☐ No
- ☐ Yes-Document Details in Notes

3. What referral is recommended based on the LCD & NAT?

- ☐ None
- ☐ CSP-Caregiver Support Program
- ☐ DC-Domiciliary Care Program
- ☐ DPW Program
- ☐ Nursing Home
- ☐ OPTIONS Program
- ☐ PCH-Personal Care Home
- ☐ Other-Document Details in Notes

19.B. NEEDS ASSESSMENT OUTCOME AND AUTHENTICATION

1. Name of Care Manager (CM)/ Service Coordinator (SC) completing this Needs Assessment Tool

_____

2. Date of Care Manager (CM)/ Service Coordinator (SC) Signature

_____/_____/_____

3. Name of Registered Nurse reviewing the Needs Assessment Tool (if reviewed)

_____

4. Date of Registered Nurse review (if reviewed)

_____/_____/_____

5. Name of Supervisor reviewing this Needs Assessment Tool

_____

6. Date Supervisor approved the Needs Assessment Tool

_____/_____/_____

Title : _____ Date

Title : _____ Date

701D Instructions

Guidance for Completion of the Department of Elder Affairs' 701B Comprehensive Assessment

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Introduction

The 701B Comprehensive Assessment is the instrument administered in a face-to-face setting to assess a client's health, function, needs, and resources. It is used to complete an initial comprehensive assessment and an annual reassessment for clients enrolled in Department-funded case-managed programs. It is also completed for active clients who have requested to update their assessment information when significant changes take place. CARES assessors use it for individuals who are being referred to community placement. The 701B is completed by the Assessor/Case Manager with information provided by the client, observed directly, or verified by records.

The 701D Instructions are a companion manual for the 701B form. To be eligible to administer the 701B, staff must complete the web-based 701B Comprehensive Training program and satisfactorily pass the competency test. This person will be identified as a certified Assessor or Case Manager, or "Assessor/CM," throughout these instructions, in the training, and on the form.

These instructions also apply to any questions from the 701B that also appear on the other assessment and screening forms, such as the 701A, 701C, and 701S. The purpose of these sub-assessment forms is:

- The 701A form is intended to be administered face to face for non-case managed clients in Local Service Programs and Older Americans Act programs.
- The 701C is intended to be administered for congregate meal clients.
- The 701S is intended to be administered over the telephone for wait list management, initial screening, and re-screening of individuals.
- The 701T is intended to be administered to individuals residing in a nursing facility with no intent to return to the community or to individuals residing in the community intending to enter a nursing facility.

TIP: The Assessor/Case Manager will find it helpful to review the previous assessment prior to conducting a reassessment. If any changes are noted during the new interview, the Assessor/Case Manager should discuss them with the client or informant to determine the effect the changes have on the client's situation and ability to function.

Assessor/Case Manager Skills

You will use many skills in conducting assessments. Your observation skills will be necessary to remain aware of both the client and your own personal safety at all times. For many assessments, you will be meeting a potential or current client in their home. Because residential environments vary widely, you should be prepared for a variety of different situations. As you are approaching and entering the home, you will need to be aware of your surroundings for your own safety's sake and make mental note of issues surrounding or within the living environment that pose any hazard to the client.

You will also need your social skills to develop rapport with clients and their families. Prior to beginning an interview, take a little time to establish a friendly conversation with the client, caregiver, and other informants who may be present. Developing rapport will make the interview go more quickly and be more productive and enjoyable. If the client feels comfortable, they will speak more openly and allow you to gather valuable information.

You will need your professionalism and preparedness skills to conduct assessments. Different topics are covered on the comprehensive form, many of which are private or sensitive. For this reason, it is important to be familiar with administering the form, to let clients know that a range of topics will be covered, and to be prepared to assure clients of the confidentiality of your discussion. It can often help put clients at ease to introduce yourself in a friendly conversation; however, remember that once you begin the assessment, conversation should feel slightly more formal, like a structured interview. Asking the questions as they are written helps convey your professional role and helps gather more reliable

information. You should read the questions and answer choices aloud and then look up for the client to respond, prompting when necessary.
Many of our potential and existing clients come from diverse backgrounds and have had a rich variety in the life experiences that they bring to their interactions with others. The services and supports that clients may need require that we have a basic understanding of their personal habits, customs, and practices so that we are able to identify any deficits in their care. Although it is understood that all people have personal beliefs, as a representative of your employer, you are expected to comport yourself as an unbiased professional in all your interactions with clients. As such, you must reserve any personal judgments that are beyond the scope of assessing an individual's functional limitations. Within your ability, you should attempt to understand and accommodate the specific cultural needs of clients and their families where applicable.

Completing the DOEA Comprehensive Assessment Instrument 701B

Florida Department of Elder Affairs
701B Comprehensive Assessment
Rule: 58-A-1.010, F.A.C.

Provider ID:	_____	**Provider Assessor/CM ID:**	_____
Assessor/Case Manager (CM) Name:	_____	**Signature:**	_____

Provider ID: This is the CIRTS Provider ID of the agency employing the Assessor/Case Manager who is completing the assessment. If a provider does not have a CIRTS Provider ID, the name of the agency must be entered. There is no Provider ID when the assessment is completed by CARES.

Provider Assessor/CM ID: This is the CIRTS worker ID of the Assessor or Case Manager (CM) completing the assessment. If the person assessing the client does not have a CIRTS worker ID, the name of the worker must be entered. There is no Provider Assessor/CM ID when the assessment is completed by CARES.

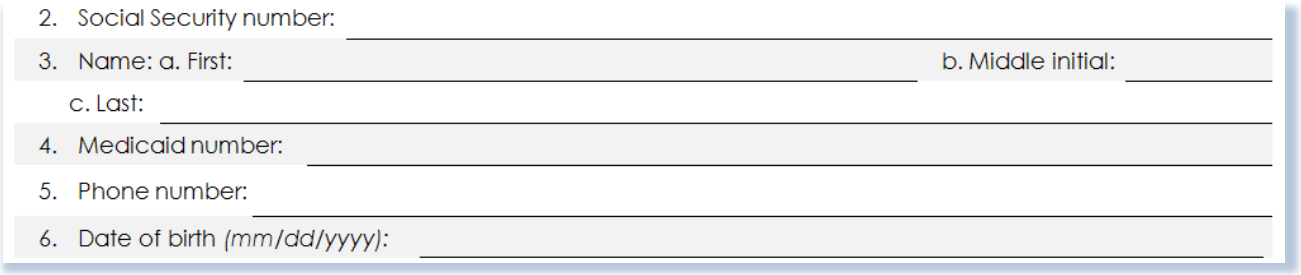
TIP: Questions that begin with the notation "**ASSESSOR/CM**" and appear in bold text should be completed by the Assessor/Case Manager without asking the client or informant for a direct response. These are questions that require staff observation or information that staff can provide without client assistance.

Assessor/CM Name and **Signature**: This space is for the legibly printed name of the Assessor/Case Manager along with her/his signature. The signature at the beginning of the form indicates that the Assessor/Case Manager is taking responsibility for the completion of the entire form in a factual and objective manner.

A. DEMOGRAPHIC SECTION

1. **ASSESSOR/CM: What is the purpose of this assessment?**
☐ Initial ☐ Annual ☐ Health ☐ Living situation ☐ Caregiver ☐ Environment ☐ Income

1. **ASSESSOR/CM: What is the purpose of this assessment?**: Mark the appropriate box for the purpose of conducting the assessment. The Assessor/Case Manager should indicate whether the assessment is an initial comprehensive assessment or an annual reassessment. For any assessment that is being completed more frequently than every 12 months, the Assessor/Case Manager must identify the significant change that is prompting the unscheduled reassessment. Common significant changes in client status that might necessitate an unscheduled reassessment include the loss of the caregiver, a change of caregiver, a change of residence, or a change in the client's medical condition or financial situation.



2. **Social Security Number (SSN)**: Enter the client's Social Security number in the space provided. This is a nine-digit number. A "unique identifier" for each client is used for tracking and comparing information.

   Under Title 42, Code of Federal Regulations, Section 435.910, Assessors/Case Managers are authorized to collect client SSNs to determine benefits or services that may be appropriate for the client. However, to comply with s. 119.071(5), Florida Statutes, all clients shall be provided a written statement that explains their SSN is confidential under law and that disclosure of their SSN is voluntary. You will bring printed copies of Attachment A to provide to the client for their information and reference.

   If a client does not wish to release her/his SSN, a nine-digit pseudo ID will automatically be created by CIRTS using the following formula: Use the initials from the client's name (first, middle or "X," and last) for the first three characters. If the middle initial is unknown, then enter "X." Enter the client's six-digit date of birth (MM/DD/YY) to create the last six characters. Do not make up a DOB.

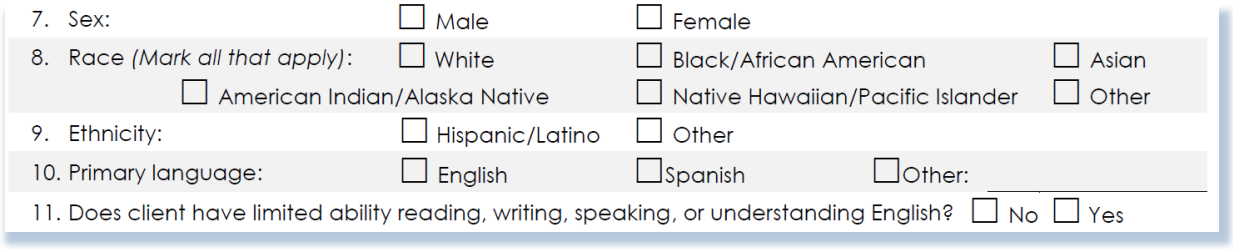
For example: Ellen Elizabeth Hyatt; DOB: January 5, 1912. Pseudo ID would be = EEH010512

3. **Name**: Obtain the client's full name (first, middle initial, and last) and note it in the spaces provided. If the client does not have a middle initial, leave the space blank.

4. **Medicaid Number:** If the client is receiving general Medicaid or services under one of the Medicaid waivers, s/he will have a ten-digit Medicaid number assigned by the Department of Children and Families (DCF). Enter the client's Medicaid number in the space provided. The client will not have a Medicaid number while their Medicaid application is in a pending status.

TIP: If a person is receiving Supplemental Security Income (SSI) through the Social Security Administration, s/he will also be eligible for Medicaid and will have a Medicaid number assigned by DCF.

5. **Phone Number:** Note the client's area code and primary phone number, if there is a phone, in the space provided. The phone number includes the area code and the seven-digit phone number. If the client does not have a phone, leave the item blank. If the client also has a mobile phone, ask for the number that is the best way to reach them and note the other in the "Notes & Summary" section.
6. **Date of Birth**: In the space provided, note the client's date of birth in a two-number format for the month (i.e., February would be '02'). Likewise, use the two-number format for the day (i.e., the third of the month would be '03') and a four-number format for the year (i.e., 2013) as indicated by "mm/dd/yyyy" throughout the form.



7. **Sex**: Mark the appropriate box to indicate whether the client identifies themselves as female or male.

8. **Race**: Obtain the client's response and mark the box or boxes, as applicable, to indicate the client's race. Clients may provide more than one response. These categories are consistent with federal reporting requirements:

   - "White"
   - "Black/African American"
   - "Asian"
   - "American Indian/Alaska Native"
   - "Native Hawaiian/Pacific Islander"
   - "Other" (Any other racial group not coded above).

9. **Ethnicity**: Obtain the client's response and mark the appropriate box to indicate the client's ethnicity. "Hispanic/Latino" is the only ethnicity required for federal reporting. A person who identifies as Hispanic or Latino may be from any racial group. If it is needed information for service referrals, use the space provided in the "Notes & Summary" section to indicate what culturally specific accommodations may be necessary.

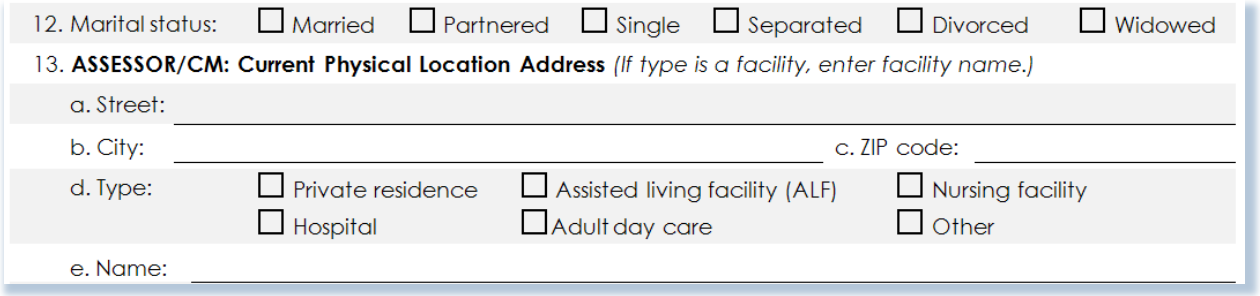
10. **Primary Language**: Mark the appropriate box to indicate the primary language spoken by the client. If collected in advance of the assessment during the screening process, this information may enable the agency to send a worker to the home or arrange for someone who will be able to communicate most effectively with the client.

    - "English"
    - "Spanish"
    - "Other" (Any other language).

    → *Write-in a brief description of the client's primary language if it is not English or Spanish, and note if an accommodation or translator is necessary in the "Notes & Summary" section.*

11. **Limited English Proficiency (LEP)**: Mark the appropriate box to indicate whether the client has limited ability to read, write, or speak in the English language, or to understand spoken English ("No" or "Yes"). This can be due to the client's primary language being other than English, literacy issues, or physical impairments. This is not meant for clients who understand English, but are deaf or hard of hearing.

TIP: Collecting information about client English proficiency is a federal reporting measure and is specifically relevant to the client's ability to be understood during the assessment and care planning process; however it is also relevant to whether they can communicate well enough to obtain assistance when needed from others. The inability to speak, read, and write in English can be a barrier to managing day to day tasks for many people for many reasons. The absence of these basic communication skills becomes a major hardship to those who rely on others to assist them for activities of daily living or in unplanned or emergency events such as hurricanes, floods, or other natural disasters. If you have LEP clients, be sure to discuss with them and their families having a plan to address this limitation for emergency situations, and note what kind of accommodation they need for future assessments or emergency situations in the "Notes & Summary" section.


12. Marital status: ☐ Married ☐ Partnered ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

13. **ASSESSOR/CM: Current Physical Location Address** *(If type is a facility, enter facility name.)*

a. Street: _____

b. City: _____ c. ZIP code: _____

d. Type: ☐ Private residence ☐ Assisted living facility (ALF) ☐ Nursing facility ☐ Hospital ☐ Adult day care ☐ Other

e. Name: _____

12. **Marital Status**: Select from the listed options. Obtain the client's response and mark the appropriate box to indicate the client's current marital status:
    - "Married:" An individual who has a legal husband or wife.
    - "Partnered:" An individual who is in a relationship with a person, other than a legal spouse.
    - "Single:" An individual who has never been married.
    - "Separated:" An individual who is legally married, but is living apart from their spouse.
    - "Divorced:" An individual whose marriage has been legally dissolved.
    - "Widowed:" An individual whose spouse died while they were still married.

13. **ASSESSOR/CM: Current Physical Location Address**: Note the address of the client's current physical location, including the a. street, b. city, and c. ZIP code in the appropriate spaces. Also, enter the d. type of physical location and, if appropriate, e. facility name:
    - "Private residence:" The client's home or the home of another person; not a facility.
    - "ALF:" Any state licensed assisted living facility.
    - "Nursing facility:" A freestanding facility, certified by AHCA to provide skilled nursing services.
    - "Hospital:" An institution that provides care for acute illnesses.
    - "Adult Day Care:" A facility which provides less than 24-hour care for eligible adults.
    - "Other" (Any other facility not coded above)

14. Home Address *(If different from current physical location)*
    a. Street: _____
    b. City: _____ c. ZIP code: _____
15. Is client home address public housing? ☐ No ☐ Yes
16. Mailing Address *(If different from current physical location)*
    a. Street: _____ b. City: _____
    c. State: _____ d. ZIP code: _____

14. **Home Address:** Note the home address, including the a. street, b. city, and c. ZIP code. The home address is where the client maintains their belongings or a home they would return to if they could be discharged from a facility. It may be the same as current physical location; if so, you may leave it blank and indicate in CIRTS that the address of the current physical location should be copied into the home address fields.

15. **Public Housing:** Mark the appropriate box to indicate whether the client's home address is currently in public housing ("No" or "Yes").

TIP: Public housing information is an important factor in care planning. For example, a low-income client may need information about housing or referral to more affordable or subsidized housing. Or, if the client is currently in subsidized housing, restrictions about modifications or services may apply that could impact the ability of the client to remain in this setting.

16. **Mailing Address:** Note the mailing address, including the a. street, b. city, c. state, and d. ZIP code if different from the address of the client's current physical location. This is especially important for the Home Care for the Elderly (HCE) program since this is the address to which the caregiver's basic subsidy is mailed. You may leave this item blank on the forms, if the client does not have a mailing address that is different from their current location.

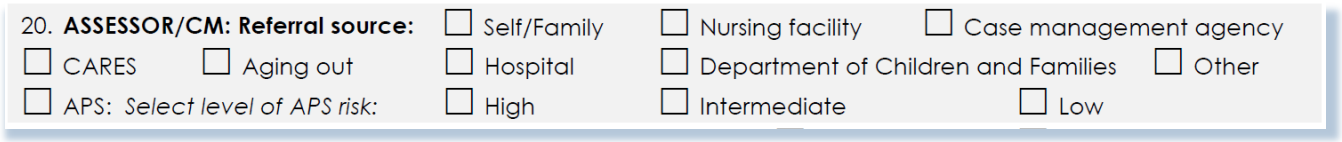
There are three different location and address fields on the forms and in the CIRTS database because many of the clients we assess are in a period of transition in their lives. For example, we may need a current location address because we have to assess someone in a temporary location like a rehabilitation facility, their home address so that we know what local providers are available for home and community care once they are discharged, and a mailing address, such as a P.O. Box.

17. **ASSESSOR/CM: Assessment date:** *(mm/dd/yyyy)* _____
18. **ASSESSOR/CM: Assessment site:**
    ☐ Home ☐ ALF ☐ Nursing facility ☐ Hospital ☐ Adult day care ☐ Other
19. **ASSESSOR/CM: Referral date:** *(mm/dd/yyyy)* _____

17. **ASSESSOR/CM: Assessment Date**: The assessment date is the date the assessment is completed by the Assessor/Case Manager. In the space provided, record the date in a two-number format for the month, two-number format for the day, and a four-number format for the year, as indicated by "mm/dd/yyyy" throughout the form.

18. **ASSESSOR/CM: Assessment Site**: The assessment site is where the assessment is taking place. Mark the appropriate box for the site at which the assessment is taking place:
    - "Home:" The client's home or private residence (not a facility).
    - "ALF:" Any state licensed assisted living facility.
    - "Nursing facility:" A freestanding facility that is certified under Medicare/Medicaid to provide skilled nursing.
    - "Hospital:" An institution that provides care for acute illnesses.
    - "Adult day care:" A facility which provides less than 24-hour care for eligible adults.
    - "Other" (Any other site not coded above).

19. **ASSESSOR/CM: Referral Date**: The referral date is the date that the referral was received at the receiving agency from the referral source. There may be an earlier date on a referral form, but the responsibility begins when the information is actually received. Enter the referral date in the space provided. Record the date in this format: mm/dd/yyyy.



20. **ASSESSOR/CM: Referral Source**: The referral source is the person or agency making the referral for an assessment or services. A referral can be received from any source. Mark the appropriate box of the source of the referral:
    - "Self/Family:" The client has referred him or herself or the client's family has referred him/her.
    - "Nursing facility:" A freestanding facility that is certified under Medicare/Medicaid to provide skilled nursing.
    - "Case management agency:" An agency that provides case management services.
    - "CARES:" Comprehensive Assessment and Review for Long-Term Care Services.
    - "Aging out:" CCDA Aging Out of the Community Care for Disabled Adults Program or HCDA Aging Out of the Home Care for Disabled Adults Program.
    - "Hospital:" An institution that provides care for acute illnesses is making the referral.
    - "Department of Children and Families."
    - "Other" (Any other referral source not coded).
    - "APS:" Adult Protective Services; Abuse/Neglect/Exploitation at DCF is making the referral.

Note the level of risk as High, Intermediate, or Low. "High Risk" referrals are tracked to ensure that the persons are contacted and begin to receive needed services (besides case management) within 72 hours of the receipt of the referral. "High Risk" referrals from APS are given first consideration for services.

21. **ASSESSOR/CM: Transitioning out of a nursing facility?**	☐ No	☐ Yes
22. **ASSESSOR/CM: Imminent risk of nursing home placement?**	☐ No	☐ Yes
23. Do you need outside assistance to evacuate?	☐ No	☐ Yes
24. Are you enrolled on a special needs registry?	☐ No	☐ Yes

21. **ASSESSOR/CM: Transitioning Out of a Nursing Facility**: Mark the appropriate box to indicate whether the client has a desire to transition out of a nursing facility ("No" or "Yes"). "Nursing home transition" is the voluntary transfer of an individual from a nursing facility to a community setting such as a family member's home, the individual's apartment or home, an assisted living facility, or an adult family care home. Individuals transitioning out of a nursing facility may also include those in a nursing or rehabilitation facility on a short-term basis. A referral from CARES may be for a client who is transitioning out of a nursing facility.

22. **ASSESSOR/CM: Imminent Risk of Nursing Home Placement**: Mark the appropriate box to indicate whether the client is in imminent risk of nursing home placement ("No" or "Yes").

An imminent risk designation is also used for certain clients transitioning out of a nursing home. A referral from CARES or a lead agency may be for a client who is at imminent risk of nursing home placement or for someone transitioning out of a nursing home. Refer to the imminent risk policy of the Department. It must be followed for all imminent risk designations.

23. **Outside Assistance to Evacuate**: Mark the appropriate box to indicate whether the client needs outside assistance to evacuate during emergencies ("No" or "Yes"). If the individual is able to evacuate the home or has arrangements with a caregiver or another person to help them to evacuate, then outside assistance is not needed. This question determines if there is a need for assistance to be set up by the Assessor/Case Manager.

24. **Special Needs Registry**: Mark the appropriate box to indicate whether the client is registered with the County Special Needs Registry ("No" or "Yes"). Each county in Florida has a listing of persons who have disabilities or health conditions that make it vital for them to receive help with evacuation during emergencies. Ensuring that clients with evacuation needs are on the county listing is a function of the Assessor/Case Manager.

For clients in a facility of any kind (nursing home, assisted living facility, adult family care home, hospital, etc.), the response will be "No," and the evacuation needs will be the responsibility of the facility not the county emergency staff.

25. Is there a primary caregiver?			☐ No	☐ Yes
26. Living situation:	☐ With primary caregiver	☐ With other caregiver	☐ With other	☐ Alone
27. Individual monthly income:	$		☐ Refused	
28. Couple monthly income:	$		☐ Refused	☐ N/A
29. Estimated total individual assets:	$			
	☐ $0 to $2,000	☐ $2,001 to $5,000	☐ $5,001 or more	☐ Refused

25. **Is There a Primary Caregiver**: Mark the appropriate box to indicate whether there is a Primary Caregiver ("No" or "Yes"). A primary caregiver is defined as any person who regularly can be depended on to provide or arrange help as needed with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). This person:
    - May or may not be related by birth or marriage;
    - May or may not live with the client or live nearby; and,
    - Does not include operators of assisted living facilities, nursing homes, adult family care home sponsors, home health agencies, service provider staff or other paid care providers.

26. **Living Situation**: Mark the appropriate box to indicate the client's current living situation ("With primary caregiver" (as defined above), "With other caregiver," "With other," "Alone"). If the client is in a facility, the response would be "Alone."

27. **Individual Monthly Income**: Income information is needed to give the Assessor/Case Manager an idea of whether the individual might qualify financially for Medicaid services so that appropriate referrals will be made. Indicate the client's gross monthly income in the space provided. Include income from Social Security, SSI, money received from family on a regular basis, pension, retirement, savings, disability or veteran's assistance benefits, earnings from employment, rental income, etc.

Clients may be unable or unwilling to provide individual or couple income and asset information. If a client refuses to give this information, check the "Refused" box and advise them that they will need to plan to provide it to DCF in order to determine their eligibility for Medicaid.

28. **Couple Monthly Income:** Indicate the client's gross monthly "couple" income, if applicable, in the space provided. Couple Income is only counted for persons who are married and living together. If a client refuses to give this information, check the "Refused" box. If the client is not currently married/living with a spouse, check the "N/A" (not applicable) box.

29. **Estimated Total Individual Assets**: Asset information is needed to give the Assessor/Case Manager an idea of whether the individual might qualify financially for Medicaid services so that appropriate referrals will be made. In the space provided, indicate the client's estimated total assets, excluding the worth of the client's home, one car, and $2,500 in designated burial assets. If the client cannot or will not provide a specific figure, give the three ranges and ask which range the assets would fall within: "$0 to $2,000," "$2,001 to $5,000," "$5,001 or more." If a client refuses to give this information, check the "Refused" box.

TIP: If the individual has over $2,000 in individual assets, or a couple has $3,000 in combined assets, they will generally not qualify for Medicaid waiver programs. However, there are some exceptions where the asset limits are slightly higher in limited Medicaid programs. So, even if the individual assets are over the asset limit, it does **not** automatically disqualify the individual from receiving needed services. Only DCF can make the final financial determination for Medicaid.

30. Estimated total couple assets: $
☐ $0 to $3,000 ☐ $3,001 to $6,000 ☐ $6,001 or more ☐ Refused ☐ N/A

31. Are you receiving S/NAP (food stamps)? ☐ No ☐ Yes

32. Do you need other assistance for food? ☐ No ☐ Yes

30. **Estimated Total Couple Assets:** In the space provided, indicate the client's estimated total "couple" assets, excluding the worth of the couple's home, one car, and $5,000 in designated burial assets. Next, indicate which of three categories best represents the client's couple assets. If the client cannot or will not provide a dollar figure, give the three ranges and ask which range the assets would fall within, marking the box that is applicable ("$0 to $3,000," "$3,001 to $6,000," "$6,001 or more"). If a client refuses to give this information, check the "Refused" box. If the client is not currently married/living with a spouse, check the "N/A" (not applicable) box.

31. **Are You Receiving S/NAP (Food Stamps)?:** Mark the appropriate box to indicate whether the client is currently receiving S/NAP (Supplemental Nutritional Assistance Program) ("No" or "Yes").

This is an important referral opportunity for those clients who are food insecure or do not have enough income to buy the food that they need. Supplemental nutrition assistance programs are usually easy to qualify for and can make a huge difference in the monthly grocery bill, yet these programs are widely under-utilized in many areas.

32. **Do You Need Other Assistance for Food?** Mark the appropriate box to indicate whether the client needs other assistance for food ("No" or "Yes"). The client may not be eligible for S/NAP (Food Stamps) but still need help in obtaining food. Other sources of food assistance could be local food pantries, religious groups, or service organizations.

33. **ASSESSOR/CM: Is someone besides the client providing answers to questions?** ☐ No *(Skip to 34)* ☐ Yes

a. Name: _____ b.Relationship: _____

33. **ASSESSOR/CM: Client Answering Questions?** Mark the appropriate box to indicate whether someone besides the client is providing answers to the questions in the assessment ("No" or "Yes").
- If someone else is not providing answers ("No"), skip a-b.
- If someone else is providing answers ("Yes"), indicate the **name** of the person as well as **their relationship** to the client in spaces a. and b.

TIP: There are several places on the form where you will ask clients and caregivers to identify other people in their lives and the nature of their relationship. The reason you ask for this information is because it is important to identify all the potential resources a client and a caregiver may have, what their level of involvement is with the client's care, and what their commitment is to meeting the client's needs should they be called upon to help.

34. Besides your own children, how many children under age 19 do you live with and provide care for? *(if zero, skip to 35)*		#
a. How many are grandchildren?	#	Name(s):
b. How many are other related children?	#	Name(s):
c. How many are other non-related children?	#	Name(s):
35. How many disabled adults age 19 to 59 do you live with and provide care for? *(if zero, skip to 36)*		#
a. How many are grandchildren?	#	Name(s):
b. How many are other relatives?	#	Name(s):
c. How many are other non-relatives?	#	Name(s):

Notes & Summary:

34. **Children the client lives with and provides care for**: Indicate the total number of children, besides the client's own children, under age 19 that live with and are cared for by the client by entering a number on the line provided.
    - If the response is zero, skip a-c.
    - If the response is one or more, enter the number and name(s) in items a-c.
    - If any number response is zero in a-c, leave the name(s) blank.

Since many people enjoy discussing the little ones in their lives, some Assessors/Case Managers recommend using information about kids and grandkids to help establish rapport with clients.

35. **Disabled adults the client lives with and provide care for**: Indicate the total number of disabled adults, aged 19 to 59 that live with and are cared for by the client by entering a number in the box provided.
    - If the response is zero, skip a-c.
    - If the response is one or more, enter the number and name(s) in items a-c.
    - If any number response is zero in a-c, leave the name(s) blank.

701D Instructions-

Section B. Memory

Guidance for Completion of the Department of Elder Affairs' 701B Comprehensive Assessment

Section B. Memory

The items in this section are intended to determine the client's attention, orientation, and ability to register and recall new information. These items are crucial factors in many care planning decisions.

- ✓ Awareness of possible impairment may be important for maintaining a safe environment.
- ✓ A client's performance on cognitive tests can be compared over time to identify a decline in their cognitive abilities.

TIP: Direct, performance-based testing of cognitive function decreases the chance of incorrect labeling of memory issues and cognitive ability. However, be aware that some clients may appear to be cognitively impaired, but are instead experiencing symptoms from other factors - such as extreme fatigue, hearing impairment, or emotional or psychological issues. Conversely, some clients may appear more cognitively aware than they actually are, or they may have cognitive issues that are infrequent, more episodic in nature, or only evident when triggered by particular stimuli.

Introduce this section by telling the client that you are going to ask some questions about their memory. Explain that the questions will test their ability to remember certain items and determine their ability to carry out daily activities. If the client is not giving full attention to the questions being asked, you may need to remind them to remove any source of distraction that may impair their ability to answer the questions accurately. It may also be necessary to remind anyone else who might be sitting in the room during the assessment that the responses to the memory questions must come from the client alone.

36. Has a doctor or other health care professional told you that you suffer from memory loss, cognitive impairment, any type of dementia, or Alzheimer's disease? ☐ No ☐ Yes

36. **Medical Diagnosis of Memory Issues**: The purpose of this question is to determine whether the client has been officially diagnosed with any type of memory problem. This is meant to make you aware of any formal diagnosis of a decline in memory or cognitive function based on an evaluation by a doctor, therapist, nurse, or memory disorder specialist. Indicate the answer to the question by marking the appropriate box ("No" or "Yes").

37. **ASSESSOR/CM: If the client is not answering questions, skip to Question 47 and check:** ☐

37. **If the Client is Not Answering Questions**: If someone other than the client is answering the questions, check the box on Question 37, skip Questions 38- 46, respond to Question 47, and then proceed to the next section of the 701B form (Section C).

Clients may not always be able to answer the questions in an assessment, and the reasons why they are unable to do so will vary. However, some sections of the assessment are only appropriate for the client to respond to, like memory tests and mental health screening. So, when the client is unable to participate in the assessment, you will simply check the indicator box circled in the example above and move on to the next section.

38. "I am going to say three words for you to remember. Please repeat the words after I have said them. The words are: sock (something to wear), blue (a color), and bed (a piece of furniture). Now you tell me the three words." **ASSESSOR/CM: Select the number of words correctly repeated after the first attempt:**
☐ Sock ☐ Blue ☐ Bed *Total number of correct words:* ☐ None ☐ One ☐ Two ☐ Three
"Thank you. I will ask you to repeat these to me again later."

39. Please tell me what year it is: ☐ Correct ☐ Missed by one year ☐ Missed by two to five years ☐ Missed by five or more years ☐ No answer

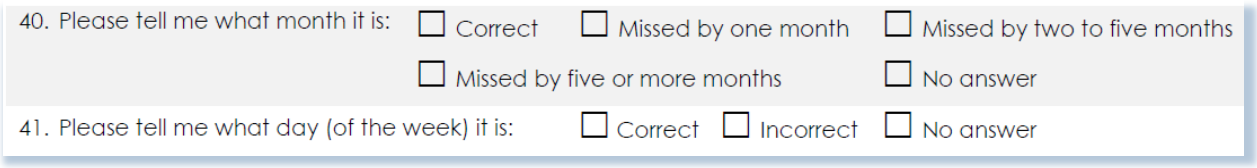
38. **Three-Word Recall, Part 1**: As indicated by the quotation marks, the Assessor/Case Manager should say this exact phrase to the client – "I am going to say three words for you to remember. Please repeat the words after I have said them. The words are: Sock (something to wear), Blue (a color), and Bed (a piece of furniture). Now you tell me the three words." If the interview is being conducted with an interpreter present, the interpreter should use the equivalent words and similar, relevant prompts for category cues.

Assessor/Case Managers need to use the exact words and related category cues as indicated. Category cues serve as a hint that helps prompt clients' recall ability. Putting words in context stimulates learning and fosters memory of the words that clients will be asked to recall later, even among clients able to repeat the words immediately.

After the client's first attempt to repeat the items, you will check off the words that the client repeats, and then indicate the total number of correct words repeated by the client. The words may be recalled in any order and in any context. So, it is allowable for the words to be repeated back in a different order or in a sentence format, like "I sat on the bed to put on my blue sock." Then the client would be credited with repeating all the words. If the client correctly stated all three words, simply say: "Thank you. I will ask you to repeat these again to me later." However, if the client recalled two or fewer words, you are permitted to prompt them with: "Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now, will you repeat those three words for me?"

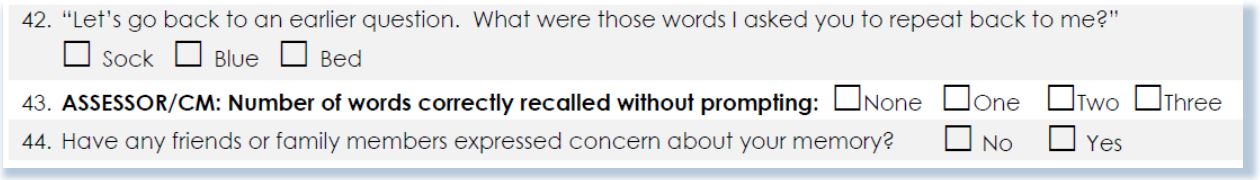
If the client still does not recall all three words correctly, *you may repeat the words and category cues for a third time*. However, the number of repeated words on the second or third attempt are all scored zero. These attempts help the client with learning the item, *but only the number of words recalled correctly on the first attempt goes into the total score*.

39. **Current Year (Long-term Temporal Orientation)**: Ask the client to indicate what year it is. Allow up to 30 seconds for an answer and do not provide clues. If the client specifically asks for clues (e.g., "Is the election this year?"), respond by saying: "I need to know if you can answer this question without any help from me." You might also have to remind the client that they cannot look at a newspaper or anything else to help them with the response.
- "Correct:" If the client provides a correct response
- "Missed by 1 year:" If the client's response is within one year of the current year
- "Missed by 2-5 years:" If the client's response is within two to five years of the current year
- "Missed by 5+ years:" If the client's response is more than five years from the current year
- "No answer:" The client cannot or chooses not to answer the item



40. **Current Month (Long-term Temporal Orientation)**: Ask the client to indicate what month it is. Allow up to 30 seconds for an answer and do not provide clues. If the client specifically asks for clues (e.g., "Is my birthday this month?"), respond by saying: "I need to know if you can answer this question without any help from me." You might also have to remind the client that they cannot look at a newspaper or anything else to help them with the response.
    - "Correct:" If the client provides a correct response
    - "Missed by 1 month:" If the response is within one month of the current month
    - "Missed by 2-5 months:" If the response is within two to five months of the current month
    - "Missed by 5+ months:" If the response is more than five months from the current month
    - "No answer:" The client cannot or chooses not to answer the item

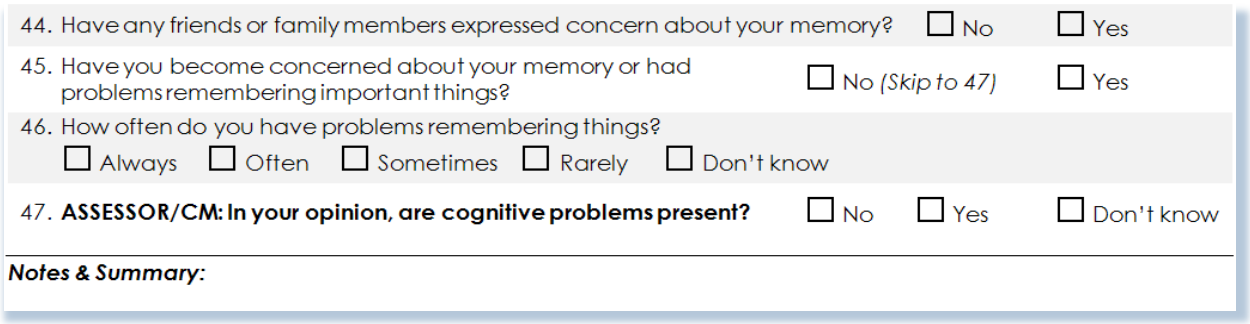
41. **Current Day of the Week (Short-term Temporal Orientation)**: Ask the client to indicate what day of the week it is. Allow up to 30 seconds for an answer and do not provide clues. If the client specifically asks for clues (e.g., "Is it bingo day?"), respond by saying: "I need to know if you can answer this question without any help from me." You might also have to remind the client that they cannot use other clues to help them respond (e.g., looking at the newspaper, calendar on the wall, television, etc.)
    - "Correct:" If the client provides a correct response
    - "Incorrect:" If the client provides an incorrect response
    - "No answer:" The client cannot or chooses not to answer the item



42. **Three-Word Recall, Part 2:** Ask the client – "Let's go back to an earlier question. What were those words I asked you to repeat back to me?" Allow up to 5 seconds for spontaneous recall of each word. Mark the words that the client recalls.

It is important to ask the three-item recall question in the order it is given and within the established time frame to get an accurate reflection of the client's recall ability. If the interview is interrupted for longer than a few minutes between initial and follow-up questions, the three-item recall test is invalid. If this happens, be sure to leave the responses blank on the form and include this information in the "Notes & Summary" section.

43. **Words Recalled without Prompting**: Indicate the total number of words (on a scale of 0-3) that the client recalled without any prompting and without you providing any hints or any cues.



44. Have any friends or family members expressed concern about your memory? ☐ No ☐ Yes
45. Have you become concerned about your memory or had problems remembering important things? ☐ No *(Skip to 47)* ☐ Yes
46. How often do you have problems remembering things? ☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Don't know
47. **ASSESSOR/CM: In your opinion, are cognitive problems present?** ☐ No ☐ Yes ☐ Don't know

Notes & Summary:

44. **Concern from Friends/Family about Memory:** Indicate whether the client's friends or family members have expressed concern about his or her memory ("No" or "Yes").

TIP: Family and friends may be hesitant to directly express concern about a client's memory loss or cognitive problems. So instead they show this concern indirectly by asking questions about whether the client is managing their personal affairs properly. You may need to provide clients with examples, such as: "Do your friends or family members call to ask about how often you are eating or showering?" or "Do they double check the tasks you perform, like balancing the checkbook or making sure you locked the door when you leave the house?"

45. **Client Concern about Memory:** Indicate whether the client has become concerned about their memory, or had problems remembering details about things that are normally important to them like birthdays, appointments, plot lines to favorite television shows, etc. ("No" or "Yes"). If the client has not become concerned about his or her memory, or had problems remembering important things ("No"), skip Question 46.

46. **Frequency of Memory Problems:** If the client indicates that they have become concerned about having memory problems, next indicate how often the client has problems remembering things: "Always," "Often," "Sometimes," "Rarely," or "Don't know" as appropriate.

47. **Cognitive Problems Present:** Based on the client responses to the preceding questions in Section B, this is where the Assessor/Case Manager should provide her/his opinion of whether cognitive problems are present.
    - "No:" Client answered questions appropriately and accurately.
    - "Yes:" Client has demonstrated, been diagnosed, or has disclosed problems with memory, thinking, judgment, or orientation to time/place/people.
    - "Don't know:" The Assessor/Case Manager could not determine if cognitive problems were present.

TIP: Throughout the assessment form, you will see "Notes & Summary" sections provided for you to jot down any relevant elaborations or details that may assist you with determining level of care and designing the care plan. Document issues not covered by the questions on the form or document discussions you have had with the client, family, and/or facility about problems you observe.

701D Instructions-

Section C. General Health, Sensory Function & Communication Impairment

Guidance for Completion of the Department of Elder Affairs' 701B Comprehensive Assessment

Section C. General Health, Sensory Function & Communication Impairment

The items in this section are intended to determine the client's perception of their general health, sensory health and function, and identify any communication impairments or accommodation needs. In the exceptional event that the client is unable to answer the questions, consult with a caregiver, health care provider, or other informant to fill out the form. Then note that the client did not provide answers, identify the source of the information in the "Notes & Summary" section, and include this in the case narrative for this visit.

48. How would you rate your overall health at this time? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

49. Compared to a year ago, how would you rate your health?
☐ Much better ☐ Better ☐ About the same ☐ Worse ☐ Much worse

48. **Overall Health:** This item is meant to be a subjective reflection by the client about their overall opinion of their own health. This opinion can be relative to other people, relative to their own history, or without any qualification.

TIP:

A client's self-perception can either boost or undermine her/his health and independence. If the answers to Questions 48 or 49 are negative, it is important to use these questions as an introduction to a broader conversation about what the client has gone through over the past year. For example, if the client states their health is worse, ask what has changed and for examples of how this change has affected their daily activities and ability to care for her/himself.

49. **Health Compared to One Year Ago:** This item is meant to be a subjective reflection by the client about their opinion of their own health relative to their own health a year ago. This item should give you some perspective on their progress or decline over the course of the last year.

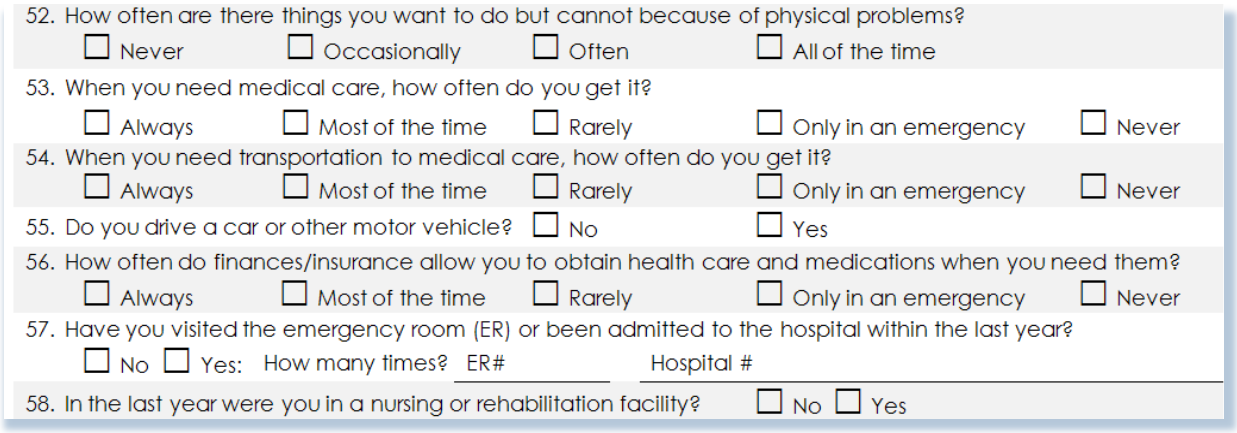
50. How often do you change or limit your activities out of fear of falling?
☐ Never ☐ Occasionally ☐ Often ☐ All of the time

51. How many times have you fallen in the last six months? **#** _____

50. **Fear of Falling**: People with a history of falling may limit activities because of a fear of falling and should be evaluated for reversible causes of falling. Moreover, when an individual fears falling, they often self-restrict the activities they engage in outside the home, which can severely diminish the amount of interactions they have with friends, family, and support networks.

51. **Six Month History of Falls**: This question counts any fall, no matter where it occurred. Record the total number of falls in the appropriate box.

A "fall" is an unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). Falls are not a result of an overwhelming external force (e.g., a client being pushed by someone else). An intercepted fall occurs when the client would have fallen if s/he had not caught her/himself or had not been intercepted by another person – this is still considered a "fall" for purposes of the assessment.



52. How often are there things you want to do but cannot because of physical problems?
☐ Never ☐ Occasionally ☐ Often ☐ All of the time

53. When you need medical care, how often do you get it?
☐ Always ☐ Most of the time ☐ Rarely ☐ Only in an emergency ☐ Never

54. When you need transportation to medical care, how often do you get it?
☐ Always ☐ Most of the time ☐ Rarely ☐ Only in an emergency ☐ Never

55. Do you drive a car or other motor vehicle? ☐ No ☐ Yes

56. How often do finances/insurance allow you to obtain health care and medications when you need them?
☐ Always ☐ Most of the time ☐ Rarely ☐ Only in an emergency ☐ Never

57. Have you visited the emergency room (ER) or been admitted to the hospital within the last year?
☐ No ☐ Yes: How many times? ER# _____ Hospital # _____

58. In the last year were you in a nursing or rehabilitation facility? ☐ No ☐ Yes

52. **Limitations from Physical Problems**: This item captures the range of activities and tasks that speak to the client's overall goals for their life. This information should assist in care planning and in evaluating satisfaction with services at reassessment.

53. **Medical Care Availability**: Medical care refers to treatment and care provided by doctors, nurses, and therapists at the hospital, clinic, office, or other location.

54. **Transportation to Care is Readily Available:** This item is meant to include any means of transportation that the client is able to arrange on their own. Explain this does not include calling 911.

55. **Drive a Car/Motor Vehicle:** Indicate the client's response to this question by marking the appropriate box ("No" or "Yes"). Driving a car should never prevent someone from receiving services.

Many times clients drive out of necessity, whether or not it is still safe or appropriate for them to do so in all circumstances. If the client says 'yes,' but is very frail or has disclosed memory or vision problems, the Assessor/Case Manager may ask the client if anyone has suggested they no longer drive or may suggest they discuss with their doctor whether or not they should continue driving.

56. **Finances Permit Access to Health Care and Medications:** This item refers to the client's overall ability to afford treatment that can be achieved in combination with insurance and other means.

57. **ER/Hospital Visits in Last Year:** Ask and record the approximate number of times the client visited the emergency room or was admitted to the hospital in the past 12 months.

An ER visit is counted when the client visits the ER and is not admitted to the hospital. A hospital admission is counted when the client is admitted to the hospital from the ER or community. If the client visits the ER and is hospitalized from there, it is counted as only one event: a hospital admission, not two events: an ER visit *and* a hospital admission.

58. **Nursing Facility or Rehabilitation Facility stays:** Ask and record if the client has been admitted to a nursing home or rehabilitation facility in the last 12 months.

59. Are you usually able to climb two or three stair steps? ☐ No ☐ Yes ☐ Don't know

60. **ASSESSOR/CM: Are there any stairs within the dwelling or leading into/out of the dwelling?** ☐ No ☐ Yes

61. Are you usually able to carry a full glass of water across a room without spilling it? ☐ No ☐ Yes ☐ Don't know

62. Has a doctor told you that you currently have vision problems? ☐ No ☐ Yes ☐ Blind *(If blind, Skip to 63)*
    a. Have you had an eye exam in the past year? ☐ No ☐ Yes
    b. Do you bump into objects (people, doorways) because you don't see them? ☐ No ☐ Yes
    c. Is your vision getting worse than it was last year? ☐ No ☐ In one eye ☐ Slightly worse ☐ Much worse

59. **Ability to Climb Steps:** This refers to the client's usual ability, not their abilities on their worst day or best day. The ability to climb stairs is not covered by walking/mobility in the ADL section; so if the client is unable to climb stairs and has stairs in the home, this could indicate a safety or care plan issue.

60. **Assessor/Case Manager: Are there stairs in or leading to the dwelling:** This question is for you to respond to with your own observation or recollection regarding the presence of a change in elevation that requires traversing stairs. For clients with any noted impairment to their mobility, it is especially important that you note the presence of stairs that may inhibit the client from accessing important areas of their residence and evacuating the dwelling if necessary.

61. **Ability to Carry a Glass of Water:** This refers to their usual ability to perform the task, not on their worst day or their best day. The ability to carry a glass of water is a measure of grip strength, balance, steadiness of gait, and overall function. This is not covered in the IADL section; so if the client is unable to carry a glass of water, this could indicate an independence barrier or a need to be addressed in the care plan.

TIP: If the client is unable to walk steadily or maintain enough grip strength to carry a glass of water, it could indicate a dehydration risk or indicate a barrier to preparing meals. In some clients, grip can be improved with supports in the care plan, like occupational therapy, and supported with assistive devices to restore the client's ability to prepare meals and other tasks.

62. **Vision Problem Diagnosis:** Indicate the client's response to this question by marking the appropriate box ("No," "Yes," or "Blind"). If the client has been diagnosed as totally blind, you may skip questions a., b., and c. Be aware that acute or profound vision loss may limit the client's ability to manage personal business requiring reading or signing documents, such as checks or consent forms.
    a. **Eye exam in the past year:** Indicate the client's response in the appropriate box ("No" or "Yes").
    b. **Bump into objects (i.e., people, doorways) because you don't see them:** Indicate the client's response by marking the appropriate box ("No" or "Yes").
    c. **Vision getting worse than it was last year**: Indicate the client's response by marking the appropriate box ("No," "Only in one eye," "Slightly worse," or "Much worse," as appropriate).

Although many people minimize or joke about sensory impairments, problems like vision loss are serious and may be a symptom of a major illness or threaten independence. If uncorrected, vision impairment can limit a client's ability to participate in both functional and pleasurable activities, with profound impact to their quality of life. Fortunately, vision loss can often be improved with treatment. So, if the client indicates to you that they are experiencing some recent vision loss, refer them to be screened or ask them to make an appointment to have it checked by a doctor.

63. Has a doctor told you that you currently have hearing problems?	☐ No	☐ Yes	☐ Deaf *(If deaf, skip to 64)*	
a. Have you had a hearing exam in the past year?	☐ No	☐ Yes		
b. Can you understand words clearly over the telephone?	☐ No	☐ Yes		
c. Is your hearing worse than it was last year?	☐ No	☐ In one ear	☐ Slightly worse	☐ Much worse

63. **Hearing Problems:** Indicate the client's response to this question by marking the appropriate box ("No," "Yes," or "Deaf"). If the client has been diagnosed as totally deaf, skip a., b., and c.

    a. **Hearing exam in the past year:** Indicate the client's response by marking "No" or "Yes."
    b. **Understand words clearly over the telephone:** Indicate the client's response by marking "No" or "Yes." (Note, if the client answers "no", a sensory device may be helpful.)
    c. **Hearing worse than it was last year:** Indicate the client's response by marking "No," "Only in one ear," "Slightly worse," or "Much worse," as appropriate.

Like other sensory impairments, hearing loss should be treated seriously. It may contribute to a client's feelings of social isolation, exacerbate some mood and/or behavioral disorders, and can even be mistaken for cognitive or memory impairment. Fortunately, hearing loss can often be improved with treatment. If the client indicates they are experiencing some hearing loss, refer them to be screened or ask them to make an appointment to see their doctor to have it checked.

TIP: If you suspect or are told that a client has hearing loss, it is important to determine if they hear and understand the assessment questions. If they are having a hard time hearing, you should face them directly, ask them to turn up the volume on any hearing aids, turn off competing noise from the television or radio. You may also need to speak louder and more slowly or more clearly enunciate unexpected words.

64. **ASSESSOR/CM: Does client rely on writing, gestures, or signs to communicate?**	☐ No	☐ Yes
65. **ASSESSOR/CM: Are the client's words formed properly, not slurred or clipped?**	☐ No	☐ Yes

64. **ASSESSOR/CM: Non-verbal Communication:** Indicate whether the client relies on writing, gestures, or signs to communicate by marking the appropriate box ("No" or "Yes"). If yes, please indicate if the client has developed means or devices to assist communication with others, like TTY for the telephone, etc. in the "Notes & Summary" section.

65. **ASSESSOR/CM: Speaking Ability:** Indicate whether the client's words are formed properly, not slurred or clipped, by marking "No" or "Yes." It is important for basic as well as emergency communication for clients to be comprehensible - so note if detectable speech impairment is minor or major.

Note that slurred speech can be an indicator of acute health problems, such as recent stroke, head injury, extreme fatigue, dehydration, mismanaged medications, mouth or tooth problems. It is important to discuss speech impairment with the client and/or caregiver to determine if this is a new occurrence. Recent deterioration in a client's ability to speak or enunciate words should be brought to the immediate attention of a physician.

66. **ASSESSOR/CM: Are any sensory aids or assistive devices currently used?** ☐ No ☐ Yes
If yes, please list the type(s) used: _____

67. **ASSESSOR/CM: Is there an unmet need for a sensory aid or assistive device?** ☐ No ☐ Yes
If yes, please list the type(s) needed: _____

66. **ASSESSOR/CM: Sensory Aids/Assistive Devices:** Indicate whether the client currently uses any sensory aids or assistive devices by marking the appropriate box ("No" or "Yes"), and if yes, list the type(s) in the space provided.

TIP: A sensory aid is a small object that can be worn or held by the user to improve a sensory deficit, such as a hearing aid, glasses, magnifying glass, etc. A sensory device is a larger object or article of technology that assists the user by intensifying images and sounds, or translates cues into a more detectable format (e.g., amplifiers, buzzers, flashing lights, etc.)

67. **ASSESSOR/CM: Unmet Need for Sensory Aids/Assistive Devices:** Indicate whether the client has an unmet need for a sensory aid or assistive device by marking the appropriate box ("No" or "Yes"). If there is an unmet need ("Yes"), describe the types of aids or devices needed in the text box.

701D Instructions-

Sections D & E. Activities of Daily Living & Instrumental Activities of Daily Living

Guidance for Completion of the Department of Elder Affairs' 701B Comprehensive Assessment

Section D. Activities of Daily Living (ADL)

The items included in this section identify the client's ability to functionally perform the tasks needed to maintain a healthy and independent life, and the amount of assistance with personal care tasks that the client is currently receiving from others. Activities of Daily Living (ADL) measure self-care tasks. The objective of this assessment is to determine what additional assistance the client may need to function as normally and independently as possible. To introduce this section, explain to the client that you are going to ask some questions about her/his ability to do a list of personal care activities. Ask whether s/he needs help in performing each activity, and explain the tasks that each activity includes by reviewing the definition on the form with the client. The possible answers are on the form and repeated below. Read all of the choices verbatim and ask the client to select one. Do not assume the answer for the client, or attempt to infer it from your earlier conversations.

TIP: If the client seems to be self-conscious discussing personal care problems, you may need to reassure them of your confidentiality and underscore the importance of identifying all of their impairments. You might say something like: *"I understand that these topics might make you uncomfortable, but I assure you that I speak to a lot of people with many different needs and have probably heard it all. The better I understand the kind of specific limitations you have, the more helpful I can be to you."* For more information, you can also refer to the "Asking Difficult Questions" module of the web-based 701B training program.

If the client gives you a response that you have reason to disagree with, or if you strongly suspect that the client has given an incorrect response or is masking her/his inability, you may need to make a determination based on other sources or your own observation. For example, the client states that s/he needs no assistance using the bathroom, but you notice the client has difficulty in walking, is wearing soiled clothing, has a strong body odor, or you detect a urine odor in the house. You ask the client directly about these observations but s/he denies any issue. Your recourse is to seek information about the client's ability from a caregiver, family member or other informant. In the absence of information from others, you make the determination of the client's capacity in the answer choice for the question, and note the discrepancy between the client's response and your observations in the "Notes & Summary" section to include in the case narrative for this visit.

68. How much assistance do you need with the following tasks?

Task	No assistance needed	Uses assistive device	Needs supervision or prompt	Needs assistance (but not total help)	Needs total assistance (cannot do at all)
a. Bathing	☐	☐	☐	☐	☐
b. Dressing	☐	☐	☐	☐	☐
c. Eating	☐	☐	☐	☐	☐
d. Using the bathroom	☐	☐	☐	☐	☐
e. Transferring	☐	☐	☐	☐	☐
f. Walking/Mobility	☐	☐	☐	☐	☐

68. **Activities of Daily Living (ADLs):** Ask the client how much assistance s/he needs with completing the tasks listed on the form for activities a-f, and determine the amount of help needed from the following range:

- "No assistance needed:" Indicates that client needs no help to perform any part of the activity.
- "Uses assistive device:" Indicates that the client needs an assistive device or technology to complete the activity.
- "Needs supervision or prompt:" Indicates that the client needs reminders or supervision during the activity. Otherwise s/he needs no physical help to perform the activity.
- "Needs assistance (but not total help):" Indicates that the client needs hands-on physical help during part of the activity.
- "Needs total assistance (cannot do at all):" Indicates that the client cannot complete activity without total physical assistance.

Assistive devices* for Activities of Daily Living include, but are not limited to:	
Bathing	*Shower stool, long-handled sponge, removable shower head sprayer*
Eating	*Suction-bottomed bowls and plates, wide-handled utensils*
Transferring from bed or chair	*Grab bars, non-slip mats, bed lifts or rails*
Dressing	*Buttoning claws, Velcro closures, zipper pulls or extender tabs*
Toileting/using the bathroom	*Hand-rails, seat lifts, spray or squirt bottles*
Walking/mobility	*Walker, cane, motorized chairs or lifts, ramps*

**For other examples and images of devices, please refer to the web-based comprehensive assessment training.*

For both ADLs and IADLs, a client can use or need a device AND need some help from a person. Therefore you may need to check both boxes. For example, a client may use grab bars to steady themselves while they take a shower and also require supervision or prompt to remember or to properly complete the task of bathing. For that client, you would check the box for "Uses an Assistive Device" AND check the box that they require "Needs Supervision or Prompt."

Activities of Daily Living include the following tasks and examples:

a. **Bathing**: Bathing includes running the water, taking the bath or shower, and washing all parts of the body, including hair. Note whether deficits are the result of mental impairment, physical limitations, or environmental barriers.

b. **Dressing**: Dressing includes getting out clothes, putting them on, taking them off and fastening/unfastening them; it also includes putting on shoes.

c. **Eating**: Eating includes eating, drinking from a cup, and cutting foods.

d. **Using the bathroom**: Using the bathroom independently includes adjusting clothing, getting to and on the toilet, cleaning oneself and getting off the toilet. If a client can manage without an accident alone, they are independent.

Incontinence accidents can be hard for some people to discuss. For more information on ways you can be more at ease with this and other sensitive topics, please refer to the "Asking Difficult Questions" module of the web-based 701B training program.

e. **Transferring**: Transferring is defined as getting in and out of a bed or chair. Make a mental note to observe the client actually demonstrating this ability and whether s/he needed a device to do so.

f. **Walking/Mobility**: Independence in walking refers to the ability to walk short distances at home, but it does not include the ability to climb stairs. Note whether the client actually demonstrated this ability and whether s/he needed a device or some help to do so.

69. ASSESSOR/CM: ***Is there an unmet need for an ADL assistive device?*** ☐ No ☐ Yes

Type(s) needed:

69. **Unmet Need for ADL Assistive Device:** Is there a need for assistive devices to help the client to handle her/his ADL functions? If there is no unmet need, mark "No." If there is an unmet need, mark "Yes" and indicate the specific devices needed in the text box.

TIP: The questions in the assessment about "unmet needs" are referring to the individual needing a device that s/he does not currently have, but may benefit from. Notes about what devices are already in use should be made in the "Notes & Summary" section on the form or in the client's case narrative for the visit.

SCENARIO EXAMPLE: SCORING CLIENT DRESSING ASSISTANCE NEEDS

How much assistance do you need with dressing?	No assistance needed	Uses assistive device	Needs supervision or prompt	Needs some assistance	Needs total assistance, cannot do at all
Client is able to get their clothes out of the closet, put them on unassisted, fasten/unfasten clothing articles, and put on their own socks and shoes.	☑				
Client is able to perform all parts of dressing activities because of the use of an assistive device(s), such as Velcro tabs on shoes and zipper pulls on pants.		☑			
Client is able to perform all parts of dressing activities listed above if another person is there during the activity to lend support by her/his presence or to coach the client through the activity, without any hands-on assistance being given.			☑		
Client is able to perform some parts of the dressing activities listed above and needs hands-on assistance. This may be a small amount of assistance, such as putting on the client's shoes, or may be a lot of assistance, such as holding up the clothing for the client to step into and fastening all the closures.				☑	
If client is unable to perform any part of the dressing activities and another person is needed to perform the activity for them. This level of help would be for a client who must rely on someone to select the clothing, put it on and take it off their body, fasten all buttons, snaps and zippers, and put on the client's shoes.					☑

70. **Assistance with Activities of Daily Living (ADLs):** Assessing the frequency a client has assistance with a task is different from identifying how much assistance the client needs. You will ask the client how much assistance they have with completing the tasks listed on the form for activities a-f, and determine the frequency of help they have from the following range:

    - "No assistance needed:" Indicates that client receives no help from others because they do not need any help to perform any part of the activity.
    - "Always has assistance:" Indicates that the client always has an adequate level of help to meet their need in performing the activity.
    - "Has assistance most of the time:" Indicates that the client usually has the help they need to perform the activity, or more often than not they have an adequate level of help for the activity.
    - "Rarely has assistance:" Indicates that the client has unpredictable, unreliable or seldom has the amount of assistance they need to complete the activity.
    - "Never has assistance:" Indicates that the client has absolutely no assistance to complete the activity.

EXAMPLE: SCORING CLIENT DRESSING RESOURCES

How much assistance do you have with dressing?	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
Client is able to dress appropriately for the weather and circumstances without any prompt or supervision. Client is able to put on and take off clothing, socks, and shoes without any assistance.	☑				
If client has a responsible and reliable source of daily assistance that helps with any part of the activity, as the client's needs dictate.		☑			
If client has assistance that meets the majority of their needs. "Most of the time" can mean that they have help on either most of the days or every day but only with most of the activities involved with the task.			☑		
If client has infrequent or unreliable assistance with dressing needs. This is scaled to what they need - so if they only need a reminder that it is cold outside and to wear a sweater when they go to church, and they have help once a week, then they always have assistance. However, if they need help putting on pants every day, but they only have help to get dressed once a month, then they would rarely have assistance.				☑	
If client is unable to perform the dressing activity and another person is never available to assist with what articles are needed for the weather or occasion and manage their daily putting on and removal of clothing and shoes. This could be a client who "needs total assistance" or a client who only "needs some assistance" or needs prompting, as long as they never have the assistance they need.					☑

Section E. Instrumental Activities of Daily Living (IADL)

Instrumental Activities of Daily Living (IADL) included in this section identify the client's ability to complete moderately complex tasks that are generally necessary in daily life to maintain independence. These items are also thought of in terms of the client's ability to function in relation to the general community. The objective of this section is to determine what assistance the client needs with key tasks that enable him/her continue to function as normally and independently as possible.

To introduce this section, explain to the client that you are going to ask some questions about her/his ability to do a list of specific activities. Ask whether s/he needs help in performing each activity, and explain the tasks that each activity includes by reviewing the definition on the form with the client. The possible answers are on the form and repeated below. Read all of the choices verbatim and ask the client to select one. Do not assume the answer for the client, or infer it from your conversation.

71. How much assistance do you need with the following tasks?

Task	No assistance needed	Uses assistive device	Needs supervision or prompt	Needs assistance (but not total help)	Needs total assistance (cannot do at all)
a. Heavy chores	☐	☐	☐	☐	☐
b. Light housekeeping	☐	☐	☐	☐	☐
c. Using the telephone	☐	☐	☐	☐	☐
d. Managing money	☐	☐	☐	☐	☐
e. Preparing meals	☐	☐	☐	☐	☐
f. Shopping	☐	☐	☐	☐	☐
g. Managing medication	☐	☐	☐	☐	☐
h. Using transportation	☐	☐	☐	☐	☐

In the rare event that the client gives you a response that you have reason to disagree with, or if you strongly suspect that the client has given an incorrect response or is masking her/his inability; you may need to collect input from other sources like a caregiver, family member or other informant, or you may need to make a determination based on your observation of the client's performance of the task. If you score a client's functioning differently than they would have scored themselves, you will make a note of this discrepancy between the client's response and your observations in the "Notes & Summary" section to include in the case narrative for this visit.

TIP: With repetitive daily activities, deficits in the adequacy of assistance a person receives can occur for some tasks but not others, due to variance in the frequency a task needs to be completed in a day, week or month. So, for example, your client tells you that they have assistance for an hour once a day for any task they need help with. That means that some task needs will be adequately met, while other tasks will need additional assistance to be adequately fulfilled. For example, some ADLs are high frequency needs, like being mobile and able to ambulate frequently throughout the day. Likewise for IADLs, most people need to prepare meals to eat and may need to manage medications several times a day. However, most people will only need to transfer and dress twice daily, do shopping or light housekeeping a few times a week, and have transportation to go to appointments or have the lawn mowed a few times a month.

71. **Instrumental Activities of Daily Living (IADLs):** Ask the client how much assistance s/he needs with completing the tasks listed on the form for activities a-h, and determine the amount of help needed from the following range:

    - "No assistance needed:" Indicates that the client needs no help to perform any part of the activity.

    - "Uses assistive device:" Indicates that the client needs an assistive device or technology to complete the activity. Remember, a client may use a device and also require assistance from a person to complete a task. So, when applicable, both the assistive device box and an assistance needed box may be checked for a single task. For example, a client may need a pill minder to track their medications, and they may also require their caregiver to pick up their medications from the pharmacy for them. That client would have both "Uses Assistive Device" and "Needs Assistance (but not total help)" checked.

    - "Needs supervision or prompt:" Indicates that the client needs reminders or supervision during the activity. Otherwise s/he needs no physical help to perform the activity.

    - "Needs assistance (but not total help):" Indicates that the client needs hands-on physical help during part of the activity.

    - "Needs total assistance (cannot do at all):" Indicates that the client cannot complete the activity without total physical assistance.

Assistive devices* for Instrumental Activities of Daily Living include, but are not limited to:	
Heavy Chores	*Grabber, extension poles, non-skid bumpers, slider pads*
Light Housekeeping	*Grabber, extension poles, specialty appliances*
Using the Telephone	*Extra-large buttons, amplifier on the handset, light-up ringer*
Managing Money	*Extra signers or other account safeguards*
Preparing Meals	*Rubber-grip utensils, edge guards or suction-grip bowls and plates, stools or chair*
Shopping	*Electric cart, in-store assistive technology like order-ahead or car-side service*
Managing Medications	*Pill-minder, reminder alarms or phone service, pill crusher or sleeve*
Using Transportation	*Chair lifts, stabilizers, rubberized mats, ramps, extra mirrors, seat lifts*

**For other examples and images of devices, please refer to the web-based comprehensive assessment training.*

Instrumental Activities of Daily Living include the following tasks and examples:

a. **Heavy Chores:** These chores may include yard work, washing windows, moving furniture, doing laundry, etc. Laundry includes putting clothes in the washer or dryer, starting and stopping the machine, and drying the clothes. Hand washing of clothes and line drying are also included. (Laundry is still authorized as a homemaker service. It is included under heavy chores in these instructions as the best match with Administration on Aging definitions of services.)

b. **Light Housekeeping:** Light housekeeping includes dusting, vacuuming, and sweeping. If the client needs help, record who helps and how housekeeping tasks are done.

c. **Using the telephone:** This activity may include the use of an amplifier or special equipment. If the client requires special equipment, describe what is needed. If the client can use the telephone independently but is slow to answer or unable to use a dial phone, note this also.

d. **Managing money:** Managing money includes paying bills and balancing a checkbook. If the client needs help, identify the person who manages the client's financial affairs.

e. **Preparing meals:** Preparing meals is making sandwiches, cooking meals, and heating frozen meals. If the client needs help, describe how her/his meals are obtained.

f. **Shopping:** This is the ability to shop for food and other things needed but is not managing transportation.

g. **Managing medication:** This is the ability to take one's own medication. Indicate how the client manages her/his medication regimen, either with a personal reminder system or with assistance from others.

h. **Using Transportation:** This is the ability to use local transportation or to drive to places beyond walking distance. You should record the client's main source of transportation.

<table>
<tr><th colspan="6">SCENARIO EXAMPLE: SCORING CLIENT MEDICATIONS MANAGEMENT ASSISTANCE NEEDS</th></tr>
<tr><td>How much assistance do you need with managing medications?</td><th>No assistance needed</th><th>Uses assistive device</th><th>Needs supervision or prompt</th><th>Needs some assistance</th><th>Needs total assistance, cannot do at all</th></tr>
<tr><td>If client is able to take medications as prescribed by a doctor or as instructed on an over-the-counter package.</td><td>☑</td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="3"></td><td rowspan="4"></td></tr>
<tr><td colspan="2">If client is able to perform all parts of the taking medication activity because of the use of an assistive device(s), such as use of a pill minder or other helping device that the client fills her/himself.</td><td>☑</td></tr>
<tr><td colspan="3">If client is able to perform all parts of the taking medication activity listed above if another person is there during the activity to lend support by her/his presence or to coach the client through the activity, without any hands-on assistance being given.</td><td>☑</td></tr>
<tr><td colspan="4">If client is able to perform some parts of the taking medication activity listed above and needs another person to be present during the activity to lend some hands-on assistance. This may be a small amount of assistance, such as filling the pill minder for the client, or may be a lot of assistance, such as actually handing the pills to the client.</td><td>☑</td></tr>
<tr><td colspan="5">If client is unable to perform the taking medication activity and another person is needed to perform the activity for them. This level of help would be for a client who must rely on someone to administer medications, including such action as putting the pill in the client's mouth, holding the water, and rubbing the client's throat to assist with swallowing.</td><td>☑</td></tr>
</table>

72. **ASSESSOR/CM:** ***Is there an unmet need for an IADL assistive device?*** ☐No ☐Yes

Type(s) needed: _____

72. **Unmet Need for IADL Assistive Device:** Is there a need for assistive devices to help the client to handle her/his IADL functions? If there is no unmet need, mark "No." If there is an unmet need, mark "Yes" and indicate the specific devices needed in the text box. This question is referring to the individual needing a device that s/he does not have. Notes about what devices are already in use should be made on the form or in the client's case narrative for the visit.

73. How much assistance do you have with the following tasks?

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Heavy chores	☐	☐	☐	☐	☐
b. Light housekeeping	☐	☐	☐	☐	☐
c. Using the telephone	☐	☐	☐	☐	☐
d. Managing money	☐	☐	☐	☐	☐
e. Preparing meals	☐	☐	☐	☐	☐
f. Shopping	☐	☐	☐	☐	☐
g. Managing medication	☐	☐	☐	☐	☐
h. Using transportation	☐	☐	☐	☐	☐

73. **Assistance with Instrumental Activities of Daily Living (IADLs):** Assessing the frequency a client has assistance with a task is different from identifying how much assistance the client needs. You will ask the client how much assistance they have with completing the tasks listed on the form for activities a-h, and determine the frequency of help they have from the following range:

- "No assistance needed:" Indicates that client receives no help from others because they do not need any help to perform any part of the activity.
- "Always has assistance:" Indicates that the client always has an adequate level of help to meet their need in performing the activity.
- "Has assistance most of the time:" Indicates that the client usually has the help they need to perform the activity, or more often than not they have an adequate level of help for the activity.
- "Rarely has assistance:" Indicates that the client has unpredictable, unreliable or seldom has the amount of assistance they need to complete the activity.
- "Never has assistance:" Indicates that the client has absolutely no assistance to complete the activity.

Scoring Instrumental Activities of Daily Living Resources:

a. **Heavy Chores:** Record how often the client receives help with heavy chores like yard work, washing windows, moving furniture, doing laundry, etc. Also record who helps and which tasks are done for the client.

b. **Light Housekeeping:** Record how often the client receives help with housekeeping tasks like dusting, vacuuming, and sweeping. Also record who helps and which tasks are done for the client.

c. **Using the telephone:** Record how often the client receives help from another person to use the telephone to make or receive calls (do not include the use of an assistive device like an amplifier or other special equipment unless it requires another person to put it in place for the client). Examples of assistance using the telephone include keeping track of numbers, dialing, holding the phone, etc. If the client can use the telephone independently but is slow to answer or unable to use a dial phone, make a note of this also.

d. **Managing money:** Record how often the client receives help managing their money, paying bills, balancing a checkbook, or other monetary matters. Also record who helps and which tasks are done for the client.

e. **Preparing meals:** Record how often the client has assistance with meeting their multiple daily meal requirements. Common examples include family members preparing simple meals like making a sandwich or heating up a frozen dinner, caregivers who prepare separate components of meals that the client uses to assemble into meals later, and neighbors that provide "plates" for the client comprised of leftover food from their own meals. Also record who helps and which tasks are done for the client.

f. **Shopping:** Record how often the client has the help they need when shopping for food and other items. This does not include transportation to and from the store, but rather refers to the assistance drafting a shopping list, selecting items from the shelves, purchasing them and unloading them from the car into the home. Also record who helps and which tasks are done for the client.

g. **Managing medication:** Record how often the client has help managing a medication regimen, this includes taking their medication as prescribed, filling prescriptions, and monitoring why and under what circumstances medications are properly taken. Also record who helps and which tasks are done for the client.

h. **Using Transportation:** Record how often the client has help with their main source of transportation- this could include using local transit options like cabs, shuttles, and busses, or simply how often someone helps the client by driving them to the places they need to go. Also record who helps and which tasks are done for the client.

EXAMPLE: SCORING CLIENT MEDICATIONS MANAGEMENT RESOURCES

How much assistance do you have with managing medications?	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
If client is able to take medications as prescribed by a doctor or as instructed on an over-the-counter package.	☑				
If client has a responsible and reliable source of daily assistance that helps with any part of the activity, as the client's needs dictate.		☑			
If client has assistance that meets the majority of their needs. "Most of the time" can mean that they have help on either most of the days or every day but only with most of the activities involved with the task.			☑		
If client has infrequent or unreliable assistance with medications. This is scaled to what they need - so if they only need a pill minder filled once a week, and they have help once a week, then they always have assistance. However, if they need that pill minder filled once a week, but they only get help to fill it once a month, then they would rarely have assistance.				☑	
If client is unable to perform the managing medication activity and another person is needed to remember what ailments are treated with which prescriptions, arrange to have the medications refilled as needed, and manage their daily administration and other aspects of completing the task.					☑

701D Instructions-

Section F. Health Conditions & Therapies

Guidance for Completion of the Department of Elder Affairs' 701B Comprehensive Assessment

Section F. Health Conditions & Therapies

This section helps to generate an updated, accurate picture of the client's current health status and need for medical treatment and therapies. The items in the first half of this section are intended to document diagnosed past or current health conditions that have a direct relationship to the client's current functional status, behavior, medical treatments, or risk of death. It is understood that the presence of several major or many minor health conditions such as those listed in this section can have a significant adverse effect on an individual's health status, quality of life, and level of assistance they need to function.

74. **Health Conditions:** Ask the client whether they have been told by a physician that they currently have or ever have had any of the health conditions listed. The Assessor/Case Manager should review the entire list with the client and have the client stop to discuss each condition they have or have had that is listed on the form. If the client indicates that s/he had the condition in the past, mark the first box ("Past"). If the client indicates that s/he currently has the condition (or is still affected by the condition), mark the second box ("Current"). In addition, specific information is requested with certain conditions. A list of each condition is provided on the form, and a discussion of each is provided in the following list. For more information on the region, symptoms, and etiology of these diseases, please consult the web-based 701B comprehensive training.

74. Have you been told by a physician that you have any of the following health conditions?
ASSESSOR/CM: Indicate whether a problem occurred in the past by marking the first box and when a problem is current by marking the second box. Mark all that apply.

Past	Current	Health Conditions			
☐	☐	Acid reflux/GERD			
☐	☐	Allergies, list:			
☐	☐	Amputation, site:			
☐	☐	Anemia	☐ Severe	☐ Moderate	☐ Mild

- **Acid reflux/GERD** (Gastroesophageal reflux disease) – A condition in which the stomach contents (food or liquid) leak backwards from the stomach into the esophagus (the tube from the mouth to the stomach). This action can irritate the esophagus, causing heartburn and other symptoms.
- **Allergies** – Indicate the types of allergies the client has/had. Allergic reactions occur when a person's immune system reacts to normally harmless substances in the environment or diet. For example: hay fever, hives, insect stings, mold, latex, sulfa, penicillin, dairy, wheat, peanuts, etc.
- **Amputation** – Indicate the site of the amputation(s). Amputation is the removal of a limb, or part of a limb, that is no longer useful and causing great pain, or threatens a person's health because of extreme infection. For example: leg, arm, foot, etc. Be sure to indicate if it is the right or left arm, etc. Most people who require an amputation have Peripheral Artery Disease (PAD), a traumatic injury, or cancer.
- **Anemia** – Indicate whether the condition is/was: severe, moderate, or mild. Anemia is a condition in which the body does not have enough healthy red blood cells, which provide oxygen to body tissues. The lack of oxygen may cause a person to feel tired, the heart may beat too quickly and may cause chest pain and dizziness. The lack of oxygen to the brain may cause a person to feel confused, have a headache and have cold hands and feet.

☐	☐	Arthritis, type:		
☐	☐	Bed sore(s) (Decubitus), location:		
☐	☐	Blood pressure	☐ High	☐ Low
☐	☐	Broken bones/fractures, location:		
☐	☐	Cancer, site:		
☐	☐	Chlamydia		
☐	☐	Cholesterol	☐ High	☐ Low

- **Arthritis** – Indicate the type of arthritis the client has/had. For example: osteoarthritis, rheumatoid arthritis, gout, psoriatic arthritis, lupus, etc. Arthritis is the inflammation of one or more joints. A joint is the area where two bones meet. Arthritis involves the breakdown of cartilage, which normally protects a joint, allowing it to move smoothly and to absorb shock when pressure is placed on the joint. Without the normal amount of cartilage the bones rub together causing pain, swelling (inflammation), and stiffness.

- **Bed sore(s)** (*Decubitus*) – Indicate the location of the bed sore(s) the client has/had. For example: spine, coccyx (tailbone), hip, heel, elbow, ankle, etc. Decubitus is an ulceration of tissue deprived of adequate blood supply by prolonged pressure. Pressure sores/bed sores are grouped by their severity. Stage I is the earliest stage, and Stage IV is the worst. Stage I: reddened area when pressed does not turn white. Stage II: skin blisters or forms an open sore. Stage III: skin develops an open, sunken hole called a crater. Stage IV: ulcer is so deep that there is damage to the muscle and bone, and sometimes to tendons and joints.

- **Blood pressure** – Indicate whether the client has/had high or low blood pressure. Blood pressure is the pressure exerted by circulating blood upon the walls of blood vessels and is one of the principal vital signs.

- **Broken bones/fractures** – Indicate the location of the fractures the client has/had. For example: hip, leg, arm, ankle, etc. Be sure to indicate if it is/was the left or right hip, etc.

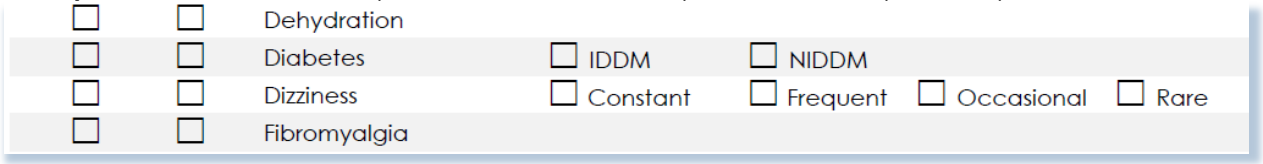
- **Cancer** – Indicate the site of the cancer the client has/had. Examples: lung, bone, breast, prostate

- **Chlamydia** - A bacterial sexually transmitted disease (STD) known as a "silent disease" because 75 percent of infected women and at least half of infected men carry the disease without recognizing any symptoms. When symptoms occur, they most often appear within 1 to 3 weeks of exposure. Symptoms for women may include abnormal vaginal discharge, burning when urinating, low back pain, nausea, fever, pain during sexual activities and general lower abdominal pain. Symptoms for men may include discharge from penis, burning when urinating, and pain and swelling in the testicles.

TIP: Older people are less likely to use condoms than other age groups, both because they do not consider themselves to be at risk of pregnancy and they were not a target for the national efforts in education that protection from STDs should be part of their sex lives.

- **Cholesterol** – Indicate whether the client has/had high or low cholesterol. Cholesterol is an organic chemical substance classified as a waxy steroid of fat. Although it is important and necessary for human health, high levels of cholesterol in the blood have been linked to damage to arteries and cardiovascular disease. Low cholesterol could increase the risk of some health problems.

- **Dehydration** – Occurs when you lose more fluid than you take in and your body does not have enough

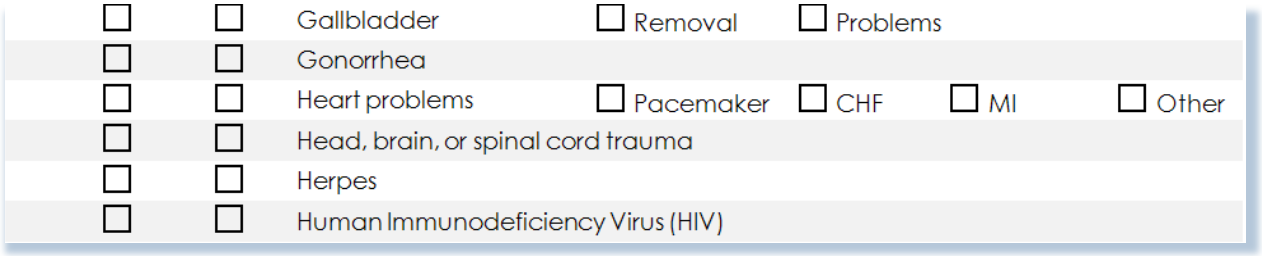


water and other fluids to carry out its normal functions. Dehydration is a major health risk in hot climates and is a leading cause for emergency hospitalization in the elderly. Dehydration can lead to serious complications, including: falls, heat injury, swelling of the brain, seizures, low blood volume shock, kidney failure, coma and death.

- **Diabetes (IDDM/NIDDM)** - IDDM refers to insulin-dependent diabetes mellitus. NIDDM refers to noninsulin-dependent diabetes mellitus. Diabetes is a lifelong (chronic) disease in which there are high levels of sugar in the blood. People with diabetes have high blood sugar because their body cannot move sugar into fat, liver, and muscle cells to be stored for energy. This is because either their pancreas does not make enough insulin, their cells do not respond to insulin normally, or both. Symptoms of high blood sugar levels may include: blurry vision, excessive thirst, fatigue, frequent urination, hunger, and weight loss. Having diabetes can complicate other medical issues.

- **Dizziness** – Indicate whether the client's dizziness is/was: constant, frequent, occasional, or rare. Dizziness is a term used to describe everything from feeling faint or lightheaded to feeling weak and unsteady. Dizziness that creates the sense that you or your surroundings are spinning or moving is called vertigo.

- **Fibromyalgia** – Is a common syndrome in which a person has long-term, body-wide pain and tenderness in the joints, muscles, tendons, and other soft tissues. Fibromyalgia has also been linked to fatigue, sleep problems, headaches, depression, and anxiety.



- **Gallbladder** – Indicate whether the client had her/his gallbladder removed or has/had problems. The gallbladder is a pear-shaped organ under the liver. It stores bile, a fluid made by the liver to digest fat. The gallbladder releases bile through a tube called the common bile duct to aid in digestion. The gallbladder is most likely to cause trouble if something blocks the flow of bile through the bile ducts; usually the blockage is due to a gallstone. Signs of a gallbladder attack may include nausea, vomiting, or pain in the abdomen, back, or just under the right arm.

TIP: Asking a client about sexually transmitted diseases such as Chlamydia, Gonorrhea, and Herpes may seem intrusive; however, it is imperative to gather this information for the following reasons:

- ✓ To properly recognize a medical condition. For example, the symptoms might be related to the manifestation of a sexually transmitted disease instead of another medical condition.
- ✓ To provide appropriate treatment. Many primary care physicians do not discuss these issues with disabled and elderly patients, and as a result these diseases go untreated for longer periods of time.
- ✓ To educate the client of risks associated with sexual behaviors. Many clients were never educated about the use of condoms in sexual activity to prevent the spread of disease.
- ✓ To inform caregivers or other personnel of possible contagious conditions in order to ensure additional precautions are taken.
- ✓ To monitor the course of the disease. For example, a client with untreated syphilis in the late stage may not have symptoms until 20 years after infection; these symptoms can lead to paralysis, blindness, dementia, and even death.
- ✓ To mitigate the interaction with other diseases. Sexually transmitted diseases can greatly complicate or worsen other medical conditions. For example, the treatment of a bed sore is complicated by a herpes outbreak.
- ✓ To determine the reason for the client's functional limitations. Mobility can be impaired by disease symptoms and therefore can be restored with proper identification and treatment.

- **Gonorrhea** – A bacterial sexually transmitted disease (STD), characterized by a white, yellow, or green discharge or an itching or burning sensation when urinating or defecating, occurs in the genital area, mouth, or throat, and is spread from person to person through skin-to-skin contact.

- **Heart problems** (Pacemaker, CHF, MI, etc.) – Heart disease is a broad term used to describe a range of diseases that affect the heart. These include: diseases of the blood vessels, such as coronary artery disease (CAD); heart infections; heart defects that people are born with (congenital heart defects); and heart rate or rhythm problems called arrhythmias. During an arrhythmia, the heart can beat too fast, too slow, or with an irregular rhythm. A pacemaker is a small device that is placed in the chest or abdomen to help control abnormal heart rhythms. This device uses electrical pulses to prompt the heart to beat at a normal rate. Congestive heart failure (CHF) means your heart cannot pump enough blood to meet your body's need; symptoms may include fatigue and weakness; swelling (edema) in the legs, ankles, and feet; sudden weight gain from fluid retention; and swelling of the abdomen (ascites). Myocardial infarction (MI), or "heart attack," occurs when a blood clot blocks the flow of blood through a coronary artery. Symptoms vary, but may include shortness of breath, sweating, fainting, nausea, vomiting, and increasing episodes of chest pain.

- **Head, brain, or spinal cord trauma** – Traumatic brain injury is sudden physical damage to the brain. The damage can result from a closed head injury, such as that caused by impact of the head with an object like the windshield or dashboard of a car. The damage can also result from a penetrating brain injury, such as that caused by a bullet piercing the skull. Traumatic spinal cord injury is damage to the spinal cord that results in loss of mobility or feeling. In most cases, the spinal cord remains intact, but the damage results in loss of nerve function.

- **Herpes** – A viral sexually-transmitted disease (STD), characterized by episodic outbreaks of sores or lesions in the genital area, that through touch can be spread to any orifice (eyes, nose, mouth).

- **Human Immunodeficiency Virus (HIV)** – A viral disease, characterized by compromised immune functions, slow wound healing, skin degradation, and fatigue. It can be spread by blood-to-blood contact of any kind, including sexual contact, needle sharing from drug use, piercings or tattoos, and in rare cases, from improperly screened blood transfusions or tissue donations.

☐	☐	Human Papilloma Virus (HPV)/ Genital warts				
☐	☐	Incontinence, bladder	☐ Constant	☐ Frequent	☐ Occasional	☐ Rare
☐	☐	Incontinence, bowel	☐ Constant	☐ Frequent	☐ Occasional	☐ Rare
☐	☐	Kidney problems or renal disease		End stage?	☐ No	☐ Yes

- **Human Papilloma Virus (HPV)/Genital warts** – A viral sexually-transmitted disease (STD), characterized by few symptoms other than small bumps in the genital area, mouth or throat. It can be spread from person to person through skin-to-skin contact.
- **Incontinence, Bladder** – Indicate whether the client's bladder incontinence is: constant, frequent, occasional, or rare. Urinary incontinence is the inability to control the release of urine from your bladder. There are different types of urinary incontinence: stress incontinence is loss of urine when coughing, sneezing, laughing, etc.; urge incontinence is a sudden, intense urge to urinate followed by an involuntary loss of urine; overflow incontinence is frequently or constantly dribbling urine; mixed incontinence is having symptoms of more than one type of urinary incontinence; functional incontinence is when a physical or mental impairment prevents you from getting to a toilet on time; total incontinence is continuous leaking of urine, day and night, or the periodic uncontrollable leaking of large volumes of urine.
- **Incontinence, Bowel** – Indicate whether the client's bowel incontinence is: constant, frequent, occasional, or rare. Bowel incontinence (fecal incontinence) is the inability to control your bowel movements, causing stool (feces) to leak unexpectedly from your rectum. Fecal incontinence ranges from an occasional leakage of stool while passing gas to a complete loss of bowel control in someone who is older than four years old.

TIP:

Although it is typically thought of as a symptom in the very frail, clients of all ages, conditions, and level of health may have problems managing incontinence. In particular, you should be aware that experiencing bladder and bowel incontinence can be very difficult for some people to handle emotionally, interpersonally, and socially. As a result, it has been linked to issues like homeboundedness, deterioration in perceived social support, decreased physical activity, and caregiver burnout. In an effort to minimize episodes and avoid purchasing incontinence supplies, some people attempt to manage incontinence with lifestyle changes, such as restricting fluids, delaying or skipping meals if away from home, and other individualized strategies. Unfortunately those efforts can have unintended physical consequences like dehydration, urinary tract infection, constipation, and others.

- **Kidney problems or renal disease** – Indicate whether the condition is end stage. End Stage Renal Disease (ESRD) is the complete or almost complete failure of the kidneys to work. Other kidney problems include: Chronic Kidney Disease (CKD); blood in the urine (hematuria); protein in the urine (proteinuria); kidney stones, etc. Kidney problems may have no symptoms until the disease is very far along and may include nausea; fatigue; dizziness; swelling in feet, hands, or face; back pain; high blood pressure; bloody, foamy or dark-colored urine. If diseases and symptoms persist without treatment, permanent kidney damage or failure may result.

☐	☐	Liver problems	☐ Cirrhosis	☐ Hepatitis		
☐	☐	Lung problems	☐ Emphysema	☐ Asthma	☐ Pneumonia	☐ COPD
☐	☐	Lupus				
☐	☐	Multiple Sclerosis				
☐	☐	Muscular Dystrophy				
☐	☐	Osteoporosis				

- **Liver problems** – Indicate whether the client's liver condition is/was cirrhosis or hepatitis. Cirrhosis is scarring of the liver and poor liver function. It is the final phase of chronic liver disease. Hepatitis is swelling and inflammation of the liver. It is not a specific pathogenic type of condition, but is often used to refer to a viral infection of the liver. There are 5 types of hepatitis (A, B, C, D, E); each type is caused by a different hepatitis virus. Liver problems include a wide range of diseases and conditions that can affect your liver. Your liver is an organ about the size of a football that sits just under your rib cage on the right side of your abdomen. Without the liver you cannot digest food, absorb nutrients, get rid of toxic substances from your body, or even stay alive. Some symptoms of liver problems are: appearance of yellowish skin and eyes, abdominal pain and swelling, dark urine color, pale stool color, chronic fatigue, and/or itchy skin that will not go away.

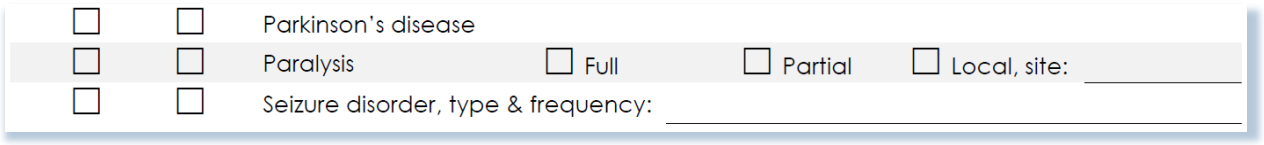
- **Lung problems** – Indicate whether the client's lung problem is/was Asthma, Emphysema, Pneumonia or Chronic Obstructive Pulmonary Disease (COPD), or some other lung problem. Lung diseases are some of the most common medical conditions worldwide. Chronic bronchitis and Emphysema are the most common conditions that make up COPD. However, COPD refers to an entire group of other lung diseases that cause damage to your lungs and make it increasingly difficult to breathe. Pneumonia is a breathing (respiratory) condition in which there is an infection of the lung. Other lung fluid problems could be pleural effusion, pulmonary edema, bronchitis, etc. Indicate the recentcy of any pneumonia episode, and the type of COPD or asthma the client has/had in the "Notes & Summary" section below. (For example: allergic, exercise-induced, nighttime, cough-variant, or occupational)

- **Lupus** – Is a chronic inflammatory disease that occurs when the body's immune system attacks its own tissues and organs. Inflammation caused by lupus can affect many different body systems--including your joints, skin, kidneys, blood cells, brain, heart, and lungs.

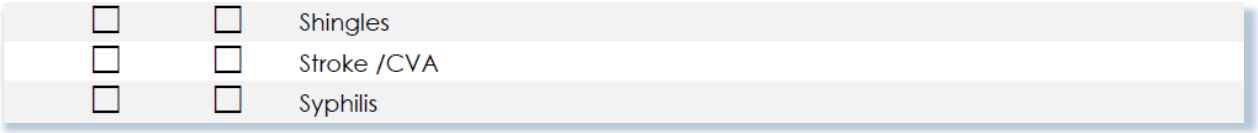
- **Multiple Sclerosis** – Is a potentially debilitating disease in which the body's immune system eats away at the protective myelin sheath that covers your nerves. Damage to myelin causes interference in the communication between your brain, spinal cord, and other areas of your body. This condition may result in deterioration of the nerves themselves, a process that's not reversible.

- **Muscular Dystrophy** – Is a group of genetic diseases in which muscle fibers are unusually susceptible to damage. These damaged muscles become progressively weaker. Most people who have muscular dystrophy will eventually need to use a wheelchair. There are many different kinds of muscular dystrophy. Symptoms of the most common variety begin in childhood, mostly in boys. Other types of muscular dystrophy don't surface until adulthood.

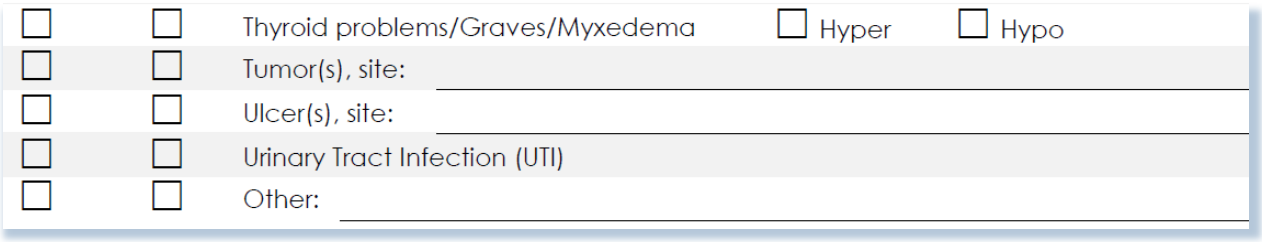
- **Osteoporosis** – Is the thinning of bone tissue and loss of bone density over time and is a major risk for women, and complicates falls, injuries, and the risk for broken bones.



- **Parkinson's disease** – Is a degenerative disorder of the central nervous system, marked by involuntary twitches, shakes and writhing movements.
- **Paralysis** – Indicate whether the client's paralysis is/was: full, partial, or local (and if local, the site of the paralysis). Local paralysis is a loss of motor control that is confined to a single muscle, muscle group, or part of the body. For example: left arm, right side, left side, etc. Paralysis is the loss of muscle function in part of the body. It can be complete (all sensation and function is cut off from affected part of the body) or partial (some movement or sensation remains in the affected muscles or muscle group). It can occur on one or both sides. Paralysis of the lower half of the body, including both legs, is called paraplegia. Paralysis of the arms and legs is called quadriplegia. Most paralysis is due to strokes or injuries, such as spinal cord injury or a broken neck.
- **Seizure disorder** – Indicate the type and frequency of the client's seizure disorder. For example, type: grand-mal, absence, myoclonic, clonic, tonic, atonic, etc. The frequency could be daily, monthly, several times a day, etc. Seizures are a symptom of abnormal electrical activity in the brain, and have many causes, including medicines, high fevers, head injuries, and some diseases.



- **Shingles** – Also referred to as herpes zoster, is a painful, blistering skin rash caused by the same virus that causes chickenpox (varicella-zoster virus). Shingles may develop in any age group, but you are more likely to develop the condition if: you are older than 60, you had chickenpox before age one, your immune system is weakened by medications, or some diseases.
- **Stroke/CVA** – CVA refers to cerebrovascular accident. There are ischemic strokes, hemorrhagic strokes, and transient ischemic attacks (TIAs), which are also called mini-strokes. A stroke happens when blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack."
- **Syphilis** – A bacterial sexually-transmitted disease (STD), characterized by three stages. The first is the appearance of a chancre sore at the site of infection (usually the mouth or genital area). The second is the development of more generalized mucous membrane lesions, skin rashes on one or more areas of the body, may also include fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches, and fatigue. The third and final stage (if left untreated) is called the latent phase. Without treatment, the infected person will continue to have syphilis even though there are no signs or symptoms; infection remains in the body. This latent stage can last for years. The late stages of syphilis can develop in about 15 percent of people who have not been treated for syphilis and can appear 10–20 years after infection was first acquired. In the late stages of syphilis, the disease may subsequently damage the internal organs, including the brain, nerves, eyes, heart, blood vessels, liver, bones, and joints. Signs and symptoms of the late stage of syphilis include difficulty coordinating muscle movements, paralysis, numbness, gradual blindness, and dementia. This damage may be serious enough to cause death.



- **Thyroid problems/Graves/Myxedema** – Indicate whether the client's thyroid problems are/were: hyper or hypo. Hyper is when there is too much of the thyroid hormone (Graves disease); hypo is insufficient thyroid hormone (Myxedema).
- **Tumor(s)** – Indicate the site of the client's tumor(s). For example: brain, breast, colon, lung, prostate, cervix, ovary, etc. A tumor is an abnormal growth of body tissue. A tumor can be cancerous (malignant) or noncancerous (benign).
- **Ulcer(s)** – Indicate the site of the client's ulcer(s). For example: throat, tongue, stomach, digestive tract, foot, etc. An ulcer is a lesion that is eroding away the skin or mucous membrane.
- **Urinary Tract Infection (UTI)** – An infection that involves any of the organs or structures of the urinary tract, including the kidneys, ureters, bladder, and urethra. Some of the common symptoms of a urinary tract infection are burning or pain in the lower abdomen (that is, below the stomach), fever, burning during urination, or an increase in the frequency of urination. UTIs are the most common type of healthcare-associated infection (HAI) and are most often caused by the placement or presence of a catheter in the urinary tract.
- **Other** – Indicate any other health conditions that a doctor has stated the client has/had.

Frequency of Current Therapies Table

Items in the second half of the health conditions and therapies section identify the frequency of current therapies and specialty care the client may be receiving. The current therapies and specialty care that a client is receiving have a profound effect on an individual's health status, self-image, dignity, quality of life, and rigor of their daily routine. Evaluation of the intensity of these treatments is important to ensure continued appropriateness of the plan of care.

75. **Current Therapies or Specialty Care**: Ask the client whether s/he is currently receiving any of the therapies or specialty care listed on the form (a-q). If not, mark the box in the first column, "N/A or None." If so, ask the frequency of this therapy or care, and indicate it by marking the appropriate box. The possible responses are "Monthly," "Weekly," "Several times a week," "Daily," or "Several times a day."

75. Provide information on the frequency of current therapies or specialty care:

Treatment type:	N/A or None	Monthly	Weekly	Several times a week	Daily	Several times a day
a. Bladder/bowel treatment	☐	☐	☐	☐	☐	☐
b. Catheter, type: _____	☐	☐	☐	☐	☐	☐
c. Dialysis	☐	☐	☐	☐	☐	☐
d. Insulin assistance	☐	☐	☐	☐	☐	☐
e. IV Fluids/IV Medications	☐	☐	☐	☐	☐	☐
f. Occupational therapy	☐	☐	☐	☐	☐	☐
g. Ostomy, site: _____	☐	☐	☐	☐	☐	☐

a. **Bladder/bowel treatment** – For example: dietary change, exercise program, medication, surgery, medical devices, behavioral techniques, electrical stimulation, etc.

b. **Catheter** – Indicate the type. In medicine, a catheter is a tube that can be inserted into a body cavity, duct, or vessel. Catheters thereby allow drainage, administration of fluids or gases, or access by surgical instruments. Placement of a catheter may allow, for example: drainage of urine from the urinary bladder (e.g., indwelling catheter, condom catheter, intermittent catheter, Foley catheter, suprapubic catheter, etc.); administration of IV fluids, medication, or nutrition (peripheral venous catheter); administration of oxygen and other breathing gases into the lungs (tracheal tube); subcutaneous administration of insulin or other medications (infusion set and insulin pump).

c. **Dialysis** – When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis: hemodialysis and peritoneal dialysis. Both types filter the blood to rid the body of harmful wastes, extra salt, and water. Hemodialysis does that with a machine. Peritoneal dialysis uses the lining of the abdomen, called the peritoneal membrane, to filter the blood.

d. **Insulin assistance** – For example: someone other than the client draws up the insulin or administers it.

e. **IV Fluids/IV Medications** – Is the infusion of liquid substances or medications directly into the vein.

f. **Occupational therapy** – Is a health profession where the goal is to help people achieve independence, meaning, and satisfaction in all aspects of their lives. The occupational therapist's goal is to provide the client with skills for the job of living – those necessary to function in the community or in the client's chosen environment.

g. **Ostomy** – Indicate the site. For example: colostomy (large intestine), ileostomy (small intestine), and urostomy (small intestine). All have an opening in the abdomen and use some sort of external means to collect the contents of the bowel (like a bag, pouch, etc.)

Treatment type:	N/A or None	Monthly	Weekly	Several times a week	Daily	Several times a day
h. Oxygen	☐	☐	☐	☐	☐	☐
i. Physical therapy	☐	☐	☐	☐	☐	☐
j. Radiation/Chemotherapy	☐	☐	☐	☐	☐	☐
k. Respiratory therapy	☐	☐	☐	☐	☐	☐
l. Skilled nursing	☐	☐	☐	☐	☐	☐
m. Speech therapy	☐	☐	☐	☐	☐	☐
n. Suctioning	☐	☐	☐	☐	☐	☐
o. Tube feeding	☐	☐	☐	☐	☐	☐

h. **Oxygen** – Oxygen is an important chemical element that is colorless, odorless, and tasteless. It has many common uses. Obviously, oxygen is important for human respiration. Therefore, oxygen is used for people who have trouble breathing due to some medical condition (such as emphysema or pneumonia). The nasal cannula is a device used to deliver supplemental oxygen or airflow to a patient or person in need of respiratory help. This device consists of a plastic tube which fits behind the ears, and a set of two prongs which are placed in the nostrils. The nasal cannula is connected to an oxygen tank, a portable oxygen generator, or a wall connection in a hospital.

i. **Physical Therapy** – Is a health profession primarily concerned with the correcting of impairments and disabilities and the promotion of mobility, functional ability, quality of life, and movement potential through examination, evaluation, diagnosis, and physical intervention.

j. **Radiation/Chemotherapy** – Radiation therapy involves the use of ionizing radiation in an attempt to cure or improve the symptoms of cancer. Radiation is often used in conjunction with chemotherapy. Chemotherapy is the treatment of cancer with one or more cyctoxic anitneoplastic (chemotherapeutic agents) drugs as part of a standardized regimen. Both radiation and chemotherapy act by killing cells that divide rapidly.

k. **Respiratory Therapy** – Is a therapeutic treatment for respiratory diseases and conditions. A respiratory therapist is a health care professional who usually provides these treatments and evaluates the patient's response to the treatments.

l. **Skilled Nursing** – A term that refers to a client's need for care and treatment that can only be done by a licensed nurse, such as complex wound dressings and tube feedings.

m. **Speech Therapy** – Is the treatment of speech defects and disorders, especially through the use of exercises and audio-visual aids that develop new speech habits.

n. **Suctioning** – A term that refers to the process of removing foreign matter, such as mucus, fluids, or blood, from a person's upper airway.

o. **Tube feeding** –A feeding tube is a medical device used to provide nutrition to patients who cannot obtain nutrition by swallowing. The state of being fed by a feeding tube is called gavage, enteral feeding, or tube feeding. Placement may be temporary for acute conditions or lifelong for chronic disabilities. The types of feeding tubes are: Nasogastric (NG-tube), which is passed through the nostril to the stomach and is used short term; Gastric (G-tube), which is surgically inserted through a small incision

in the abdomen into the stomach and is used long term; Jejunostomy (J-tube), which is surgically inserted through the abdomen and into the jejunum (second part of the small intestine).

Treatment type:	N/A or None	Monthly	Weekly	Several times a week	Daily	Several times a day
p. Wound care/Lesion irrigation	☐	☐	☐	☐	☐	☐
q. Other therapy, type:	☐	☐	☐	☐	☐	☐

p. **Wound care/Lesion irrigation** –There are many types of wounds that can damage the skin including abrasions, lacerations, rupture injuries, punctures, and penetrating wounds. Many wounds are superficial and require only local first aid including cleansing and dressing. Some wounds are deeper and need medical attention to prevent infection and loss of function due to damage to underlying structures like bone, muscle, tendon, arteries, and nerves. Wound irrigation is the steady flow of a solution across an open wound surface to achieve wound hydration, to remove deeper debris, and to assist with the visual examination. Combined with debridement (medical removal of dead, damaged, or infected tissue), irrigation is a critical step in wound healing.

q. **Other therapy** – Indicate any other type of therapy or specialty care the client is receiving on a regular basis.

701D Instructions-

Section G. Mental Health

Guidance for Completion of the Department of Elder Affairs' 701B Comprehensive Assessment

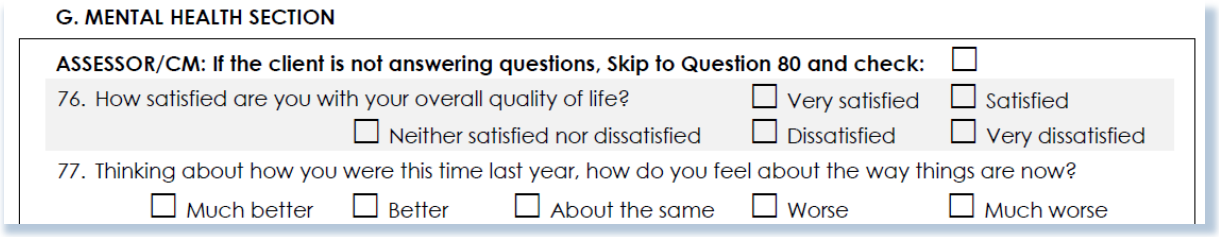
Section G. Mental Health

Mental health problems and severe emotional distress are serious and surprisingly common issues in elderly and disabled populations. An estimated 15 to 30 percent of U.S. adults aged 65 and over experience depressive symptoms on any given day. For example, did you know that older white men comprise the highest risk group for suicide, and adults over 65 have suicide rates that are six times higher than the national average? Compounding this problem is that these populations may underuse mental health services. This occurs for a variety of reasons, including social stigma, transportation problems, costs, and misconceptions about mental health problems.

The items in this section address mental health and mood distress, serious conditions that are frequently under-diagnosed and undertreated among adults with disabilities and the elderly. Be aware that asking about problems with depression or thoughts of suicide will not make a client feel depressed or suicidal - but the assessment may be the first time anyone has asked them about these feelings; so some clients may be hesitant to report these symptoms. However, if the Assessor/Case Manager has developed rapport with the client and approaches questions in a straightforward, compassionate manner, most clients will answer these questions honestly.

TIP: You can make a difference! Research suggests that Case Managers using validated tools can successfully help clients identify depression symptoms, self-manage these symptoms [see Healthy IDEAS http://www.careforelders.org/healthyideas] and provide clients with the encouragement they need to seek assistance from a professional when appropriate.

If the assessment process identifies problems, then remember, you are not expected to try to handle critical situations alone. Your responsibility as an Assessor/Case Manager is to immediately report any potentially serious problems to your supervisor, a primary care physician, emergency care, law enforcement, and/or Adult Protective Services, as appropriate.



G. MENTAL HEALTH SECTION

ASSESSOR/CM: If the client is not answering questions, Skip to Question 80 and check: ☐

76. How satisfied are you with your overall quality of life? ☐ Very satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐ Dissatisfied ☐ Very dissatisfied

77. Thinking about how you were this time last year, how do you feel about the way things are now?

☐ Much better ☐ Better ☐ About the same ☐ Worse ☐ Much worse

Assessor/CM: Because the questions in this section relate to the intimate emotional processes of the client, information provided by others is less relevant here. So if someone besides the client - such as a family member, a caregiver, etc. is providing answers to the questions in the other sections of the assessment, and the client is unable to do so for themselves, you should mark the box and skip Questions 76 through 80.

76. **Satisfaction with Quality of Life:** Mark the appropriate box ("Very satisfied," "Satisfied," "Neither satisfied nor dissatisfied," "Dissatisfied," or "Very dissatisfied") to indicate how satisfied the client is with her/his overall quality of life. This question opens the conversation for discussing what might be preventing the client from being more satisfied with her/his life at present.

77. **Comparison to Prior Year:** Mark the appropriate box ("Much better," "Better," "About the same," "Worse," or "Much worse") to indicate how the client feels about the way things are now compared to how s/he was doing this time last year.

78. Over the past two weeks, how often have you been bothered by any of the following problems? *(Adapted from the Patient Health Questionnaire PHQ-9, ©Pfizer)*	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people noticed – Or, the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way*	☐	☐	☐	☐

78. **Frequency of Depression Symptoms in two week period**: This table can be used to identify the presence and frequency of each of the nine symptoms of depression listed in items a. through i. The possible responses for the frequency of occurrence in each symptom are: "Not at all," "Several days," "More than half the days," or "Nearly every day."

Thoughts of suicide or self-injury are potentially serious and should be reported immediately to a supervisor, primary care physician, emergency care, law enforcement, and/or Adult Protective Services, as appropriate.

ASSESSOR/CM: Only ask Question 79 if client answered "more than half the days" or "nearly every day" to at least one item in Question 78. Otherwise, skip to Question 80.

79. How difficult have these problems made it for you in your daily life activities and interactions with others?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Assessor/CM: If the client answered "more than half the days" or "nearly every day" to at least one item in Question 78, then you will follow up by asking Question 79. If they experienced any of those symptoms at a lower rate of frequency, you can skip Question 79 and move on to Question 80.

79. **Severity of Problems:** The intent of this question is to determine how any problems identified have impacted the client's quality of life and ability to carry out their daily activities. Indicate the client's response by marking the appropriate box ("Not difficult at all," "Somewhat difficult," "Very difficult," or "Extremely difficult").

The PHQ-9, from which these questions are adapted, is a multipurpose instrument for screening, monitoring, and measuring the severity of depression. These questions can be asked by a lay-person or self-administered over time to evaluate improvement or worsening of depression symptoms. To be used for diagnostic purposes or for evaluating response to treatment, the responses must be reviewed and scored by a clinician.

Referral to a Mental Health Professional

The Assessor/Case Manager may need to make a mental health referral. The purpose of a mental health referral is to get a professional assessment of a client's mental health needs and determine if mental health services are needed. If a client is having emotional problems with ongoing depressive symptoms that cause significant personal discomfort or interfere with daily activities, has ongoing anxiety and sleep difficulties, or is agitated or angry most of the time (but does not pose a threat to others), s/he should be considered for a **non-emergency** mental health referral.

TIP:

Some research suggests that adults with disabilities and older adults are more likely to make use of a mental health referral if they are encouraged to try the service by someone they trust or respect. Your client may need your encouragement and reassurance that mental health services have helped many others. For clients who are reluctant to see a mental health professional, encourage them to at least discuss their symptoms with their primary care physician and advise them that primary care physicians can often help with these symptoms.

Generally, the Assessor/Case Manager should use her/his professional judgment in making a referral based upon her/his observation and all information provided. However, if a client has acted out in a manner that is dangerous to themselves or others, or if they expressed thoughts of suicide to you or a caregiver, consult with your supervisor about whether they should be referred for **emergency** mental health intervention.

80. Are you currently working with a professional to help with this condition? ☐ No ☐ Yes *(Skip to 81)*

a. Have you or do you plan to discuss these issues with a professional? ☐ No ☐ Yes *(Skip to 81)*

b. Do you talk about any of these issues with anyone else you know? ☐ No ☐ Yes

81. Have you been diagnosed with a mental condition or psychiatric disorder by a health professional?

☐ No *(skip to 82)* ☐ Yes: *List conditions:* _____

80. **Currently Working with a Professional:** Indicate whether the client is currently working with a professional to help with the issues listed in Question 79 ("No" or "Yes"). If the client is already working with a professional ("Yes"), skip to Question 81. If <u>not,</u> mark ("No"), and follow up by asking question a. If the response to a. is "Yes," you can skip b. If the client does <u>not</u> plan to contact a professional and the response to a. is "No," then follow up by asking if they would be more comfortable discussing the problems they are experiencing with someone else (question b).

a. **Plan to discuss these issues with a professional?** Indicate the client's response by marking the appropriate box ("No" or "Yes"). If the client does not have plans to discuss mental health issues with a professional ("No"), ask question b.

b. **Talk about any of these issues with anyone else?** Indicate the client's response by marking the appropriate box ("No" or "Yes"). "Anyone else" refers to another person, such as a family member, friend, clergy, neighbor, etc.

Make sure that you do not "dead-end" a conversation after a client tells you they are in distress. You are not expected to counsel a client, but when you identify they are having problems, you should confirm they are receiving help elsewhere or make every effort to connect them with an appropriate resource.

81. **Diagnosis of Mental Condition:** Indicate whether the client has been diagnosed with a mental condition or psychiatric disorder by a health professional ("No" or "Yes"). If the client has not been formally diagnosed, mark "No" and skip to Question 82. If the client has been diagnosed, mark "Yes," and list the conditions in the space provided.

Although the focus here is collecting information about mental conditions that have been diagnosed by a professional, some clients may reveal that they are experiencing distress that has not been formally identified. You are encouraged to note these statements in notes, and include consideration for these issues in the referral or care planning process.

82. **ASSESSOR/CM: Indicate whether you noticed problem behaviors or any recurring problems have been reported to you by the client, caregiver, in-home worker, family, or staff, and note the frequency of occurrence in the last month. Please provide details in the Notes & Summary section, below.**

Problem behaviors	Not at all	Once	Several days	More than half the days	Nearly every day
a. Forgetful or easily confused	☐	☐	☐	☐	☐
b. Gets lost or wanders off	☐	☐	☐	☐	☐
c. Easily agitated or disruptive	☐	☐	☐	☐	☐
d. Sexually inappropriate	☐	☐	☐	☐	☐
e. Threatens or is verbally hostile*	☐	☐	☐	☐	☐
f. Physically aggressive or violent*	☐	☐	☐	☐	☐
g. Intentionally injures or harms him/herself*	☐	☐	☐	☐	☐
h. Expresses suicidal feelings or plans*	☐	☐	☐	☐	☐
i. Hallucinates, hears/sees things that are not there*	☐	☐	☐	☐	☐
j. Other:	☐	☐	☐	☐	☐

82. **Problem Behaviors:** Indicate if you noticed problem behaviors or if any recurring problems have been reported to you by the caregiver, in-home worker, family, or staff, and note the frequency of occurrence for these behaviors in the last month ("Once," "Several days," "More than half the days," or "Nearly every day"). Remember that potentially serious problems should be reported immediately to your supervisor, the client's primary care physician, emergency care, law enforcement, and/or Adult Protective Services, as appropriate. If no problem behaviors are reported, check "not at all."

83. **ASSESSOR/CM: Does client need supervision?** ☐ No ☐ Yes

Notes & Summary:

83. **Need for supervision:** Indicate "Yes" or "No" if the client needs to be supervised for any reason. If you indicate "Yes" that supervision is required, detail the reason, intensity level, and whether the amount of supervision they are receiving is sufficient and appropriate in the "Notes & Summary" section.

TIP: Be aware that clients that require high intensity or constant supervision can be very difficult for a single caregiver to properly attend to, and some research suggests that clients with high supervision needs are at elevated risk for abuse, neglect, caregiver burnout, and institutionalization.

Consider these and other resources that may be available in your area if you have a client with cognitive, mental, or behavioral health issues:

- **Florida Abuse Hotline Information System** (Florida Protective Services System) for cases in which abuse, neglect, or exploitation is suspected (1-800-96 ABUSE or 1-800-962-2873).
- **Alzheimer's Disease Initiative** program or local mental health provider. These are typically for non-emergency situations when services and further evaluation are necessary. However, mental health providers can also help in an emergency.

701D Instructions-

Section H. Residential Living Environment

Guidance for Completion of the Department of Elder Affairs' 701B Comprehensive Assessment

Section H. Residential Living Environment

Home safety is an important area of opportunity for injury prevention. For this reason, the items in this section have been included to evaluate the client's physical environment for minimum safety and accessibility requirements. To complete this section, you will need to combine observation, direct questioning, and professional judgment.

Many older persons and individuals with disabilities or chronic illnesses are vulnerable to serious injuries from falls and home accidents. Impairments in the senses of sight and touch, as well as physical disabilities, may limit client perception or movement, and some memory and cognitive impairments may slow judgment and reaction time. As a result, many clients are more prone than the general public to falls and accidents. In fact, home accidents are a major source of injuries, and falls are the number one cause of injury to persons 65 years of age and older in Florida. Sadly, many of these injuries can be seriously debilitating or fatal. Even a minor fall can result in a broken bone, which can become an injury that limits one's independence.

Over 60 percent of all elder falls occur inside the home. So precautions, adjustments, and modifications to residential safety hazards could greatly reduce the threat of injury and greater impairment. It may help you to keep this section of the assessment in mind during your entire visit. When you notice issues, you will want to revisit them so you can provide specifics about the problems and areas in need of attention. In discussions with the client, you will want to indicate the immediacy of the need based on the level of risk. On the form, be sure to indicate both your concerns and any that the client may have articulated, as well as any ideas for how to fix the issues you both identify. These concerns will need attention in the care plan and will be used to determine appropriate referrals. Pay particular attention to safety or accessibility problems for the client as these may greatly affect the client's ability to evacuate in an emergency. The HCE Safety and Accessibility Worksheet may be used to help with this assessment (See Attachment B).

84. **ASSESSOR/CM: If information about the client's residence is reported to you, without your observation, check here ☐ and all that apply below. If residence issues are directly observed by you, use the list below to observe and check off the specific issue(s) with the potential for safety or accessibility problems.**

Check all that apply:

a. Exterior issues(s):	☐ Road	☐ Driveway	☐ Yard	☐ Ramp	☐ Windows	☐ Roof
b. Interior issues(s):	☐ Doors	☐ Stairs	☐ Floor	☐ Walls	☐ Ceiling	☐ Lights
c. Restroom issues(s):		☐ Door	☐ Handrails	☐ Tub	☐ Shower	☐ Toilet

84. **Potential Safety or Accessibility Problems**: Mark the items on the form that are problematic for the client. Write in any other issues that do not appear on the assessment form. These items will be checked based on the direct observation of the Assessor/Case Manager or as reported by an informant.

TIP:

If information about the client's residence is reported to you, without your direct observation, check the indicated box and then mark all applicable issues in the sections that follow (Question 84 a-h). This box will be checked when the Assessor/Case Manager is not assessing the client in her/his home. For example, the client may be assessed in a nursing facility but is planning to return to her/his home setting and information regarding the client's residence is reported to the Assessor/Case Manager by an informant.

Check all that apply:

a. **Exterior issue(s)**: Note any potential safety or accessibility issues with the road, driveway, yard, doors, windows, or roof of the home, keeping in mind the importance of a clear line of site and pathway for entering and exiting the residence. The residence should have secure surfaces (such as railings near exterior stairs); proper lighting; ability to see outside (so as not to have to open the door to greet someone); door locks that work properly and can be opened by those who visit the residence; a doorbell that can be heard in all areas of the residence; frequently traveled outside surfaces (i.e., to and from the mailbox, garbage cans, pet walking areas) that are free from trip hazards; wheelchair and walker accessibility as needed; easy access to the garage with proper lighting and working doors (automatic garage doors should be checked for functionality and the client should know how to exit in case of power failure).

b. **Interior issue(s)**: Note any potential safety or accessibility issues including ramps and stairs or issues with the flooring, walls, ceiling, or lighting, keeping in mind that the client should be able to move around the area without having to make special accommodation to enter or exit a room. Spaces in the residence should generally allow 42" or greater in all pathway areas of the home; extension, phone, or appliance cords should not be present in ambulation pathways; entrances to rooms should provide lighting access; windows should be easy to open and close; blinds and curtains should easily allow the client to open and close them to reduce glare (glare negatively impacts visual capability in the elderly and increases the likelihood of a fall); carpeting should be properly secured or removed; all rooms should be adequately lit; flooring height differences should be noted and changes made if a trip hazard is present; floors should be clean and dry; pet food, water, pet sleeping areas, and toys should not be walking obstacles.

In residences in which stairs are present: stairway surfaces should be free of objects; check for loose steps and ensure that each step is visible in all lighting situations; if steps are unequal in height, depth, or width, make sure the resident is aware of the differences; light switches should be available at the top and bottom of the stairs; make sure all carpeting on stair surfaces is adequately secured and install "skid-strips" in areas where the surface presents a slip hazard; check the security of rails and, if possible, install a rail on both sides of the stairway.

Refer back to the General Health and Function Section to the item regarding the client's ability to climb a few stair steps. If they are not able to use steps, but have steps within or leading from the home, they may be severely restricted from freely moving in the home.

c. **Restroom issue(s)**: Note any potential safety or accessibility issues in the restroom with the door, handrails, tub, shower, or toilet. Keep in mind that walker and wheelchair access may not be possible in some Florida residences and, in other instances, turning the walker and ambulating "sideways" may allow entrance/exit from the bathroom. In the restroom, all rugs must be secured to the floor despite the dangers of water on the floor; toilet seat height must be appropriate to meet elder needs; grab bars should be located in the shower, tub, and near the toilet area; water temperature should not present a burn hazard; shower benches are very important to those with balance problems; "anti-slip strips" should be installed in the tub and shower; nightlights should be installed; all "most frequently used" personal supplies should be easy to reach; installation of a hand-held shower wand should be considered; and, if opportunities are available, a phone in the bathroom is useful.

d. Utility issue(s):		☐ Plumbing	☐ Water	☐ Electric ☐ Gas
e. Furniture issue(s):		☐ Chair	☐ Couch	☐ Bed ☐ Table
f. Telephone issue(s):	☐ Broken	☐ No phone	☐ Disconnected/No service	
g. Temperature issue(s):	☐ Heat	☐ Smoke detector	☐ Air conditioning	
h. Unsanitary condition(s):	☐ Odors	☐ Insects	☐ Rodents	
		☐ Accumulating items or garbage	☐ Floors or pathways cluttered	
i. Other hazards: _____				

d. **Utility issue(s)**: Note any potential safety issues with the plumbing, water, electric, or gas. For example, is there an unofficial electrical hookup to the home; does the home have running water and indoor plumbing; are there space heaters or generators being used, etc.?

e. **Furniture issue(s)**: Note any potential safety or accessibility issues with the furniture in the home, such as chairs, couches, beds, or tables. Furniture that presents trip hazards should be moved out of common pathways. Chairs that require "low seating" should be removed, and use of wheeled furniture or furniture that is broken should be avoided. Any furniture that is used for stability (i.e., frequently grasped while ambulating through a room) should be secured to the floor – in particular, check furniture that is on wood or terrazzo flooring, and ensure chairs that are frequently used have secure arm rails. Bed height should allow the client to get easily in and out with minimal effort.

f. **Telephone issue(s)**: Note any potential safety or accessibility issues with telephone service in the residence, including lack of a phone, broken phone(s), or no/disconnected service. Whenever possible, it is advisable to have phone availability in all rooms of the home. Note: A referral for emergency alert response may be needed if the client does not have phone availability in all rooms of the home.

g. **Temperature issue(s)**: Note any potential safety issues with heat, air conditioning, or smoke detectors in the residence. A clear path to thermostats should be present, and all smoke detectors should be in proper working order. Note: Most fire departments will come to a residence and check smoke detectors, as well as provide new ones.

h. **Unsanitary condition(s)**: Note any potential issues with unsanitary conditions including odors, insects, rodents, cluttered floors or pathways, or accumulating items or garbage. Be sure to note any other unsanitary condition not listed on the form in the space provided ("Other hazards").

85. Is there a pet in your home or yard?	☐ No *(Skip to 86)* ☐ Yes
a. Please specify the type and size:	_____
b. **ASSESSOR/CM: Pet comments/concerns**:	_____

85. **Pet in Home or Yard**: Indicate the client's response to this question by marking the appropriate box ("No" or "Yes"). If the client does not have a pet in the home or yard ("No"), skip questions a. and b. If a pet is present ("Yes"), indicate a. the type and size of the pet, and b. any comments or concerns related to the pet. This information will be useful to the Assessor/Case Manager and others visiting the home for the safety of staff and the pet. For example, the client may ask the Assessor/Case Manager to call before arriving so s/he can secure the dog or put the cat in a different room.

86. **ASSESSOR/CM: Please rate the level of risk in the client's residential living environment:**

- ☐ No/low apparent risk from current living conditions.
- ☐ Minor risk (*One or more aspects are substandard and should be addressed in the following year to avoid potential injury.*)
- ☐ Moderate risk (*Major aspects are substandard and must be addressed in the next few months to remain in home safely.*)
- ☐ High risk (*Serious hazards are present. The client must change dwellings or immediate corrective action must be taken to correct the issues noted above.*)

Notes & Summary:

86. **Level of Risk in Living Environment**: The items identified above are to be used as a guide to assist the Assessor/Case Manager in evaluating the level of risk in the client's living environment.

TIP: The Assessor/Case Manager is to use her/his professional judgment, not personal choice, in determining the issues in the client's home environment. For example, the floors in the client's home may not be as clean as you think they should be or there may be dirty dishes in the sink, but if they do not negatively affect the client's safety or accessibility, they would not be checked or considered in determining overall level of risk.

Determine the environmental assessment risk level based on the description that best describes the client's physical environment:

"No/low apparent risk from current living conditions" - The client's residential living environment appears to be safe and accessible.

"Minor risk" – One or more aspects are substandard and should be addressed in the following year to avoid potential injury.

"Moderate risk" – Major aspects are substandard and must be addressed in the next few months to remain in home safely.

"High risk" – Serious hazards are present. The client must change dwellings or immediate corrective action must be taken to correct the issues noted.

701D Instructions-

Section I. Nutrition

Guidance for Completion of the Department of Elder Affairs' 701B Comprehensive Assessment

Section I. Nutrition

The items in this section evaluate the client's weight, diet, fluid intake, and overall nutritional health. This section is included in the comprehensive assessment because the warning signs of poor nutritional health are often overlooked by healthcare providers. So, a standard set of measures was established as a federal screening under the Older Americans Act, called the "DETERMINE" Checklist, to identify common risk factors and warning signs of poor nutritional health. Although these factors were initially developed for identifying risks in an older population, they are quite relevant to younger adults with disabilities and chronic illnesses, too.

"D:" Disease – Any disease, illness, or chronic condition that causes someone to change the way they eat, or makes it hard for them to eat, puts their nutritional health at risk. Four out of five adults have chronic diseases that are affected by diet. Additionally, cognitive and emotional problems play a role in nutrition. For example confusion or memory loss is estimated to affect at least one out of five older adults, which can make it hard for them to remember what, when, or if they have eaten. And feeling sad or depressed, which happens to about one in eight older adults, can cause big changes in appetite, digestion, energy level, weight, and well-being.

"E:" Eating Poorly – Eating too little and eating too much both lead to poor health. Eating the same foods day after day, or not eating fruit, vegetables, and milk products daily will also cause poor nutritional health. One in five adults skips meals daily. Only 13 percent of adults eat the minimum amount of fruits and vegetables needed.

"T:" Tooth Loss/Mouth Pain – A healthy mouth, teeth, and gums are needed to eat. Missing, loose, or rotten teeth or dentures which do not fit well may cause mouth sores and make it hard to eat.

"E:" Economic Hardship – As many as 40 percent of older Americans have incomes of less than $6,000 per year. Having less – or choosing to spend less – than $25 to $30 per week on food makes it very hard to get the foods needed to stay healthy.

"R:" Reduced Social Contact – One-third of all older people live alone. Being with people daily has a positive effect on morale, well-being, and eating.

"M:" Multiple Medicines – Many older Americans must take medicines for health problems. Almost one half of older Americans take multiple medicines daily. Growing old may change the way people respond to medication. The more medicines a person takes, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and others. Vitamins or minerals, when taken in large doses, act like drugs and can cause harm.

"I:" Involuntary Weight Loss/Gain – Losing or gaining weight, when one is not trying to do so, is an important warning sign that must not be ignored. Being overweight or underweight also increases the chances of poor health.

"N:" Needs Assistance in Self Care – Although most older people are able to eat, one of every five has trouble walking, shopping, buying, and cooking food, especially as they get older.

"E:" Elder Years above Age 80 – Most older people lead full and productive lives. But, as age increases, the risk of frailty and health problems also increases.

87. Do you usually eat at least two meals a day? ☐ No ☐ Yes
88. On a typical day, what types of food do you eat for:
    a. Breakfast: _____
    b. Lunch: _____
    c. Dinner: _____
    d. Snacks: _____

87. **Two meals a Day**: Indicate the client's response to this question by marking the appropriate box ("No" or "Yes"). It is important to determine how many meals a client eats a day, as nutrition is vitally important to good health. If the client states s/he does not eat at least two meals a day, the Assessor/Case Manager needs to ask the client why. Be sure to include this information in the "Notes & Summary" section.

88. **Types of Food**: Ask the client to describe what types of food s/he eats in a typical day for a. breakfast, b. lunch, c. dinner, and d. snacks.

TIP: When asking what the client eats each day, you might want to walk the client through the previous day, from the time s/he woke up in the morning until s/he went to bed at night. Remember that weekends could be different from the rest of the week. Try to determine whether the diet is balanced, how much food is consumed, and when the food is normally eaten. Record the responses in the appropriate text boxes.

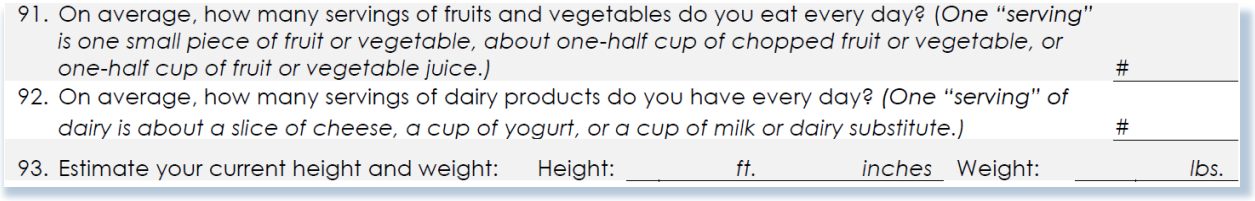
89. Do you eat alone most of the time? ☐ No ☐ Yes
90. How many cups of water, juice, or other liquid do you drink daily? *(If more than eight, Skip to 91)* #_____
    a. Do you ever limit the amount of fluids you drink? ☐ No *(Skip to 91)* ☐ Yes
    b. Why and when do you limit the fluids you intake? _____

89. **Eat Alone**: Ask the client whether s/he eats alone most of the time and mark the appropriate response ("No" or "Yes"). This question is very important, as it could indicate social isolation. If the response is "Yes," the Assessor/Case Manager needs to discuss the reasons with the client. Be sure to include this information in the "Notes & Summary" section.

90. **Liquid Intake**: First, ask the client how many cups of water, juice, or other liquid s/he drinks daily. If the response is more than eight, skip questions a. and b. If the response is less than eight, ask question a. :

a. **Limits Fluids**: Ask the client if s/he ever limits the amount of fluids s/he drinks and mark the appropriate response ("No" or "Yes"). If the response is negative ("No"), skip question b. If the client does limit fluids ("Yes"), then ask b.

b. **Reason for Limiting Fluids**: Ask the client why and when s/he limits fluids and record the response in the text box. Sometimes clients limit their intake due to incontinence issues, but can cause other health problems by doing so. For example, a client may not drink any fluids several hours prior to going to bed to avoid accidents, and notice they start feeling dehydrated in the warmer months, or have had frequent urinary tract infections as a result.


91. On average, how many servings of fruits and vegetables do you eat every day? *(One "serving" is one small piece of fruit or vegetable, about one-half cup of chopped fruit or vegetable, or one-half cup of fruit or vegetable juice.)* #

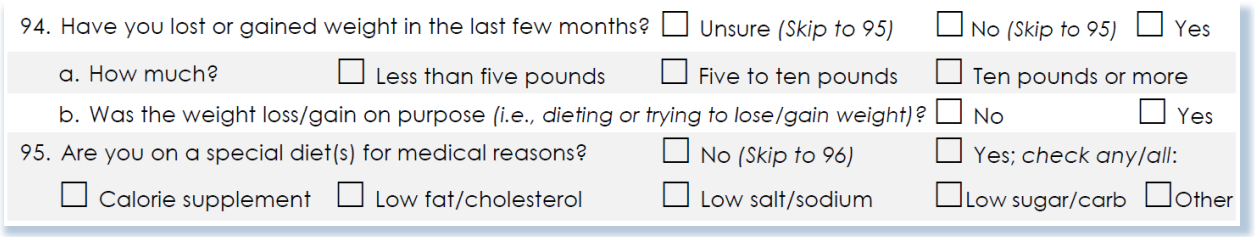
92. On average, how many servings of dairy products do you have every day? *(One "serving" of dairy is about a slice of cheese, a cup of yogurt, or a cup of milk or dairy substitute.)* #

93. Estimate your current height and weight: Height: ___ *ft.* ___ *inches* Weight: ___ *lbs.*

91. **Fruits/Vegetable Intake**: Read the description of serving size and then ask the client how many servings of fruits and vegetables s/he eats every day, on average. Record the numerical response in the box.

92. **Dairy Intake**: Read the description of serving size and then ask the client how many servings of dairy products s/he has every day, on average. Record the numerical response in the box.

93. **Height/Weight Estimate**: Current height and weight are also related to nutrition. The client may not know her/his current height or weight, or may not care to divulge the information, but note the information you are able to obtain from the client. Record weight in pounds and height in feet and inches.


94. Have you lost or gained weight in the last few months? ☐ Unsure *(Skip to 95)* ☐ No *(Skip to 95)* ☐ Yes

a. How much? ☐ Less than five pounds ☐ Five to ten pounds ☐ Ten pounds or more

b. Was the weight loss/gain on purpose *(i.e., dieting or trying to lose/gain weight)?* ☐ No ☐ Yes

95. Are you on a special diet(s) for medical reasons? ☐ No *(Skip to 96)* ☐ Yes; *check any/all*:

☐ Calorie supplement ☐ Low fat/cholesterol ☐ Low salt/sodium ☐ Low sugar/carb ☐ Other

94. **Gained/Lost Weight**: Ask the client if s/he has lost or gained weight in the last few months and mark the appropriate response ("Unsure," "No," or "Yes"). Note: "The last few months" is used instead of a specific time frame to allow for ambiguity of client recall. The Assessor/Case Manager may need to prompt the client with "in a time frame of the last 3 to 6 months." If the response is "Unsure" or "No," skip questions a. and b. If the response is "Yes," ask questions a. and b.:

a. **Amount of Weight**: Ask how much weight the client has lost or gained in the last few months and mark the appropriate response ("Less than 5 pounds," 5 to 10 pounds," or "10 pounds or more").

b. **Purposeful Change**: Ask the client whether the weight gain/loss was on purpose – for example, whether they were trying to lose or gain weight, and record the response ("No" or "Yes"). An unintended weight change could indicate a health problem, and the client's doctor should be notified.

95. **Special Diet**: Ask the client whether s/he is on a special diet(s) for medical reasons and record the appropriate response ("No" or "Yes"). If the response is "No," do not check any of the diet types and skip questions a. and b. If the response is "Yes," indicate the type of special diet(s) by marking the appropriate boxes ("Calorie supplement," "Low fat/cholesterol," "Low salt/sodium," "Low sugar/carb," or "Other"). Be sure to note any "other" type of diet that is not listed on the form in the space provided in the "Notes & Summary" section.

a. How long have you been on this diet? _____

b. Why are you on this diet? _____

96. Do you have any problems that make it hard for you to chew or swallow? ☐ No ☐ Yes; *check any/all*:

☐ Mouth/tooth/dentures ☐ Pain or difficulty swallowing ☐ Taste ☐ Nausea

☐ Saliva production ☐ Other, *describe*: _____

a. **Length on diet:** If a client answers "Yes" to having a special diet prescribed for medical reasons, indicate how long the client has been on this diet.

b. **Reason for diet:** If a client answers "Yes" to having a special diet prescribed for medical reasons, indicate the reason for the diet.

Be aware that multiple dietary restrictions indicate that the client is at greater nutritional risk. If a client is receiving home-delivered meals, a special diet may be requested from some providers.

96. **Difficulty Chewing/Swallowing**: Ask the client if s/he has any problems that make it hard to chew or swallow and mark the appropriate response ("No" or "Yes"). If the response is "No," do not check any of the problem boxes. If "Yes," indicate what these problems are by checking the appropriate boxes ("Mouth/tooth/dentures," "Pain or difficulty swallowing," "Taste," "Nausea," "Saliva production," or "Other"). Be sure to note any "other" problem that is not listed on the form in the space provided. More than one problem can be checked; the intent is to capture any and all problems affecting the client's ability to chew or swallow.

97. What working appliances do you have for storing/preparing food? ☐ None

☐ Refrigerator ☐ Microwave ☐ Toaster/Oven ☐ Stove ☐ Other: _____

97. **Working Appliances**: Indicate what working appliances, if any, the client has for storing/preparing food ("Other," "Refrigerator," "Microwave," "Toaster/Oven," "Stove," or "None"). Be sure to note any "other" source that is not listed on the form in the space provided. More than one item can be checked; the intent is to capture all sources the client has for storing and preparing food. If the response is "None," the Assessor/Case Manager needs to ask the client how they store and prepare food. Be sure to include this and any other relevant information about their ability to store and prepare food in the "Notes & Summary" section.

TIP: The Nutrition Score will be calculated by CIRTS and will appear on the turnaround document. The range of risk for malnutrition is Low = 0 to 2, Medium = 3 to 5, and a High = 5.5 to a maximum score of 21. Clients with nutrition scores that are 5.5 or higher show a high risk for malnutrition. It is strongly suggested that these clients be referred for nutrition counseling.

701D Instructions-

Section J. Medications & Substance Use

Guidance for Completion of the Department of Elder Affairs' 701B Comprehensive Assessment

Section J. Medications & Substance Use

With the progression of the diseases, conditions and ailments that many clients manage, their use of different medicines may increase and become more complex to manage properly. These medicines are prescribed to ease, control, or cure ailments and are usually safe when used correctly. However, the combination of increased numbers of medications being used at once, paired with the normal bodily changes that occur over the course of some diseases, can increase the chance of unwanted and harmful drug interactions. Elders and disabled adults may be at increased risk from medicines for various reasons, such as:

- **As the body ages, the liver becomes less efficient at breaking down medicines and the kidneys become less efficient at excreting them, which means that normal adult doses of certain medicines may cause more side effects in an older client;**
- **The brain and nervous system become more sensitive to certain medicines with some conditions and may make some clients more susceptible to the side effects of opioid painkillers such as morphine and sleeping tablets such as diazepam;**
- **Sensory disabilities, such as visual impairment, are linked with improper administration of medication and can cause problems with differentiating medications from one another, reading small print labels, and understanding all the information supplied with medicines.**

Individual medications may pose greater risk for some groups, and the opportunities for misuse in multiple medications are compounded. According to one study of adults taking five or more medications, 35 percent experienced an adverse effect from at least one prescribed drug, 63 percent of these events required physician intervention, 10 percent required an ER visit, and 11 percent were hospitalized. Non-adherence to medication regimens is also a major cause of nursing facility placement of older adults. In the same study, 28 percent of all hospitalizations among older adults were found to be drug-related, 11 percent of which were for improper prescription adherence. These findings and others suggest that more effort is needed in educating clients about the risks and precautions in managing medications. There are four basic tips that can aid with medication awareness, medication knowledge, and communication regarding medications:

1. Help clients make a list of all medications they take, why and when they take it, the dose, and possible side effects or special instructions;
2. Suggest that the client use only one pharmacy and involve a pharmacist in medication management;
3. Suggest that the client keep their medications organized with a pill minder or other assistive system; and
4. Recommend that the client update the medication list and review with the primary care physician as often as needed.

The more a client knows about the medicines they take and the more they talk with their healthcare professionals, the easier it is to avoid potential medication problems. This section collects medication use information and will enable you to have the conversation with the client about these medications to determine if they are managing their medications properly.

Medications, Prescribers, Compliance and Management

98. Do you take three or more prescribed or over-the-counter medications a day? ☐ No ☐ Yes

98. **Three or More Medications Daily**: Ask the client if s/he takes three or more prescribed or over-the-counter medications daily and mark the appropriate response ("No" or "Yes"). Be aware that taking three or more medications daily (including prescription, non-prescription, herbal or dietary supplements) puts the client at a higher risk for medication management and interaction problems.

TIP: "Polypharmacy" is the term used to describe when someone takes multiple prescriptions and over-the-counter medicines each day. Although this may often be necessary to manage multiple conditions, clients and caregivers should be especially careful when there are multiple medications to manage to practice good medication management habits to prevent clients from taking them incorrectly.

99. May I see all the medications you take, both regularly and those taken only as needed? Also, please show me all types of over-the-counter medications and any supplements that you regularly take.

ASSESSOR/CM: Check the original bottles in the medicine cabinet, nightstand, and refrigerator, as well as non-prescription drugs, over the counter drugs, sleep aids, herbal remedies, vitamins, and supplements.

Medication name	Prescribed dose	Prescribed Frequency	Taken as prescribed? Yes/No*	Administration method	Prescriber name

99. **Record of Medications**: Record any medications used by the client. These will be prescription and non-prescription (over–the-counter drugs, sleep aids, herbal remedies, supplements, and vitamins). For each, indicate the medication name; the prescribed dose of the medication; the prescribed frequency of the medication dosage; whether or not the medication is taken as prescribed; the administration method; and, when applicable, the prescriber's name.

TIP: You should check the original containers for information, keeping in mind that some may be in the medicine cabinet, nightstand, refrigerator, etc. If there are more medications to record, use the "Notes & Summary" section or a blank sheet of paper to write the information. If you have a printed list of medications managed by a facility, attach the sheet.

100. ***ASSESSOR/CM: Only ask when the client is <u>not</u> taking medications as indicated:**
"Why do you take [name of medication] differently than prescribed?" and explain each below:

Medication and reason: _____

Medication and reason: _____

Medication and reason: _____

100. **Reason for Non-Compliance**: If the client indicates that s/he is taking a medication improperly or is not taking any given medication as prescribed in Question 99, the Assessor/Case Manger should ask them why they are taking the medication differently than prescribed. Ask the client about each medication and record the medication and reason for non-compliance in the space provided. Consider the following possible compliance-related issues:

Cannot afford: May clients on fixed incomes cannot afford to maintain their medications if they increase in price or if they have other expenses come up. As a result, some clients try to "stretch" their medication by doing things like cutting pills in half, taking it only once a day or otherwise less often than as prescribed, letting a few weeks pass without refilling a prescription, or other ways that may cause the client to receive the incorrect dosage or frequency.

Confused: Confusion can come from many sources or a combination of sources and may be the cause or the symptom of misuse of medications. The client may suffer from disorientation from the side effects of sedatives or sleeping pills, urinary tract infection, dehydration, sleep disorder, emotional problems, dementia, vision or hearing loss, illiteracy, or some other reason that causes them to not stick to a medication routine, or lack clarity on how to take the medications as prescribed.

Self-Assessment: The client may have decided they feel better and no longer need to take the medicine; they may have decided that the effort to take the medication as prescribed is too difficult, or the side effects of the medication are not tolerable. Conversely, they may self-diagnose that they have a problem that they saw advertised on TV, or heard about from a friend, and decide to start taking over-the-counter medications they may not need or that may interact with others they were already prescribed.

Drug interaction or side-effects: The client may be taking medications that duplicate or compete with each other, or have similar side effects. The Assessor/Case Manager should look for possible drug interaction if the client reports not feeling well when they take a medication or reports stopping some medication because of intense side effects. Also, clients may be at greater risk for drug interaction if they get prescriptions from multiple doctors or multiple pharmacies.

Alcohol or controlled substance interaction: Use of alcohol or illegal "recreational" drugs with some medications may greatly diminish, enhance, or change their effect on the client and her/his conditions. Moreover, the use of these substances may impair the client's judgment in managing their medications, may make the client less likely to go see their physician or be honest with them, and may strain the financial resources needed to afford some medications.

101. Please list the doctors you usually go to for treatment and medications:

Physician name	Phone number	Approx. date of last visit	Reason for last visit:

If you have more than ten physicians to record, use the Notes & Summary section or a blank sheet of paper to write the information.

101. **Physician Listing**: List all of the doctors that the client usually goes to for treatment and medications along with his/her phone number, the approximate date of the client's last visit with the doctor, and the reason for that visit. If there are more than 10 physicians of record, use the "Notes & Summary" section to write the information on each. Be aware that clients may use multiple doctors as drug diversion. This is where they intentionally request prescriptions for the same drug from multiple prescribers to avoid suspicion in an attempt to obtain more of the medication.

102. What pharmacies or drug stores do you use? _____

103. Are you able to tell the difference between your pills (i.e., colors, shapes, print)? ☐ No ☐ Yes ☐ N/A

102. **Pharmacies Used**: List the pharmacies or drug stores that the client uses in the space provided. When clients use more than one pharmacy to fill their prescriptions, there is an increased chance of a drug interaction, duplicate therapy, or a possible decrease in compliance. Be aware that clients may use multiple pharmacies as drug diversion. This is where they intentionally fill prescriptions for the same drug at multiple pharmacies to avoid suspicion in an attempt to obtain more of the medication.

103. **Differentiate Medication**: Ask the client whether s/he is able to tell the difference between her/his pills, including colors, shapes, and print, and mark the appropriate response:

- "No" - Client cannot tell the difference between the characteristics of the pills they take
- "Yes" – Client can tell the difference between shapes, colors, and print of the pills they take
- "N/A" - Client does not take any medication

TIP: "Medication awareness" means the client fully understands what they take, when they take it, what it looks like (color, shape, print), and why they take it. Making sure that a client who is managing their own medications has full medication awareness can help prevent a great deal of harm.

104.	**ASSESSOR/CM: Are the client's medications managed by a facility/caregiver?**	☐ No	☐ Yes	☐ N/A
105.	**ASSESSOR/CM: In your opinion, are the client's medications managed properly?**	☐ No	☐ Yes	☐ N/A
106.	**ASSESSOR/CM: Should client have a new medication review by a doctor or pharmacist?**	☐ No	☐ Yes	☐ N/A

104. **Medications Managed by Others**: Indicate whether the client's medications are managed by a facility or caregiver ("No – client medications are self-managed, not assisted by a facility or caregiver," "Yes – medications are managed by a facility or caregiver," "N/A – client takes no medications to manage").

Examples: If the client resides at home and manages to fill, take, and monitor any adverse effects of all medications, the response would be "No." If a client resides in a nursing facility, where all medications are administered and reviewed by the facility staff, then the response would be "Yes."

105. **Medications Managed Properly**: Based on the client's responses to the medication questions, indicate whether you believe the client's medications are managed properly ("No," "Yes," or "N/A").

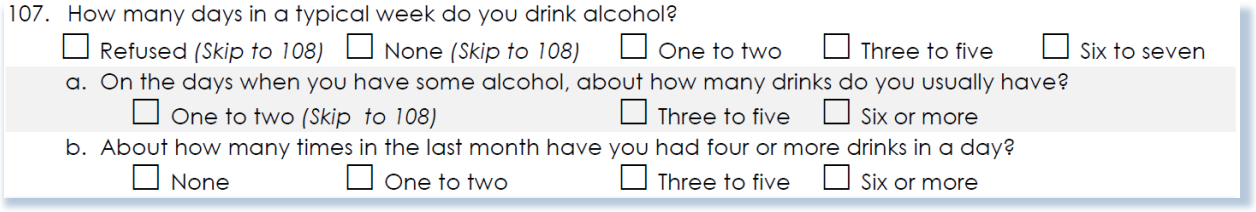
- "No" – The client is non-compliant with medications, cannot differentiate medications, and/or has no medication awareness (what medications are for, side effects, when and how to take them, etc.). The response would also be "No" if a facility or caregiver is not properly following the prescribed medication regimen.
- "Yes" – The client, caregiver, or facility is well aware of all medications and follows the medication regimen appropriately.
- "N/A" – The client does not take any medication or the caregiver or facility refused to provide the information.

106. **Medication Review**: Based on the client's responses to the questions above in Section J, indicate whether you believe the client should have a new medication review by a doctor or pharmacist ("No," "Yes," or "N/A").

- "No" – The client does not require a new medication review. The client's medications are not complex and the client is managing all medications appropriately.
- "Yes" – The client requires a new medication review if the medication management is complex, or the client is taking many medications of the same type, or the client is inappropriately using their medications (often seen due to side effects or expense of some medications). The Assessor/Case Manager can recommend the client have all of their medications reviewed by a specialist for ways to simplify the regimen, to remove conflicting or redundant medications, or to suggest drug substitutions or lower dosages to resolve issues with non-compliance or improve medication tolerance.
- "N/A" – This question does not apply to the client as s/he has no new medication or does not take any medication.

Alcohol, Tobacco and Substance Use

Although substances like alcohol, tobacco, and illicit drugs can be expensive, dangerous, and harmful to overall health; they are commonly used in some areas of the state, in some sub-populations, and in some phases of the lifespan. Younger adults are typically portrayed as the consumers and users of alcohol, tobacco, and drugs; however substance use has been shown to peak during major life disruptions common with disabled adults and in later life. Events such as retirement, relocation, chronic sleeping problems, social isolation or loneliness, disability, chronic pain, grief and widowhood all cause major disruptions that many people find hard to work though. These major transitions are thought to be some of the main contributory factors among people who develop problems with substance use. Despite evidence that there have been significant increases in substance use in elders and adults with disabilities, these groups are often overlooked when health care providers screen for substance use issues, due to stereotypes and misconceptions. The items in this section are for your use in determining the severity of substance use, if it is impairing client function, and if referral may be desired or appropriate.

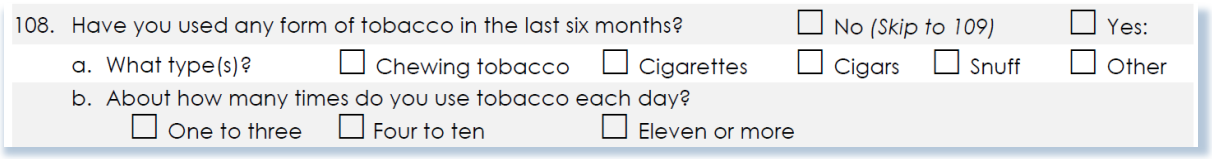

107. How many days in a typical week do you drink alcohol?
☐ Refused *(Skip to 108)* ☐ None *(Skip to 108)* ☐ One to two ☐ Three to five ☐ Six to seven
a. On the days when you have some alcohol, about how many drinks do you usually have?
☐ One to two *(Skip to 108)* ☐ Three to five ☐ Six or more
b. About how many times in the last month have you had four or more drinks in a day?
☐ None ☐ One to two ☐ Three to five ☐ Six or more

107. **Alcohol Use**: Ask the client how many days in a typical week s/he drinks alcohol and record the response in the appropriate box ("Refused,""None," "1 to 2," "3 to 5," or "6 to 7"). If the client refuses to answer the question ("Refused") or responds with "None," skip questions a. and b. If the client drinks alcohol on one or more days a week, ask question a.

a. **Number of Drinks**: Ask the client how many drinks s/he usually has on the days when s/he has some alcohol and mark the appropriate response ("1 to 2," "3 to 5," or "6 or more"). If the response is "1 to 2," skip question b. If the client usually has three or more drinks on the days when s/he drinks, ask b.

b. **Four or More Drinks**: Ask the client about how many times in the past month s/he has had four or more drinks in a day and record the response ("None," "1 to 2," "3 to 5," or "6 or more").

TIP: Did you know? One in four older adults drinks too much alcohol. Many health problems become worse if a person drinks more than one or two alcoholic beverages per day, and with some conditions and medications, *any* amount of alcohol can be dangerous.


108. Have you used any form of tobacco in the last six months? ☐ No *(Skip to 109)* ☐ Yes:

a. What type(s)? ☐ Chewing tobacco ☐ Cigarettes ☐ Cigars ☐ Snuff ☐ Other

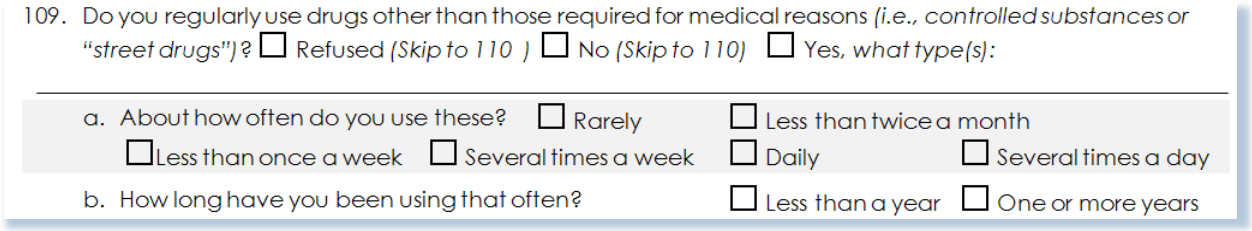
b. About how many times do you use tobacco each day?

☐ One to three ☐ Four to ten ☐ Eleven or more

108. **Tobacco Use**: Indicate whether the client has used any form of tobacco in the last six months ("No" or "Yes"). This includes use of cigarettes, cigars, chewing tobacco, and snuff. If the response is "No," skip questions a. and b. If the client has used tobacco in the last six months ("Yes"), ask questions a. and b.:

a. **Type(s) of Tobacco**: Indicate all type(s) of tobacco that the client has used in the last six months ("Chewing tobacco," "Cigarettes," "Cigars," "Snuff," "Other"). Note any other type in the "Notes & Summary" section.

b. **Frequency of Use**: Indicate how many times the client uses tobacco each day ("1 to 3," "4 to 10," or "11 or more").


109. Do you regularly use drugs other than those required for medical reasons *(i.e., controlled substances or "street drugs")*? ☐ Refused *(Skip to 110)* ☐ No *(Skip to 110)* ☐ Yes, *what type(s):*

a. About how often do you use these? ☐ Rarely ☐ Less than twice a month

☐ Less than once a week ☐ Several times a week ☐ Daily ☐ Several times a day

b. How long have you been using that often? ☐ Less than a year ☐ One or more years

109. **Drug Use**: Indicate whether the client regularly uses drugs other than those required for medical reasons (i.e., controlled substances or "street drugs") ("No" or "Yes"). If the client's response is "Refused" or "No," skip questions a. and b. If the client regularly uses drugs ("Yes"), record the types of drugs used in the space provided and then ask questions a. and b.:

a. **Frequency of Use**: Indicate how often the client uses drugs ("Rarely," "Less than twice a month," "Less than once a week," "Several times a week," "Daily," or "Several times a day").

b. **Length of Use**: Indicate how long the client has been using drugs at the frequency noted in Question 109a. ("Less than a year" or "1 or more years").

TIP:

Many people who engage in long-time drug use develop addictions and do damage to their bodies such that they do not survive until their senior years. However, in those clients who have a history of abusing drugs earlier in life, the use of a combination of substances is common. Be aware that as age-related changes take place in the body, and as the course of some diseases progress, many life-long users find that their recreational drug use is having new effects on their body and mind. With those changes, these substances pose new dangers. In particular, the concurrent use of illegal drugs with prescription medications can lead to life-threatening interactions. So, if a client is willing to discuss their substance use with you, you should make sure that they are aware of any cessation counseling services in your area.

701D Instructions-

Section K. Social Resources & Section L. Caregiver

Guidance for Completion of the Department of Elder Affairs' 701B Comprehensive Assessment

Section K. Social Resources

The intent of this section is to determine the client's degree of social isolation. Social isolation can be defined as the absence of social interactions, contacts, and relationships with family and friends, with neighbors on an individual level, and with "society at large" on a broader level. Social isolation is considered a risk factor for developing or worsening some diseases and can also intensify negative feelings about health conditions and disabilities.

110. If needed, is there someone (besides the primary caregiver) who could help you? ☐No *(Skip to 112)* ☐Yes

111. Do I have your permission to contact this person, if you need help? ☐No *(Skip to 112)* ☐Yes

a. Name: _____ b. Relationship to client: _____

c. Phone: _____

About how often do you:	Once a day	Two to six times a week	Once a week	Several times a month	Every few months	A few times a year	Never
112. Talk to friends, relatives, or others (by phone, computer, or other means)?	☐	☐	☐	☐	☐	☐	☐
113. Spend time with someone who does not live with you?	☐	☐	☐	☐	☐	☐	☐

110. **If needed, is there someone who could help you?:** Indicate the client's response to this question by marking the appropriate box ("No" or "Yes"). If the client does not have someone else to help them if needed ("No"), skip to Question 112. If the client does have another person who could help them if they needed anything ("Yes"), ask Question 111.

111. **Contact:** If the client has someone to help, ask if you have permission to contact this person if needed ("No" or "Yes"). If the client does not give permission to contact this person ("No"), skip parts a., b., and c. If the client gives permission ("Yes"), enter a. the contact person's name, b. relationship to the client, and c. phone number, including area code, in the spaces provided. If the contact person does not have a phone, this may be left blank.

If the client is uncertain of the spelling of the contact's name, see if the client has it written somewhere. If the client identifies a person by title, try to clarify what is meant. This is a vital care planning issue to be discussed with the client.

112. **Frequency of Conversations with Others:** Indicate the client's response to this question by marking the box that best corresponds to the client's response ("Once a day," "2-6 times a week," "Once a week," "Several times a month," "Every few months," "A few times a year," or "Never"). If the client's response is not covered in the options given, pick the one that is closest to the frequency of contact.

113. **Frequency of Visits with Others:** Indicate the client's response by marking the box that best corresponds to the client's response ("Once a day," "2-6 times a week," "Once a week," "Several times a month," "Every few months," "A few times a year," or "Never"). If the client's response is not covered in the options given, pick the one that is closest to the frequency of visits.

Find out who the client spends time with. Also try to determine if the client would like to do more. This could help you establish a need for some kind of companion service.

About how often do you:	Once a day	Two to six times a week	Once a week	Several times a month	Every few months	A few times a year	Never
114. Participate in activities outside the home that interest you?	☐	☐	☐	☐	☐	☐	☐

114. **Frequency of Activities Outside the Home:** Indicate the client's response by marking the box that best corresponds to the client's response ("Once a day," "2-6 times a week," "Once a week," "Several times a month," "Every few months," "A few times a year," or "Never"). If the client's response is not covered in the options given, pick the one that is closest to the frequency of activities.

TIP:

To help the client answer, you may need to prompt them with examples of hobbies or activities they may engage in. For example, do they go to a place of worship? Are they active in a local bridge group? Do they regularly attend social clubs, charitable organizations, or neighborhood association meetings? If they respond that they "Never" engage with others outside the home, you may want to ask if there are things they really liked doing but believe they cannot do anymore or find out why they stopped. If there are things the client can still do, see what help might be needed for them to reconnect and engage with others. Sometimes the solution to social isolation is as simple as incontinence supplies, a walker, or transportation services, and can have a profound impact on client quality of life.

Section L. Caregiver

Many clients do not have a person who can be relied upon to provide or arrange for assistance with their activities of daily living, also called a primary caregiver. For those who do, this person can be a lifeline to vital help and assistance - without which they would be far more vulnerable to institutionalization or worse. When a primary caregiver is present, it is important to arrange to conduct the last section of the assessment form with them in private, away from the client or other family members that may impact their comfort level in providing honest responses to questions. Although the intent of this section is to gather information about the client's caregiver to better understand the care being provided to the client, it is also to collect information about the ways that caregiving may be adversely impacting the caregiver's life, and the kinds of stress they are managing as a result. Many areas of the state have services in place for caregivers that can help prolong their ability to remain in place to help clients; so gathering this information is an important part of care planning. Additionally, many caregivers can provide valuable insight if the client has cognitive or behavioral issues you need to be aware of. If the client does not have a caregiver, stop the assessment here. The Caregiver Section fields will only appear in CIRTS if there is a primary caregiver.

115. **ASSESSOR/CM: HCE Caregiver? If yes, check** ☐

116. Caregiver full name: a. First: _____

b. Middle Initial: _____ c. Last: _____

117. Caregiver date of birth: *(mm/dd/yyyy)* _____

115. **ASSESSOR/CM: HCE Caregiver:** Check the box if the client's caregiver is an HCE Caregiver (has met all eligibility requirements and is enrolled in the Home Care for the Elderly program). Leave the box blank if the caregiver is not an HCE Caregiver.

116. **Caregiver Name**: Obtain the caregiver's full name (first, middle initial, and last) and note it in the spaces provided. If the caregiver does not have a middle initial, leave the space blank.

117. **Caregiver Date of Birth**: In the space provided, note the caregiver's date of birth in a two number format for the month (i.e., February would be '02'), likewise, use the two number format for the day (i.e., the third of the month would be '03') and a four number format for the year (i.e., 2012) as indicated by "mm/dd/yyyy" throughout the form.

118. **ASSESSOR/CM: Caregiver identification number** _____

119. Caregiver sex: ☐Male ☐Female

120. Caregiver race *(Mark all that apply)*: ☐White ☐Black/African American ☐Asian ☐American Indian/ Alaska Native ☐Native Hawaiian/ Pacific Islander ☐Other

121. Caregiver ethnicity: ☐Hispanic/Latino ☐Other

122. Caregiver primary language: ☐English ☐Spanish ☐Other _____

118. **Caregiver Identification Number**: This number is a unique identifier for the caregiver. It is comprised of her/his initials (first, middle, last) and her/his date of birth in mm/dd/yy format. In the space provided, enter the nine-digit caregiver identification number.

If the caregiver does not have a middle initial, you would use "X". For example, if the caregiver's name is Jane Ann Smith and the date of birth is 05/02/1965, you would enter JAS050265 for the caregiver identification number. If the caregiver's name is Jane Smith with no middle initial and the same date of birth, you would enter JXS050265 for the caregiver identification number.

119. **Caregiver Sex**: Mark the appropriate box to indicate whether the caregiver considers themselves to be female or male.

120. **Caregiver Race**: Obtain the caregiver's response and mark the box or boxes, as applicable, to indicate the caregiver's race. Caregivers may provide more than one response. These categories are suggested by the federal government for reporting under the Older Americans Act:

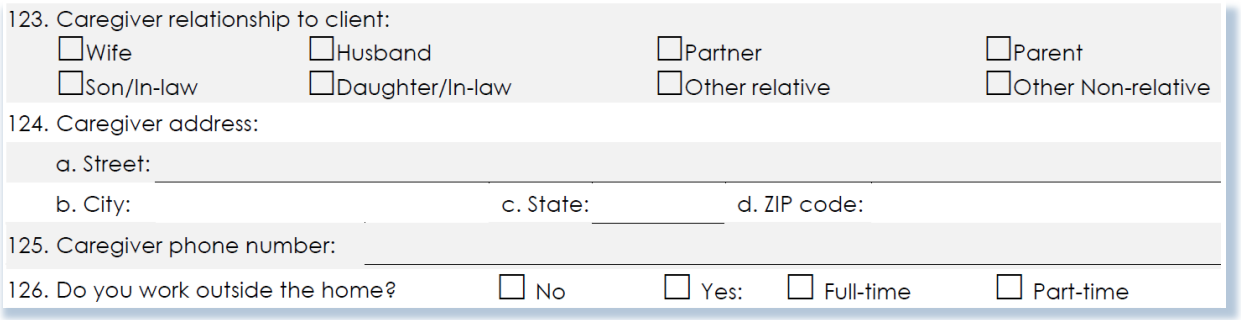
- "White"
- "Black/African American"
- "Asian"
- "American Indian/Alaska Native"
- "Native Hawaiian/Pacific Islander"
- "Other" (Any other racial group not coded above)

121. **Caregiver Ethnicity**: Obtain the caregiver's response and mark the appropriate box to indicate the caregiver's ethnicity. The only distinct ethnic grouping that must be reported to the federal government is "Hispanic/Latino." *NOTE: A person of Hispanic ethnicity may be from any race*.

- "Hispanic/Latino"
- "Other" (Any other ethnicity not coded above): If it is relevant for care planning, use the area in "Notes & Summary" to write a brief description of their ethnicity and the accommodations the client needs as a result.

122. **Caregiver Primary Language**: Mark the appropriate box to indicate the primary language spoken by the caregiver. When collected during the screening process, this information may enable the agency to send a worker to the home or arrange for someone who will be able to communicate most effectively with the caregiver.

- "English"
- "Spanish"
- "Other" (Any other language not coded above): Write-in a brief description of this "Other" language.


123. Caregiver relationship to client:
☐Wife ☐Husband ☐Partner ☐Parent
☐Son/In-law ☐Daughter/In-law ☐Other relative ☐Other Non-relative
124. Caregiver address:
a. Street:
b. City: c. State: d. ZIP code:
125. Caregiver phone number:
126. Do you work outside the home? ☐ No ☐ Yes: ☐ Full-time ☐ Part-time

123. **Caregiver Relationship to Client**: Indicate the caregiver's relationship to the client:

- "Wife:" The female legal spouse of a client.
- "Husband:" The male legal spouse of a client.
- "Partner:" The person with whom the client is in a relationship, other than a legal spouse.
- "Parent:" Includes biological or step-parents to the client.
- "Son/In Law:" Includes biological, step-son, and son-in-law to the client.
- "Daughter/In Law:" Includes biological, step-daughter, and daughter-in-law to the client.
- "Other Relative:" Includes family members such as cousins, nieces/nephews, etc.
- "Other Non-Relative:" Includes friends, neighbors, former spouses, etc.

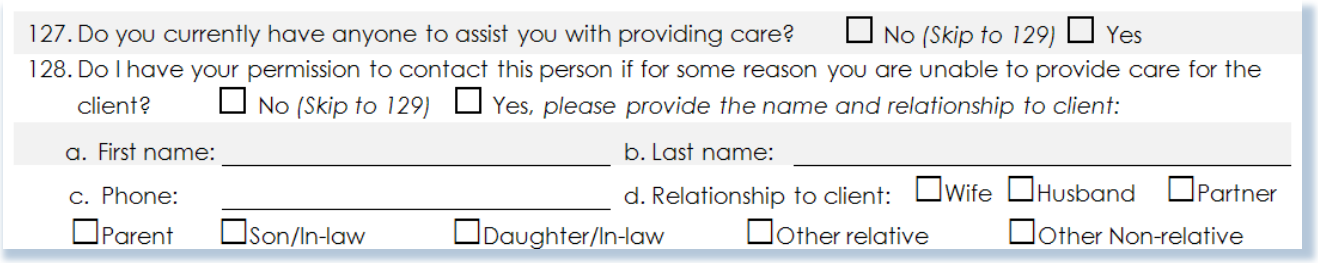
124. **Caregiver Address**: Note the caregiver's address in each lettered field provided (including the a. street, b. city, c. state, and d. ZIP code).

125. **Caregiver Telephone Number**: Note the caregiver's telephone number in the space provided. The phone number includes the area code and the seven-digit phone number. Leave this item blank if the caregiver does not have a telephone number.

If the caregiver has multiple numbers (i.e., a number for home, cell, and work), note the best way to reach them on Question 125, and document the other numbers in the "Notes & Summary" space provided.

126. **Caregiver Employed Outside Home**: Indicate whether the caregiver is employed outside the home ("No" or "Yes"). If the response is "No," skip to Question 127. If "Yes," indicate whether this employment is "Full-time" or "Part-time" by checking the appropriate box.

> **TIP:** Caregivers who are working at a full-time job, or a part-time job, or are at home with the client all of the time will each have differing needs to which the Assessor/Case Manager will need to be sensitive. For example, a caregiver who is still working may be unable to provide immediate assistance to the client, or may have periods of time where they are unavailable.


127. Do you currently have anyone to assist you with providing care? ☐ No *(Skip to 129)* ☐ Yes

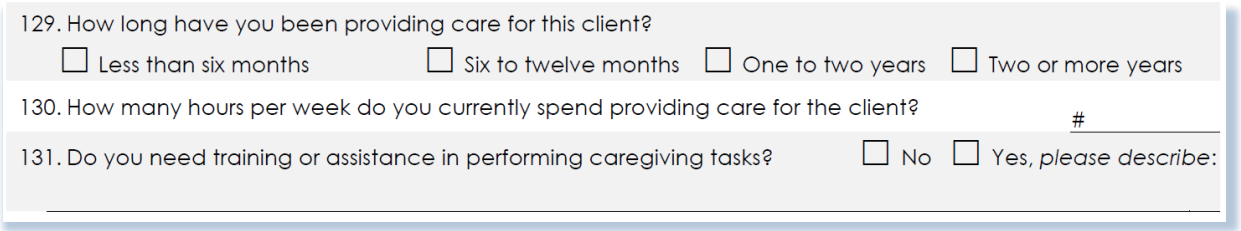
128. Do I have your permission to contact this person if for some reason you are unable to provide care for the client? ☐ No *(Skip to 129)* ☐ Yes, *please provide the name and relationship to client:*

a. First name: _____ b. Last name: _____

c. Phone: _____ d. Relationship to client: ☐Wife ☐Husband ☐Partner ☐Parent ☐Son/In-law ☐Daughter/In-law ☐Other relative ☐Other Non-relative

127. **Caregiver Assistance**: Ask the caregiver if they currently have someone to assist in providing care ("No" or "Yes"). This could be a second caregiver, a neighbor, or friend who could fill in if the caregiver were temporarily away. If they do not have assistance ("No"), skip to Question 129. If the response is "Yes," ask Question 128.

128. **Caregiver Assistance Contact Information**: If the caregiver has someone to assist in providing care, ask whether you have her/his permission to contact this person if for some reason the caregiver is unable to provide care for the client ("No" or "Yes"). If the response is "No," skip a-d. If the caregiver gives her/his permission ("Yes"), record the contact information: a. First name, b. Last name, c. Phone number, and d. Relationship to the client ("Wife," "Husband," "Partner," "Parent," "Son/In-law," "Daughter/In-law," "Other relative," or "Other Non-relative").


129. How long have you been providing care for this client?

☐ Less than six months ☐ Six to twelve months ☐ One to two years ☐ Two or more years

130. How many hours per week do you currently spend providing care for the client? #_____

131. Do you need training or assistance in performing caregiving tasks? ☐ No ☐ Yes, *please describe*:

_____

129. **Length of Time as Caregiver**: Indicate how long the caregiver has been providing care for this client ("Less than 6 months," "6 to 12 months," "1 to 2 years," or "2 or more years"). The likelihood of caregiver burn out may be able to be determined by how long the caregiver has been caring for this client. If the caregiver previously cared for another client long-term, that should be noted in the case narrative for this visit.

130. **Hours per Week as Caregiver**: Note the number of hours per week that the caregiver currently spends providing care for the client in the space provided.

131. **Training or Assistance**: Indicate if the caregiver thinks they would benefit from additional training or assistance in performing their caregiving tasks ("No" or "Yes"). If "Yes," describe the type of training or assistance the caregiver would be interested in on the line provided.

The availability, cost, variety, and schedule of training opportunities varies widely throughout different areas of the state. Additional research may be needed to identify local resources.

132. How much of a mental or emotional strain is it on you to provide care for the client?
☐ None ☐ Some strain ☐ A lot of strain

132. **Strain on Caregiver**: Ask the caregiver how much of a mental or emotional strain caring for the client places on her/him and mark the appropriate response ("None," "Some Strain," or "A lot of strain"). There are numerous OAA resources available through the ADRC to refer caregivers that answer "Some Strain" or "A lot of strain" to, as appropriate.

133. Considering other aspects of your life, please rate the level of difficulty in your:	No difficulty	Little difficulty	Some difficulty	Moderate difficulty	A lot of difficulty
a. Relationship with client	☐	☐	☐	☐	☐
b. Relationship with family	☐	☐	☐	☐	☐
c. Relationships with friends	☐	☐	☐	☐	☐
d. Physical health	☐	☐	☐	☐	☐
e. Finances	☐	☐	☐	☐	☐
f. Functional abilities	☐	☐	☐	☐	☐
g. Employment	☐	☐	☐	☐	☐
h. Time for yourself to do the things you enjoy	☐	☐	☐	☐	☐

133. **Caregiver Difficulties**: Ask the caregiver to rate the level of difficulty they have with the eight items listed (a through h) on a scale of "No difficulty," "Little difficulty," "Some difficulty," "Moderate difficulty," or "A lot of difficulty:"

a. "Relationship with client" – Since they began caregiving, have they experienced any difficulties in their relationship with the client?

b. "Relationship with family" – Has caregiving impaired their relationships with their family?

c. "Relationships with friends" – Have caregiving responsibilities prevented socialization with their friends?

d. "Physical health" – Has caregiving negatively affected their physical health?

e. "Finances" – Has caregiving caused difficulties in paying their bills or managing their finances?

f. "Functional abilities" – Has caregiving affected their ability to function? Have they had difficulties managing their own life?

g. "Employment" – If the caregiver does not work, the response should be based on whether they want/need to work but do not as a result of their caregiving demands. If the caregiver does work, the response will be based on the impact their caregiving has on performing their job-related duties.

h. "Time for yourself, to do the things you enjoy" – Has caregiving interfered with their personal time and hobbies, etc.?

134. How confident are you that you will have the ability to continue to provide care?
☐ Very confident *(Skip to 135)* ☐ Somewhat confident *(Skip to 135)* ☐ Not very confident

a. What is the main reason you may be unable to continue to provide care? _____

_____

_____

_____

135. **Assessor/CM: Is the caregiver in crisis?** ☐ No ☐ Yes; *check all that apply:*
☐ Financial ☐ Emotional ☐ Physical

136. Ask the caregiver to answer the following about the client. (An answer of "Yes, a change" indicates that there has been a change in the last year caused by thinking and memory problems.)	Yes, a change	No change	Don't know or N/A
a. Problems with judgment (problems making decisions, bad financial decisions, problems with thinking)	☐	☐	☐
b. Less interest in hobbies/activities	☐	☐	☐
c. Repeats the same things over and over (questions, stories, or statements)	☐	☐	☐
d. Trouble learning how to use a tool, appliance, or gadget (TV, radio, microwave, remote control)	☐	☐	☐
e. Forgets the correct month or year	☐	☐	☐
f. Trouble handling complicated financial affairs (balancing checkbook, income taxes, paying bills)	☐	☐	☐
g. Trouble remembering appointments	☐	☐	☐
h. Daily problems with thinking or memory	☐	☐	☐

134. **Confidence in Ability for Continued Care**: Indicate how confident the caregiver is that s/he will have the ability to continue to provide care for the client ("Very confident," "Somewhat confident," or "Not very confident"). If the response is "Very confident" or "Somewhat confident," skip question a. If the caregiver is "not very confident" in her/his ability to continue providing care, ask question a.

a. **Reason for Lack of Continued Care**: Detail the main reason why the caregiver may be unable to continue to provide care for the client in the space provided.

135. **Assessor/Case Manager: Is the Caregiver in Crisis?**: Indicate your evaluation of the primary caregiver's ability and/or willingness to continue to provide the care needed by the client. They may be unable and/or unwilling due to their own limitations and/or those of the client. The crisis may already be in effect or may be quickly approaching. If you determine the primary caregiver to be in crisis, mark "Yes" and note if that crisis is for a "Financial," "Emotional," and/or "Physical" reason, or some combination of these.

136. **Caregiver Perceptions of Changes in Client Memory**: This screening tool is based on the AD8 and has been validated against a clinical diagnosis for dementia. Ask the caregiver to answer questions a-h about the client, providing instruction that an answer of "Yes, a change" indicates that the caregiver has noticed a change in the last year in the client's thinking or memory function. If the caregiver does not know if there has been a change, or if they do not know how to answer an item, mark "N/A." If the client's thinking or memory has improved, mark "N/A."

The AD8 is an 8-item questionnaire that is designed to detect dementia. It is considered a strong instrument for self-administration or informant-based assessment. Used in this instance, the AD8 is a tool for use with an informant (usually a spouse, child, or non-family caregiver) to assess whether they have noticed changes in certain areas of the client's cognition and functioning. The AD8 is quite sensitive to detecting early cognitive changes associated with many common illnesses, including Alzheimer's disease, vascular dementia, Lewy body dementia, and frontotemporal dementia. However, if a client has been experiencing memory loss symptoms, they will need to see a physician for a diagnosis.

701D INSTRUCTIONS ATTACHMENT A:

Social Security Number Handout

WHY ARE WE COLLECTING YOUR SOCIAL SECURITY NUMBER?

We are required to explain that your Social Security number is being collected pursuant to Title 42 Code of Federal Regulations, Section 435.910, to be used for screening and referral to programs or services that may be appropriate for you.

The provision of your Social Security number is voluntary, and your information will remain confidential and protected under penalty of law. We will not use or give out your Social Security number for any other reason unless you have signed a separate consent form that releases us to do so.

701D INSTRUCTIONS ATTACHMENT B:

HCE Safety & Accessibility Worksheet

OPTIONAL HCE SAFETY AND ACCESSIBILITY WORKSHEET:

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Structure of Home, Floors—Overall Risk				
Exposed Wiring				
Creaking or uneven floors				
Ceilings with water marks				
Doors open with difficulty				
Windows cannot be opened				
Outside structure appears to be leaning				

Questions and Responses:

1. How old is your home?

Response: _____

2. Have you or your caregiver consulted anyone about problems with the structure of the home?

Response: _____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Access—Overall Risk				
Client lives above the 1st floor of the building				
Client lives above the 1st floor of the building with no elevator				
Client has limited/deteriorating mobility				
Client lives in 2-story home with bedrooms upstairs				
Client cannot climb stairs				
Client uses a wheelchair for mobility				
Entrance to the home has steps				
Doorways are too narrow, rooms to small to safely maneuver				

Question and Response:

1. If the client uses a wheelchair for mobility, ask how he/she is able to maneuver within and in and out of the home?

Response:

_____

_____

_____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Electrical System—Overall Risk				
Electrical cords are frayed				
Extension cords are overused				
Electric plugs are partially hanging out of the wall				
The wiring in the home is poor				

Questions and Responses:

1. Have you or your caregiver ever been shocked trying to plug or unplug anything?
Response: _____

2. Do you have to change fuses frequently?
Response: _____

3. Has your electric bill increased significantly even though you are not using more appliances?
Response: _____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Fire Safety—Overall Risk				
Wall-to-wall clutter				
Client and/or caregiver smoke				
No smoke alarms or alarms do not work (no batteries)				
Use of non-vented space heater				
Fireplace used without a screen guard				

Questions and Responses:

1. Have you or your caregiver ever fallen asleep while smoking?
Response: _____

2. Do you or your caregiver forget food cooking on the stove on in the oven?
Response: _____

3. Do you have a fire extinguisher and do you know how to use it?
Response: _____

4. Have you checked the smoke alarm and changed the batteries lately?
Response: _____

5. Do you use a timer to set when using the oven or toaster over?
Response: _____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Sanitation—Overall Risk				
Unpleasant odor in the house				
House is unclean				
Bathrooms are unclean and odorous				
Furniture/carpet are soiled				
Evidence of pest or pest's droppings in the house				
Evidence of dead pest odor				
Evidence of pet odor				

Questions and Responses:

1. Do you have pest control service?
Response: _____

2. Do you have pests in the house such as roaches, rats or mice?
Response: _____

3. Do you use sprays or tablets for control?
Response: _____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Hot Water/Water—Overall Risk				
Evidence of excessive amounts of dirty dishes from lack of water				
Client is unkempt, unclean and has body odor				
Client's clothing is unclean				

Questions and Responses:

1. Do you have running water?
Response: _____

2. Do you have hot water?
Response: _____

Additional Comments:

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Heating/Air Conditioning—Overall Risk				
Temperature in the house is too warm or cold				
Room is stuffy even with air conditioner on				

Questions and Responses:

1. How do you keep warm in the winter?
Response: _____

2. Do you have a central air and heating system? Does it work adequately?
Response: _____

3. Do you have to unplug another appliance to run a space heater or air conditioner?
Response: _____

4. Do you sleep with a space heater on at night?
Response: _____

5. Does the heat bother you in the warm months?
Response: _____

6. Why don't you run your air conditioner?
Response: _____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Shopping Accessibility—Overall Risk				
Evidence of little or no food in cabinets/pantry/refrigerator				
Evidence of prescriptions not filled				

Questions and Responses:

1. How do you do your shopping/errands?
Response: _____

2. When was your last trip to the grocery store?
Response: _____

3. Can you afford to pay someone to do your shopping and pick up your prescriptions?
Response: _____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Transportation Accessibility—Overall Risk				
Client is unable to get to local transportation pickup				
Client does not drive or have anyone who can drive him/her.				
Caregiver does not drive				

Questions and Responses:

1. How do you and your caregiver get to stores to shop, run errands?
Response: _____

2. Is transportation available from other local agencies?
Response: _____

3. Are you able to get on a bus?
Response: _____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Telephone Accessibility—Overall Risk				
No telephone is visible				
No phone number is listed on the referral				

Questions and Responses:

1. Are you able to afford a telephone?
Response: _____

2. Is the client able to use the telephone?
Response: _____

3. Are you able to use a neighbor or friend's phone?
Response: _____

4. How can I reach you or you reach me when necessary?
Response: _____

5. How do you get help in an emergency?
Response: _____

6. May I contact your family to discuss the possibility of getting you a telephone?
Response: _____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Emergency Evacuation Capability—Overall Risk				
The doors and windows are boarded up, nailed shut, covered with burglar bars or otherwise will not open.				
The client is unable to walk, transfer to a wheelchair, open doors or manage stairs, making evacuation attempts impossible				
Exit access is obstructive (clutter, furniture, etc.)				
Client's bedroom does not have two means of unobstructed exit				

Questions and Responses:

1. Do you feel that you could evacuate the home safely in an emergency?

Response: _____

2. Can you describe what you would do in case of an emergency?

Response: _____

3. Would the caregiver be able to get both himself/herself and the client out of the home in the case of an emergency?

Response: _____

Additional Comments:

AAA/CME _____
Assessor Name
_____
Assessor Phone
_____

Kansas Department for Aging and Disability Services

Uniform Assessment Instrument

Disaster Red Flag		
	Electric	
	Physical Impairment	
	Medication Assist	
	Cognitive/MH issues	
	No Informal Support	
	None	

Assessment Date :

Expedited Services : Yes _____ No _____

Customer Legal Name & Address: Nickname _____

First _____ M.I. _____

Last _____

Residence Address _____

City _____

County _____ State _____ Zip _____

Phone _____

Directions _____

_____

.....

Mailing or Alternative Address

Street _____

City _____

County _____ State _____ Zip _____

Phone _____

Birth Date _____ / _____ / _____
month day year

Age _____ Male ____ Female ____

Marital Status: Single ____ Married ____
Widowed ____ Divorced ____

Veteran or Spouse of Veteran? Yes ___ No ___

Receive Veteran Benefits? Yes ___ No ___

Income below poverty level? Yes ____ No ____

Does Customer live alone? Yes ____ No ____

Customer's home is: Rural ____ Urban ____

Ethnicity: Hispanic or Latino ____
Not Hispanic or Latino ____
Ethnicity Missing ____

Race:	
White Non-Hispanic	
White Hispanic	
American Indian/Alaskan Native	
Asian	
Black or African American	
Native Hawaiian or Other Pacific Islander	
Reporting some other race	
Reporting 2 or more races	

Social Security # _____

Medicaid # _____

Medicare # _____

KAMIS ID # _____

Primary Language	Speaks	Reads	Understands Orally
English			
German			
Spanish			
Sign			
Other:			

Does Customer have any difficulty :	
Communicating	
Understanding information	

Emergency or alternative contact: Relationship _____

Name _____

Address _____

City _____

State _____ Zip _____

Phone (primary) _____

Phone (alternate) _____

Legal Guardian: Relationship _____

Name _____

Address _____

City _____

State _____ Zip _____

Phone (primary) _____

Phone (alternate) _____

Comments:_____

_____

_____

KDOA Form SS-005 Revised 7/01/10

Customer Name _____ Date _____

Uniform Assessment Instrument Scoring		**Long-term Care Threshold Guide**					
Definition of Code for Cognition	Code	Multiplier for Threshold Guide					
No impairment	0	0					
Impairment	1	1					
Unable to test	9	0					
Cognition	Cog. Code	Multiplier	X	Weight	=	Total	Sum of Cog. scores
Orientation (day of the week, month, year, President)			X	2	=		
3-word recall (pen, car, watch)			X	2	=		
Spelling backward (table)			X	2	=		
Clock Draw (all #'s, spacing of #'s, hands at 11:10)			X	2	=		
Definition of Code for ADL/IADL	Code	Multiplier for Threshold Guide					
Independent	1	0					
Supervision Needed	2	1					
Physical Assistance Needed	3	1					
Unable to Perform	4	2					
Activities of Daily Living	ADL Code	Multiplier	X	Weight	=	Total	Sum of ADL scores
Bathing			X	4	=		
Dressing			X	3	=		
Toileting			X	5	=		
Transferring			X	5	=		
Walking, Mobility			X	3	=		
Eating			X	4	=		
Instrumental Activities of Daily Living	IADL Code	Multiplier	X	Weight	=	Total	Sum of IADL scores
Meal Preparation			X	5	=		
Shopping			X	3	=		
Money Management			X	4	=		
Transportation			X	3	=		
Telephone			X	3	=		
Laundry, Housekeeping			X	3	=		
Medication Management, Treatment			X	5	=		
RISKS: Current or Recent Problems (check all that apply)	Risk Code	Multiplier	X	Weight	=	Total	Sum of RISKS scores
Falls (Last 1 month _____) (Last 6 month total _____)		1	X	3	=		
Neglect ☐ abuse ☐ and/or exploitation ☐ by others		1	X	5	=		
Informal Support – check appropriate choice		If customer has difficulty in the informal support category, enter 4 at total:					
Yes – there is support *(do not multiply out)*							
Inadequate		Multiplier	X	Weight	=	Total	
No – there is no support		1	X	4	=		
Behavior - check the appropriate choice(s) if any difficulty		If customer has difficult in any behavior category, enter 5 at total:					
Wandering		Multiplier	X	Weight	=	Total	
Socially Inappropriate/Disruptive		1	X	5	=		
Decision Making/Judgment							
Total Score of all Cognition, ADL, IADL and RISKS for Threshold Guide =							

Was this person on HCBS-FE prior to 7-1-00? Yes ☐ No ☐ Is this a HCBS-PD transfer customer? Yes ☐ No ☐

Comments : _____

KDOA Form SS-005 05/01/2006

Customer Name _____ Date _____

Ask the customer the following questions

Nutrition Risk Screen	Comments	Score-if yes, circle
Do you eat less than 2 meals daily?		3
Do you eat less than 2 servings of fruits and vegetables daily?		1
Do you eat less than 2 servings of dairy products (milk, cheese, yogurt, etc.) daily?		1
Do you usually drink less than 6 glasses of water, milk, or juice daily?	# of glasses:	0
Do you drink 3 or more alcoholic beverages daily?		2
Do you take 3 or more different prescriptions and/or over-the-counter drugs daily?		1
Do you have problems with dentures, teeth, or mouth, which make it hard to eat?	Which:	2
Have you made changes in the kind and/or amount of food you eat because of an illness and/or condition?	What changes:	2
Are you physically not always able to grocery shop, cook, and/or feed yourself?	Which:	2
Do you eat alone most of the time?		1
Do you feel that you usually do not have enough money to buy the food you need?		4
Have you gained or lost more than 10 pounds in the last 6 months?	Pounds gained ____ lost ____	2
Customer does not meet any of the nutrition risk screen indicators.		0
	Add all the circled scores for a total Nutrition Risk Score	

Would you say that your appetite is:		Do any of the following cause you problems or affect your ability to eat:	
Good		Swallowing	
Fair		Taste	
Poor		Nausea, vomiting	
Comments: _____		Cutting up food	
		Opening containers (milk, plastic wrap, jars)	
		Certain foods, food allergy (specify):	
		No concerns	

How often do you:	Rarely 1 x week	Sometimes 2 x week	Frequently 4-5 x week	Never
Skip meals and just snack, “piece”, through the day?				
Lack the energy or desire to fix a meal?				
Find you don’t know what to fix or can’t fix small portions?				
Forget to turn the stove off or burn food?				
Lack the desire to eat a meal?				
Eat restaurant or fast food?				
Leave home? If not, why?				

What do you eat in a typical day (ask about "breakfast", "lunch", "supper"), describe: _____

Comments (include any special considerations for service delivery such as pets, or "go to back door"): _____

Customer Name _____ Date _____

Ask the customer:
Does anyone help you prepare food or bring food to you? Yes ☐ No ☐ If yes, answer the following:

Who	What	When

Ask the customer:
Are you following any modified diet(s)? Yes ☐ No ☐

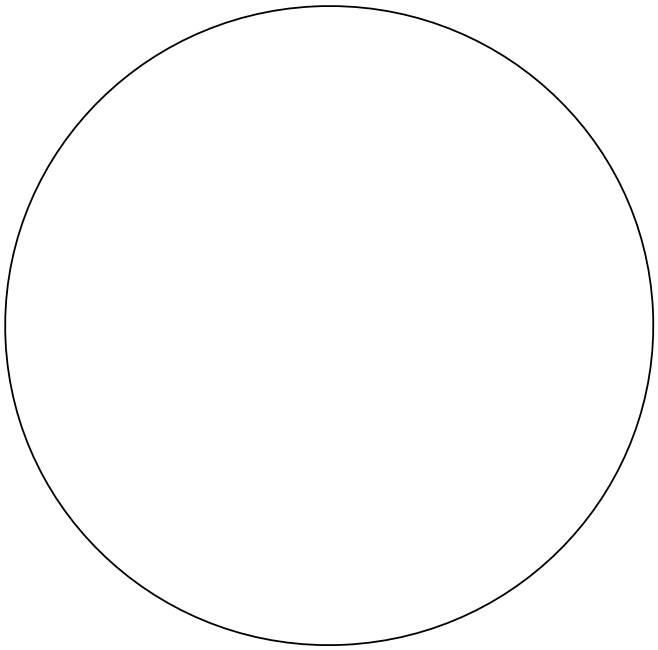
Are any of the modified diets doctor prescribed? Yes ☐ No ☐

Check each modified diet followed:		Check if doctor prescribed and indicate the name of the doctor:	
Low sodium (salt)			
Low sugar			
Low fat/cholesterol			
Renal			
Calorie controlled			
Nutrition supplements			
6 small meals daily			
Vegetarian			
Pureed			
Ethnic/religious			
Other:			

Assessor: Is the customer:	Yes	No
Physically homebound		
Socially homebound		
Isolated		

Participant Status - Home-delivered Meals	
60+ eligible Person	
Spouse, regardless of age, of 60+ eligible Person	
Disabled Person, regardless of age, residing with 60+ eligible Person	
60+ non-spouse Caretaker (IIIB home-delivered meals only)	

Clock Draw



KDOA Form SS-005 (Revised 04/01/09)

Customer Name _____ Date _____

Primary Diagnosis _____

Source of Information: Customer ☐ Record Review ☐ Other ☐

Customer: Overall, how do you rate your health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Check Health Conditions as Applicable

CARDIOVASCULAR		INFECTIOUS DISEASE		RESPIRATORY	
Ankle edema		Airborne		Asthma	
By-pass surgery/Angioplasty		Hepatitis		COPD	
Chest pain		Tuberculosis		Cough (dry/productive)	
Circulation problems		Other		Difficulty breathing at any time	
Congestive heart failure		No problem		Emphysema	
Heart attack				Oxygen	
Hypertension		**MUSCULOSKELTAL**		Other	
Hypotension		Amputation of:		No problem	
Pacemaker		Arthritis-rheumatoid or osteo			
Shortness of breath		Back pain		SKIN	
Other		Contractures		Pressure/other ulcer	
No problem		Fracture of:		Rashes	
		Joint replacement of:		Shingles	
ENDOCRINE		Osteoporosis		Stasis dermatitis	
Diabetes		Polio/Post Polio		Other	
Thyroid		Other		No problem	
Other		No problem			
No problem				VISION	
		NEUROLOGICAL		Blind	
GASTROINTESTINAL		Alzheimer's disease		Blurred vision	
Abdominal pain		Cerebral Palsy		Cataracts	
Colitis		CVA/stroke		Corrective lenses	
Constipation		Dementia		Glaucoma	
Diarrhea		Dizziness		Macular degeneration	
Difficulty swallowing		Paralysis of:		Other	
Diverticular disease		Parkinson's Disease		No problem	
Frequent use of laxatives		Seizures/epilepsy			
Gall bladder problems		Speech problem		OTHER	
Indigestion		Transient Ischemic Attack		Alcohol use	
Irritable bowel syndrome		Traumatic brain injury		Alcoholism	
Ulcers		Other		Allergies	
Other		No problem		Anemia	
No problem				Autism	
		REPRODUCTIVE SYSTEM		Cancer	
GENITOURINARY		Enlarged prostate		Developmental disability	
Dialysis		Lumps-breast/node(male, female)		Drug use/abuse	
Difficulty/frequent urination		Mastectomy of:		Mental illness	
Dribbling and/or incontinence		Nipple discharge (male, female)		Mental retardation	
Frequent bladder infections		Prostate cancer		Tobacco use	
Nighttime urination/Nocturia		Vaginal discharge		Obesity	
Other		Other		Significant weight loss/gain	
No problem		No problem		Other	
				No problem	
HEARING					
Deaf		**COMMENTS:**			
Decreased acuity					
Earaches					
Hearing aid					
Other					
No problem					

KDOA Form SS-005 10/1/99

UAI – Page 6 – Health

Customer Name _____ Date _____

Prescription, Over-the-counter, & Herbal Medications/Preparations	Dosage	Frequency	Does the customer know the purpose of the medication? Yes	No	How does the customer remember to take medications? (check all that apply)	
					Calendar	
					Person reminds/gives	
					Egg carton/envelope	
					Pill box or dispenser	
					Follow label directions	
					Other:	
					Other:	
					If set-up, reminded, or given by another, by whom? How often?	

Does the customer have any drug sensitivities? Yes ☐ No ☐ If yes, what: _____

Assessor: Do you have any concerns regarding use of medication or drugs by the customer? Yes ☐ No ☐ If yes, what concerns: _____

Ask the customer the following questions:	Yes	If yes, then ask:	No
Do you have a "Durable Power of Attorney for Health Care Decisions"?		Who?	
Do you have a "Living Will"?		Where?	
Do you have "Do Not Resuscitate" orders?		Where?	
Do you see a doctor regularly?		How often?	
Have you been hospitalized or to the emergency room in the last three months?		How many times?	
Have you been admitted to a nursing home within the last twelve months?		How many times?	

Comments: _____

SPECIAL EQUIPMENT/ASSISTIVE DEVICES (check all that apply)

	Uses	Needs		Uses	Needs
Adaptive eating equipment			Medical phone alert		
Bathing equipment			Ramps (example – wheelchair)		
Brace (leg, back), prosthesis			Supplies (example – incontinence pads)		
Cane, crutches			Toilet equipment		
Dentures			Transfer equipment		
Diabetic supplies			Walker		
Glasses, contact lenses			Wheelchair (manual, electric)		
Hearing aid(s)			Other:		
Hospital bed			Other:		

KDOA Form SS-005 10/1/99

Customer Name _____ Date _____

Assessor: Ask the customer how he/she has been feeling during the past 4 weeks. For each question, please mark the level that best describes how often she/he had this feeling.

In the last 4 weeks, about how often did you feel….	All of the time (4 pts)	Most of the time (3 pts)	Some of the time (2 pts)	A little of the time (1 pt)	None of the time (0 pt)	Don't know (0 pt)	Refused (0 pt)
… so sad that nothing could cheer you up?							
… nervous?							
… restless or fidgety?							
… hopeless?							
… everything was an effort? (If necessary, for question *e.g.,* prompt: How often did you feel everything was hard and difficult to do?)							
… worthless?							
(Score 13 or higher, offer a referral for your customer)					Total Score		

In the past 4 weeks, how many times have you seen a doctor or other health professional about these feelings?

No visits reported_____ Number of visits _____ Don't know _____ Refused _____

Comments:_____

Ask the customer:
Have there been any major changes, or disruptions in your life that you would like to talk about?
Yes ☐ No ☐ If yes, what: _____

Do any items checked on this page adversely effect:

Customer	
Caregiver	
Other	
No concerns	

Explain: _____

Does the customer have a primary caregiver?
Yes ☐ No ☐
If yes, name: _____

Is the primary caregiver overwhelmed in providing care?
Yes ☐ No ☐ If yes, explain in comments.

Comments:_____

Medical Personnel	Phone
Doctor:	
Pharmacy:	
Home Health:	
Hospital:	

Assessor: Are you making or recommending any referrals to (check all that apply):

Mental health services	
Adult Protective Services	
Community Developmental Disability Org.	
Medical/Home Health	
Other:	
Other:	
Other:	

Comments:_____

Customer Name _____ Date _____

Place of Residence:		Residence Is:		Does the customer have any difficulty getting into their home or any room in their home (check all that apply):	
Apartment, condominium		Government subsidized		Basement	
Assisted living		On Reservation		Bathing facility, bathtub	
Boarding care home		Owned, with payment		Bedroom	
Duplex		Owned, no payment		Entrances	
Home Plus		Rented		Garage	
Homeless		Rent free from _____		Kitchen	
House, townhouse		Other		Laundry area	
Mobile home		Comments:		Living, family room	
Nursing home				Porch	
Residential health care				Toilet facility	
Other				No difficulty	
Comments:				Comments:	

Does the customer's home have:	Working	Not working	Does not have
Air conditioner, fan			
Electricity			
Flush toilet			
Gas, propane			
Heating system			
Microwave			
Piped water, hot/cold			
Radio, television			
Refrigerator, freezer			
Smoke detector			
Stove, hot plate, oven			
Telephone			
Tub, shower			
Washer			
Dryer			

Comments:

Customer: Do you feel safe	Yes	No
inside your home		
outside your home		
Is there anything inside or outside your home that you are worried or uncomfortable about?		

Explain if the customer does not feel safe or if they have additional concerns: _____

Does the home have health or physical safety issues (check all that apply):	
Animals, pets	
Dirt, garbage	
Furnishings, rugs	
House, basement	
Pests	
Poor lighting	
Stairs	
Yard, storage buildings	
Other	
No problems	
Comments:	

Recommended changes to the customer's environment and/or situation (check all that apply):	
Bathroom modification	
Accessibility modification	
Weatherization	
Other:	
Other:	
No recommendations	

Referrals: _____

Are there special considerations for service delivery such as smoking, pets, or "go to the back door"? Explain: _____

KDOA Form SS-005 10/1/99

Customer Name _____ Date _____

Family Size ☐ (Family will include customer, spouse, and minor children living together.)

MONTHLY GROSS INCOME

Type of Income	Customer	Spouse	Minor Child	Total	Comments (note benefit numbers)
Social Security (SSA)					
Social Security Disability (SSD)					
Supplemental Security Income (SSI)					
Retirement pension					
Veteran pension					
Gross earnings from employment, self-employment					
Income from property					
Farm income (adjusted net income)					
Interest, dividends					
Coop dividends, royalties, etc.					
Regular support from family/others					
Cash from SRS					
Other					
Other					
Monthly Total Income (Remember to check poverty level on page 1)					

Percent of customer responsibility for co-pay program:

SCA _____ %

IE _____ %

Other _____ %

Name/address if bill for co-pay is to be sent to someone other than customer:

_____

_____

_____

Customer: Do you need legal assistance? Yes ☐ No ☐

Customer: Do you want a referral for SRS assistance?

Financial: Yes ☐ No ☐ Already received ☐

Medical: Yes ☐ No ☐ Already received ☐

Food Stamps: Yes ☐ No ☐ Already received ☐

EES Specialist: _____

Supplemental Insurance:

Company _____

Policy # _____

Premium amount $ _____

Designated person for financial matters: Self ☐ Other ☐

Durable Power of Attorney ☐ Conservator ☐

Relationship _____

Name _____

Address _____

City _____

State _____ Zip _____

Phone, home _____

Phone, work _____

Comments: _____

_____

_____

_____

_____

KDOA Form SS-005 10/1/99

Customer Name _____ Date _____

(1) Does the customer have liquid assets such as Cash (deposited or not), Certificates of Deposit (CD), Stocks or Bonds in excess of the following (If unsure complete item #2 below):

$10,001 for a 1 Person Family
$13,501 for a 2 Person Family
$17,001 for a 3 Person Family
$20,501 for a 4 Person Family (Exempt $3,500 for each additional person)

_____ Yes. Proceed to question 2.
_____ No. Stop, you do not need to proceed.
_____ Refused to provide income or asset information.

(2) Identify the approximate value for each of the following described assets.

+_____ Checking/Cash on Hand
+_____ Savings
+_____ Bonds
+_____ Certificates of Deposit (CD)
+_____ Individual Retirement Account (IRA)
+_____ Life Insurance (Cash Value)
+_____ Money Market
+_____ Mutual Funds
+_____ Savings Bonds
+_____ Stocks

Name of Stock (Name not entered in KAMIS)	# of shares	x	Last sale value	=	Stock Value
		X		=	
		X		=	
		X		=	
		X		=	

Total Stock Value _____
(enter this value on stocks)

==========

_____ Total Gross Liquid Assets

(3) Match the customer's monthly income (page 9) and gross liquid assets (page 9 Supplemental) to the SCA sliding fee scale to determine the percentage the customer is required to pay for monthly services.

_____ Total % of monthly customer responsibility.
(Record on Page 9 of the UAI)

HCBS/FE EXPEDITED SERVICE DELIVERY FINANCIAL SCREENING WORKSHEET

Customer Name: _____ **Soc. Sec. #:** _____

(1) Does the customer want HCBS?	☐ Yes, move to next question	☐ No, stop process
(2) Does the customer still plan to apply for Medicaid after Estate Recovery is explained to the customer or their legal representative?	☐ Yes, move to next question	☐ No, stop process ☐ Already has Medicaid, move to next question
(3) Is the customer already eligible for SSI?	☐ No, move to next question	☐ Yes, move to next question
(4) Is the customer already eligible for Medicaid?	☐ No, move to next question	☐ Yes, move to next question

Question	**(A) Continue If Checked**	**(B) Stop, do not Expedite**	**Section on Med. App. ES-3100.1**
(5) Is the customer a U.S. citizen and a resident of Kansas?	☐ Yes	☐ No	Section B, p. 2 and B, p. 1
(6) *From Resource Table at bottom of page:* Are the customer's total resources less than $2,000? If the customer has community spouse, are the couple's resources less than or equal to $20,328?	☐ Yes	☐ No	Section I, p. 6, 7
(7) Does the customer or spouse have a trust fund or an annuity?	☐ No	☐ Yes	Section I, p. 7
(8) Does the customer or spouse have a life estate in property?	☐ No	☐ Yes	Section I, p. 7
(9) Has the customer or spouse transferred property within last 5 years?	☐ No	☐ Yes	Section I, p. 7, 8
(10) Does the customer have a monthly income of less than $747?	☐ Yes	☐ No	Section J & K, p. 8, 9
(11) Is the customer or spouse self-employed (includes farming)?	☐ No	☐ Yes	Section J, p. 8
(12) Is the customer's monthly POC amount less than $4,000?	☐ Yes	☐ No	UAI p. 10
(13) Does the customer require over the maximum ADL/IADL time limits?	☐ No	☐ Yes	FSM 3.5 Appendix I
EXPEDITE DECISION	If all of the above in (A) are checked, expedite services for this customer.	If at least one of the above in (B) is checked, do not expedite services for this customer.	EXPEDITE? ☐ Yes ☐ No

Resource Table (Source Section I, p. 6, 7, 8)	**Value**
Checking Account	$
Savings Account	$
Stocks & Bonds	$
Funeral Plan or Burial Plan • Up to $5000/person on an irrevocable plan is exempt plus an additional amount for merchandise, enter non-exempt amount.	$
Burial Plots	exempt
Automobiles or other vehicles (Exclude one)	$
Life Insurance (exclude term insurance) • Add together the face value of all policies. If the total is less than or equal to $1,500 they are exempt. If the total is greater than $1,500, enter the total of the cash values.	$
Home(s) • If the customer owns a home and resides in it, it is exempt. Enter zero. • If the customer owns a home but does not reside in it, do they intend to return home? ❖ If yes, enter zero. ❖ If no, is there a spouse or dependent child living there? ○ If yes, enter zero. ○ If no, enter value of non-exempt home.	$
Other property (land, buildings)	$
Other assets (cash, trailers, boats, oil/mineral rights, NF personal fund account)	$
Total Resources	$

UAI – Page 10 – Plan of Care/Support Services

Customer _____ Address _____ Phone # _____

Medicaid # _____ KAMIS ID # _____ Other agency identifier _____

Emergency Contact _____ Relationship _____ Phone: home _____ work _____

AAA/ CME	Service Code	Funding Source	Provider	Unit(s)	Per	Total Units Monthly	Start Date	End Date	Dis-charge Code	Cost of Unit	Customer Obligation/ Copay	Monthly Cost

Unmet Need Service Code, Availability Code, Monthly Number of Units						SCA total cost including customer copay:	HCBS/FE monthly costs including customer obligation: (HCBS amount must be reported to EES Specialist) +
Service Code	Availa-bility	Units	Service Code	Availa-bility	Units		Medicaid Average Acute Care Cost: =
						OAA total cost:	HCBS/FE Total Cost:
						Total customer obligation/copay:	

Release of Information: I consent to the release of the information on this page so I can receive services. I understand the information included in these pages 1-10 will be released to Kansas Department for Aging and Disability Services and service providers listed above to enable the delivery of services and program monitoring.

_____ _____ _____

Customer or Guardian Signature | Date | Assessor Signature & Phone #

_____ _____ _____

Customer or Guardian Signature | Date | Assessor Signature & Phone #

Additional Support/Services from Home Health, Family, Friend, Neighbor, Attorney, Landlord, Church, Club, Other

Name	Relationship (check if primary caregiver)		Address (indicate "same" if lives with customer)	Phone		Service	Frequency	Paid	
				Home	Work			Yes	No

Lieutenant Governor's Office on Aging Assessment/Re-Assessment

☐ New Client ☐ Annual Reassessment ☐ Significant Change in Condition

Initial Contact Date: _____ Status: _____

Unique ID#: _____ Assessment Score: _____

B: _____/_____/_____ ☐ Refused Nutrition Score: _____

Client Type: ☐ Client/Care Receiver ☐ Caregiver Target Score: _____

County: _____ Region#: _____ Caregiver Score: _____

Individual Intake Information

Last Name: _____

First Name: _____ Middle Name: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Emergency Contact Information

E Contact Name: _____ E Relationship: _____

E Contact Phone: (___) _____ E Cell Phone: (___) _____ E e-mail: _____

Physical Address: _____

Apt, Lot, Box: _____

City: _____ State: SC Zip: _____

Mailing Address If Different: _____

City: _____ State: SC Zip: _____

Race: (check one) ☐ Refused

- ☐ African American/Black
- ☐ American Indian/Alaskan
- ☐ Asian
- ☐ Hawaiian/Pacific Islander
- ☐ White
- ☐ Some Other Race
- ☐ 2 or more Races
- ☐ Race Missing

Ethnicity: (check one)

- ☐ Hispanic/Latino
- ☐ Non-Hispanic or Non-atino
- ☐ Unknown
- ☐ Refused

Monthly Family Household Income
(Client, Spouse, Dep. Child)

☐ Refused

$_____ Job
$_____ SS
$_____ SSI
$_____ VA
$_____ Pension
$_____ Other

$_____
Total Family Household Income

Total # in HouseHold: #_____
(Client, Spouse, Dep Child) ☐ Refused

DOB Verification ☐ Marriage Certif
☐ Birth Certificate ☐ Verbal
☐ Driver's License ☐ None

Gender: ☐ M ☐ F ☐ Refused

Marital Status

- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Unknown
- ☐ Other

Monthly Expenses: (best estimate)

$_____ Food
$_____ Prescriptions
$_____ Medigap
$_____ Housing
$_____ Utilities
$_____ Phones
$_____ Other

$_____ Total Expenses

Limited English Proficiency: ☐ Yes ☐ No

Primary Language: _____

Client Name: _____ Uniq ID#: _____

Special Eligibility: ☐ Spouse of Client ☐ Meal Volunteer ☐ Disabled < 60 ☐ Emergency ☐ Other
☐ None ☐ Waiver ☐ < = 18 child ☐ ADRD < 60

Home Comments: (Viewable by all users)

_____

_____

_____

Other Information Comments (Directions, Dog, Smoker, Do not go alone, etc): (Viewable by all users)

_____

_____

_____

_____

Assess Date: _____ Assessment Method: ☐ In Person ☐ By Phone

Spouse Name: _____ Primary Doctor: _____

Assessor: _____ Doctor Phone 1: _____

Operator: _____ Doctor Phone 2: _____

Services Requested: (check all that apply)

☐ IR&A	☐ Exercise
☐ Group Meal	☐ Nutrition Counseling
☐ Home Delivered Meal	☐ Nutrition Education
☐ In-Home Care	☐ Ombudsman
☐ Transportation	☐ Outreach
☐ Adult Day Care	☐ Respite
☐ Sitter Service	☐ Benefits Assistance
☐ Assisted Transportation	☐ Case Management
☐ Emergency Food	☐ Residential Maintenance
☐ Home Injury Prevention	☐ Prescriptions
☐ Financial Assistance	☐ Yard Maintenance
☐ Insurance Counseling	☐ Legal Assistance
☐ Sr. Center Activities	☐ Utility Assistance
☐ Dental	☐ Health Promotion
☐ Vision	☐ Medical Escort
☐ Hearing	☐ Housing

Client Referred by: (check one)

☐ Self	☐ Provider
☐ DSS	☐ CLTC
☐ AAA	☐ DDSN
☐ Friend	☐ Hospital
☐ Comm Base Org	☐ Doctor
☐ Family	☐ Home Health
☐ Nursing Home	☐ Other

In-Home Services Currently Receiving:
(check all that apply)

- ☐ CLTC
- ☐ Home Delivered Meal
- ☐ Home Health
- ☐ Homemaker
- ☐ Hospice
- ☐ Transportation
- ☐ VA
- ☐ None
- ☐ Other

IN THE EVENT OF A DISASTER (Required)

Will someone check on you during a disaster? Y or N

Do you have meds that need refrigeration? Y or N

Are you on Oxygen? Y or N

Will you need help during an emergency evacuation? Y or N

Type of Transportation Needed in an Evacuation:
(Check ONE)

☐ None	☐ Lift Accessible
☐ Regular	☐ Ambulance

OPTIONALS:

Education:
- ☐ <3rd grade
- ☐ 3rd- 8th grade
- ☐ Some HS
- ☐ HS Grad
- ☐ Some College
- ☐ College Grad

Locomotion:
- ☐ Needs assistance to go outside
- ☐ Unable to climb stairs
- ☐ Uses cane/walker/crutch
- ☐ Uses wheelchair on occasion
- ☐ Uses wheelchair all the time

Client Name: _____ Uniq ID#: _____

IADLS ☐ Refused	Independent	Needs Some Assistance	Dependent
Preparing Meals			
Microwave Use			
Light Housekeeping			
Heavy Housekeeping			
Telephone Use			
Money Management			
Shopping			
Medication Management			
Driving or using Public Transportation			

ADLS ☐ Refused	Independent	Assistive Technology Only (No Help)	Supervision and/or Coaching	Limited Assistance (Some Help)	Extensive Assistance	Total Dependence
Walking/Mobility						
Dressing						
Eating						
Toilet Use						
Transferring						
Bathing						
Personal Grooming						

Continence	Continent	Usually Continent	Occasionally Incontinent	Frequently Incontinent	Incontinent
Bladder Incontinence					
Bowel Incontinence					

Health and Safety Health Limitations Due to the Following(Check all that Apply)	Yes		Yes
Specific Diseases:		**Broad Health and Disability Categories:**	
Alzheimer's, Dementia and Related Disorders (ADRD)		Blood Diseases/Disorders	
Arthritis		Circulatory System/Heart Diseases/Disorders	
Diabetes		Cognitive Diseases/Disorders	
Kidney/Renal Disease/ESRD (End Stage Renal Disease)		Digestive System/Diseases/Disorders	
Cancer		Hearing/Ear Diseases/Disorders	
		Intellectual/Mental Disabilities	
		Mental Illness/Disorders	
		Neurological Diseases/Disorders	
		Physical Disabilities/Diseases/Disorders	
		Respiratory Diseases/Illnesses	
		Speech Disorders	
		Vision/Eye Diseases/Disorders	
		Other Disabilities/Diseases/Disorders	

Client Name: _____ Uniq ID#: _____

Health and Safety (Cont.) Risk Factors Part 1	(Quantity Range)	0	1	2	3-5	6-8	9+
Number of Daily Prescription Medications							
mber of Falls in the Past 6 Months							

Health and Safety (Cont.) Risk Factors Part 2 - Please answer the following Y/N (a Yes response = points)	Y/N
Do you have:	
Prescriptions from more than one Doctor?	
Prescriptions filled at more than one Pharmacy?	
Nutritional concerns as determined by a healthcare professional?	
Less than a 3 day supply of food on hand?	
Were you seen at the ER or admitted to a Hospital, Rehab Facility or NH in the last 6 months?	

Health and Safety (Cont.) Risk Factors Part 3					
Do you Live with? (All people in same Household)	An Independent Spouse/ Partner/Adult	1 or 2 Dependent Children <18	More than 2 Dependent Children	Dependent Adult/ Spouse/Partner	Live Alone
Where do you live?	Boarding Home/ Assisted Living/ Group Home	Rented Room or Apartment	Home	In a Shelter	Homeless
Transportation	Has Transportation	Needs Transportation	Needs Transportation and Escort	Needs Specialized Transport	

In the last 6 months have you: Y/N	Y/N
Missed a rent/mortgage payment because you did not have the money?	
Missed a utilities payment because you did not have the money?	
Gone without medication because you could not afford it?	
Gone without food because you could not afford it?	

Support					
How close is your nearest support person?	< 20 mi	20-30mi	31-50mi	51-99mi	100+mi
Do you:					**Y/N**
Have anyone you can call if you need help or assistance?					
Live 20 or more miles from the following:					**Y/N**
Shopping (grocery, clothes, personal care items, etc)					
Pharmacy					
Your doctor					
Hospital					
Have you ever been denied services based on where you live?					

Client Name: _____ Uniq ID#: _____

Nutritional Screening Y/N (a Yes response = points)	Y/N	Pts.	Score
Do you have an illness or condition that has made you change the kind or amount of food you eat?			
Do you eat fewer than 2 meals a day?			
Do you eat a few (or less) fruits or vegetables, or milk products?			
Do you have 3 or more drinks of beer, liquor, or wine almost every day?			
Do you have tooth or mouth problems that make it hard for you to eat?			
Do you sometimes not have enough money to buy the food you need?			
Do you eat alone most of the time?			
Do you take 3 or more different prescribed or over the counter drugs per day?			
Without wanting to, have you lost or gained 10 pounds within the last 6 months?			
Are you sometimes physically unable to shop, cook, or feed yourself?			

***REQUIRED QUESTIONS:** (Not Part of Priority Score. For Reporting Purposes)

***Homebound:** ☐ Yes ☐ No

An individual who resides at home, and maybe at risk for institutionalization, and is incapable of performing at least two or more activities of daily living (ADLs) without substantial/extensive assistance, and is unable to leave home unassisted. When the individual does leave home, it must be to receive medical care or for short, infrequent non-medical reasons.

***Living Alone:** ☐ Yes ☐ No

A one person household where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting.

General Comments: (View Restricted to Provider)

JUSTIFICATIONS: (View Restricted to Provider)

Medical Comments (Current and Past Health Conditions): (View Restricted to Provider)

Medication/ JUSTIFICATIONS Comments: (View Restricted to Provider)

Client Name: _____ Uniq ID#: _____

Non-weighted questions

Behavior/Psychosocial	YES
Family Caregiver states client has issues with:	
Aggressive behaviors	
Agitation	
Fear/Paranoia	
Hallucinations/Delusions	
Hoarding	
Socially Inappropriate/Disruptive	
Sundown Syndrome	

Residential – Client Has:	YES
Safe access to all necessary areas	
Access to working laundry/washer	
Adequate cooling & heating	
Adequate electricity	
Adequate plumbing	
Animal/Pest control	
Essential repairs/replacements	
In-home safety items	
Security (window and door locks)	
Working microwave	
Working refrigerator/freezer	
Working stove	
Personal Emergency Response System	

Level of Activity	Yes
No Activity/Bedridden	
Moves around the house	
Walks in yard	
Walks in Neighborhood, Mall, Park, Gym, etc.	
Goes places (Shopping, etc.)	
Exercises at home once a week	
Exercises at home 2 or more times a week	
Exercises at Sr. Center, Church, Gym, etc. once a week	
Exercises at Sr. Center, Church, Gym, etc. 2 or more times a week	

Benefits (Currently Receiving)	YES
Medicare	
Medicaid	
Medigap	
Private Health	
Social Security	
SSI	
Food Stamps	
Rental Assistance	
Fuel Assistance	
No Health Insurance	
VA Benefits	
Other	

Client Referred to (Check all that apply)	YES
CBO	
CLTC	
COA	
DDSN	
DHEC	
DHHS	
DMH	
DSS	
Home Health	
Hospital	
Housing	
Legal/SC Bar	
Physician	
VA	

Legal Summary	Yes
Legal Will	
Living Will	
Durable Power of Attorney	
Health Care Power of Attorney	
5 Wishes	

CONSENT TO RELEASE INFORMATION

Last Name: _____

First Name: _____

Middle Name: _____

The information on this form is required by the local provider, the Area Agency on Aging (AAA), the South Carolina Lieutenant Governor's Office on Aging and the U. S. Federal Government. The information provided will be kept confidential and guarded against unofficial use.

Some of the information gathered may be used to refer or provide appropriate services for client (such as referral for other services, emergency contact or sharing pertinent information to related service agencies for the purposes of planning services to meet the needs of the client.)

My information may be used to arrange for these services: ☐ **Yes** ☐ **No**

Some of the data asked for is required by either the South Carolina Lieutenant Governor's Office on Aging and/or the U. S. Federal Government, as entities funding the services, and will be used for reporting and research. This data will not include the client's name or identifying information and is aggregated. A client has the right to REFUSE to provide information. However, by refusing to answer particular questions, the client may be waiving his/her right to receive certain services.

My information may be shared with the entity(ies) funding my service(s): ☐ **Yes** ☐ **No**

Client Signature: _____ Date: _____

If read to client, by whom : _____ Date: _____

Relation: _____

Assessor Signature: _____ Date: _____

Services you will receive:	Date Service Starts:	Frequency of Service:
____ Congregate Meals	_____	_____
____ Home Delivered Meals	_____	_____
____ Transportation	_____	_____
____ Homemaker	_____	_____
____ Other _____	_____	_____

FAMILY CAREGIVER/RECEIVER ASSESSMENT

How is CAREGIVER related to the CARE RECEIVER?

(I am the CR's _____)

- ☐ Husband
- ☐ Wife
- ☐ Son/Son-In-Law
- ☐ Daughter/Daughter-In-Law
- ☐ Other Relative
- ☐ Non-Relative
- ☐ Relationship Missing
- ☐ Grandparent
- ☐ Other Elderly Relative
- ☐ Other Elderly Non-Relative

Does the FAMILY CAREGIVER qualify for respite and other funded services?

☐ Yes ☐ No

Does the GRANDPARENT or RELATIVE RASING A CHILD qualify for funded services?

☐ Yes ☐ No

Screening Y/N (a Yes response = points)	Y/N
Due to a cognitive or other mental impairment, does the Care Receiver require substantial supervision to maintain their health and safety?	
SENIOR is Raising a Child with a severe disability?	

CAREGIVER Screening Y/N (a Yes response = points)	Y/N
Caregiver has been hospitalized or has visited ER in the past 6 months?	
Caregiver has not had an annual check-up in the past 6 months?	
Caregiver has more than 2 limiting current health problems?	
Caregiver has chronic mental health issues?	
Caregiver household is multi-generational?	
Caregiver's income has been reduced as a result of caregiving?	
Caregiver's expenses have significantly increased as a result of caregiving?	
Caregiver's living arrangements create difficulty in providing care?	
Caregiver has no one to provide respite/relief?	
Caregiver has no one to call for help or assistance?	

Caregiver provides X hours of hands on care for Care Recipient per week:	CHECK ONE ONLY
Less than 10 hrs	
10 to 19 hrs	
20 to 29 hrs	
30 to 39 hrs	
40 to 49 hrs	
50 to 59 hrs	
60 + hrs	

Caregiver:	Never	Rarely	Sometimes	Frequently	Always
Is In Crisis					
Has a Care Receiver that requires constant supervision					
Feels that because of the time spent with Care Receiver, doesn't have time for self					
Feels stressed between providing care and trying to meet other responsibilities (work/family)					
Feels strained when around your relative					
Feels uncertain about what to do about relative					

ASSESSMENT SUPPORTING DOCUMENT

This is a supporting document for Form: A001 Revision 6/26/13 (Lieutenant Governor's Office on Aging Assessment/Re-Assessment form).

> **NOTE FOR CAREGIVER PROGRAM:** The same assessment tool is used to assess clients (care receivers) and caregivers. In the FCSP, two assessments are completed, one for the CG and one for the CR. Care Receivers are assessed using pages 1-7. Caregivers are assessed using pages 1-2 and 8-9. If the Caregiver is 60 or older, assessment using pages 1-9 is encouraged.

Refused – the client has the right to refuse to answer any question. The refused selection lets the data entry person know the question was not skipped and will serve as backup in the event a client is denied service due to a scoring issue.

GENERAL INTAKE INFORMATION

1. **Initial Contact Date**: Date initial contact was made with the client.
2. **Unique ID#**: System generated number. Will replace the client's SSN.
3. **REQUIRED - Date of Birth**: Required question and is weighted on the assessment under Health and Safety Part 3. Client may Refuse to answer, but it may have an effect on his overall score and services. If the client will only give his age, enter 07/01/yyyy.
4. **Client Type**: Client/Care Receiver or a Caregiver
5. **REQUIRED - County**: County in which client resides.
6. **Region**: AAA Region.
7. **Status**: In order to access the Status and Status Date fields, you must click on the OWNERS screen. The **Status** AND the **Status Date** are critical fields. They are used to pull clients for reporting. If the client's status is Closed, Deceased, Inactive, or Pending, the client will not be included in some reports and rosters.

> **NOTE:** The **Status Date** DOES NOT automatically change when you change a clients status, you must change the date manually.

- **Active** - For a new client. **Status Date** = effective date client approved for services and **must** be entered manually. (Status Date defaults to the date the record is being inserted and is not usually the date the client became active.)
- **Closed** - **Status Date** = date client becomes ineligible for services (date client is terminated).
- **Deceased** - If a client is deceased. **Status Date** = date of death or date agency learned of client's death.
- **Inactive** - If a client becomes ineligible for services, and there is reason to believe this is only a temporary situation. **Status Date** = effective date of ineligibility for services.
- **Pending** - When information on a new client is entered into ***AIM*** before client is determined to be eligible for services. **Status Date** = date the preliminary information is entered into the system.
- **Pending** - If client is entered onto a Waiting List, BUT NOT receiving any services. **Status Date** = date client was put on Waiting List.
- **Active** - If a client is entered onto a Waiting List, BUT is currently receiving another service. **Status Date** = remains the date client became Active. (The Status Date would NOT change.)

8. **Status Date**: See above.

SCORES The scores will be generated AFTER the questions are answered in AIM and will automatically populate on the screen. The data entry person will then handwrite the score on this form for the benefit of the assessor.

9. **Assessment Score**: Derived from the Assessment screen on the bottom in red.
10. **Nutrition Score**: Derived from Nutrition questions.
11. **Target Score:** Derived from General Information.
12. **Caregiver Score:** Derived from Caregiver Assessment.

INDIVIDUAL INTAKE INFORMATION

13. **Title**: Optional
14. **Last Name**: Client's last name
15. **First Name**: Client's first name
16. **Middle Name**: Client's middle name. This box can also be used for alias names or individual identifiers
17. **Home Phone**:
18. **Work Phone**:
19. **Cell Phone**:
20. **Email**:

EMERGENCY CONTACT INFORMATION

21. **E Contact Name**: Client's personal contact in case of an emergency
22. **E Contact Phone**:
23. **E Cell Phone**:
24. **E Relationship**: Contacts relation to client
25. **E e-mail**:

INDIVIDUAL INTAKE INFORMATION

26. **Physical Address (Add 1)**: Address where client resides
27. **Apt, Lot, Box (Add 2)**: Additional line for identifying street information
28. **City**:
29. **State**:
30. **REQUIRED - Zip Code**:
31. **Mailing Address if Different (Add 1)**: Address where client receives mail if different than the residential address.
32. **City**:
33. **State**:
34. **Zip**:

OTHER INFORMATION

35. **REQUIRED - Race**: Drop down - select ONE. Client has the right to refuse, however this is a target weighted question.
    African American/Black
    American Indian/Alaskan
    Asian
    Hawaiian/Pacific Islander
    White
    Some Other Race
    2 or more Races
    Race Missing

36. **REQUIRED - Ethnicity**: Drop down, select ONE. Client has the right to refuse, however this is a target weighted question.
    Hispanic/Latino
    Non-Hispanic or Non-Latino
    Unknown
    Refused
37. **REQUIRED - Monthly Family Household Income**: Total household income for EITHER…

    a) a single client who lives alone (HH = 1), or

    b) the family household income for the client and/or spouse and/or dependent children (HH = # in family dependent upon the client).

    You are encouraged to obtain all income sources as this may lead to additional services the client may qualify for. However, if you can only obtain the TOTAL FAMILY HOUSEHOLD INCOME, that is acceptable. Place it in "Income From Other". **Click OK.**

    If Client's Income is UNKNOWN and an "educated" estimate is not feasible, refer to the most current HHS Poverty Guidelines. Ask the client for the "Household Size" (number in the household) and then ask if they are below the corresponding 125% (Low Income) figure. If YES, enter that dollar figure. If NO, and they are above that figure, enter $9999 as their income. If they still refuse, check Refused.

    NOTE: You **MUST** click on Income Source AND click OK, even if you do not plan to enter information: Income reports will not be correct, unless OK has been clicked from this window for EVERY client. It is a peculiarity of the ***AIM*** system.

    Helpful TIP: You can tell whether or not the Income Source window has been "OK'd" by whether or not the BUTTON is in **Bold Print**: If "**Income Src**"is **Bold**, then it has been "OK'd". If "Income Src" is NOT Bold, then it has NOT been "OK'd".
38. **REQUIRED - Total # in Household**: It will either = 1 if the client is single and lives alone. Or, it will = the client plus all family members in household dependent upon him, to include spouse and dependent children.
    *****INCOME AND #HH should not be entered haphazardly and requires the use of professional judgment.**
    These two fields are calculated behind the scenes in AIM to determine poverty levels based on the income and household size as set forth in the current year of HHS Poverty Guidelines. In turn, this calculation will be used to determine if your Region is targeting this population. These figures will also be report to NAPIS.
39. **DOB VERIFICATION**: Drop-down. Select how the clients DOB was verified.
40. **REQUIRED - Gender**: Male, Female and Refused.
41. **Marital Status**: Married, Single, Widowed, Divorced, Separated, Unknown and Other.
42. **Monthly Expenses**: Many of the expenses in this section are variables and change from month to month. It is not imperative for you to have the client go obtain current billing statements to gather this information. Reasonable "best estimates" are acceptable. For ex, if they know their power bill runs $120 to $150 a month, you can estimate $135. This section will help prepare the assessor for the ADLs/IADLs by looking for additional assistance for the client.
43. **REQUIRED - Limited English Proficiency**: Yes or No. If NO, you do not need to answer #44 or type English.
44. **Primary Language**: Current options are:

Spanish or Spanish Creole	Korean
French (inc Patois, Cajun)	Italian
German	Japanese

Chinese	Greek
Tagalog (Philippines)	Arabic
Vietnamese	Gujarathi (India)

None - In the event you enter a language by mistake and want to remove it immediately, you can tab the Undo button on the toolbar. However, if it not noticed until later, select None.

CLIENT's NAME AND UNIQUE ID# - OPTIONAL at the top of each new page. Included at the request of many providers so they can identify client's pages if they become separated.

45. **Special Eligibility:**
    Client type = Client - Special Eligibility options would be Client's Spouse, Meal Volunteer, Disabled < 60, Waiver, Emergency.
    Client type = Care Receiver - Special Eligibility options would be Disabled < 60, < 18 child or ADRD < 60.
    None – During re-assessment, if it is determined the special eligibility status is now None, the system will not allow you to uncheck one box without checking another. So, we have included None so that you can clear out the previous option.
    Waiver – Place explanations in the JUSTIFICATIONS comment section.
    Other – Place explanations in the JUSTIFICATIONS comment section.
    Emergency – Any event that would identify the client as an Immediate At-Risk individual.
46. **Income Comments**: These comments can be viewed by all users. They are comments that may have relevance to the client's income.
47. **Other Information Comments**: These comments can be viewed by all users. They are "catch-all" comments that may have relevance to the client's home directions, which door to knock on, if there are dogs, if there is a smoker in the home, if the assessor should not go alone…. Or any other information that the assessor may want to share with others or for future knowledge.
48. **Assess Date**: This is the date the assessment or reassessment was conducted.
49. **Spouse Name**: Name of client's spouse.
50. **Assessor**: Name of person conduction the interview with the client.
51. **Operator**: Name of the person entering the data into AIM.
52. **Assessment Method**: Was the assessment conducted in person with the client or by phone.
53. **Primary Doctor**: This will be the client's primary doctor, family physician or general practitioner.
54. **Doctor Phone 1**:
55. **Doctor Phone 2**:
56. **Services Requested**: You will check all that apply to the client.
57. **REQUIRED - In the Event of a Disaster**: This is a new section and will be need to assist the client in an event of a disaster. They are Y/N questions.
    Type of Transportation Needed: Check only ONE. This determines how a client would be taken out of their home in the event of an evacuation or emergency.
58. **Client Referred by**: Check only ONE. How the client came to our agency.
59. **In-Home Services Currently Receiving**: Check ALL that apply.
60. **Optionals**: Education and Locomotion: Many providers asked that we return these fields for their own information. They are here to help assist you in how to conduct an interview with the client or what type of transportation assistance they may need.
61. **IADLS:**
    You must answer ALL QUESTIONS in this category, regardless of the clients level of ability or inability to perform the tasks listed. Use the following definitions for each of the tasks:

The IADL self-performance categories measure what the client actually did without assistance in the last 7-14 days, indicating balance between the client's self-performance and assistance caregivers provided for each activity. The assessor should use professional judgment to determine if the last 7-14 days are representative of the client's overall IADL ability.

Levels of Ability:

INDEPENDENT – Indicates the client is totally capable of completing the activity without assistance. The client can also be coded as "Independent" if the client received minor assistance or supervision only one or two times over the past 7 days due to special circumstances, but completed the activity independently all other times for that week.

NEEDS SOME ASSISTANCE – Indicates the client is capable of completing the activity with the assistance of a walker, wheelchair, cane, crutches, rails, or other type of assistive device. Or the client is capable of completing the activity independently with only supervision, cuing (reminders), or encouragement. Or the client is capable of completing the activity with only minor assistance from caregivers. The client can also be coded as "Needs Some Assistance" if the client received extensive assistance less than 50% of the time, but was capable of completing the activity all other times during that week.

DEPENDENT – Indicates the client is capable of part of the activity, but needs human assistance (hands-on) or verbal directions (continuous step-by-step direction) in relation to the activity 50% or more of the time. The client can also be coded as "Dependent" if receiving Total Assistance with the activity less than 50% of the time, but was capable of completing part of the activity all other times for that week. Or the client was unable to assist in the activity all seven (7) days.

- Preparing Meals: Ability to prepare a full, nutritious meal at least twice a day;
- Microwave Use: Ability to operate a microwave.(See page 6 of the Assessment for microwave ownership.)
- Light Housekeeping: Ability to pick up small, light items, dust, sweep, wash own dishes or put dishes in dishwasher, do light laundry;
- Heavy Housekeeping: All of the above plus vacuum, heavy laundry, mop, clean bathroom(s);
- Telephone Use: Ability to look up numbers, dial phone, and carry on a conversation;
- Money Management: Ability to manage household finances properly;
- Shopping: Ability to purchase items, get them into the house, and put them away;
- Managing Medications: Ability to take medications timely and properly;
- Driving or Using Public Transportation: Ability to drive a vehicle or able to use public transportation in their area. (See page 4 for Transportation.)

62. ADLs:

You must answer ALL QUESTIONS in this category, regardless of the clients level of ability or inability to perform the tasks listed. Use the following definitions for each of the tasks and to accurately assess the client's level of ability:

The ADL self-performance categories measure what client actually did without assistance in the last 7-14 days, indicating balance between client's self-performance and assistance caregivers provided for

each activity. The assessor should use professional judgment to determine if the last 7-14 days are representative of the client's overall ADL ability.

Levels of Ability:

INDEPENDENT - Indicates the client is totally capable of completing the activity without assistance. Indicates no physical assistance or direction is needed with routine daily bathing. Indicates no assistance is needed in setting up and eating meals; to include the ability to prepare food, warm it and serve it for eating.

ASSISTIVE TECHNOLOGY ONLY (NO HELP) – Indicates even though the client uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, they are totally independent. The type of device should be identified in the comments section.

SUPERVISION AND/OR COACHING – Indicates with or without assistive device, intermittent supervision may be needed with ambulation or wheelchair use. Indicates oversight or reminders are needed for dressing, meal preparation and/or to eat meals and safety in toileting. Indicates standby oversight or supervision is necessary to ensure safety and completion, regardless of method of bathing.

LIMITED ASSISTANCE (SOME HELP) – Indicates direction or guidance is needed for correct positioning of limbs/appliances (eg braces, prosthesis), but can transfer self. Or assistance is needed in difficult wheelchair/ambulation maneuvers or for safety with ambulation/wheelchair. Client has the capability to ambulate or propel wheelchair independently to a destination (more than 20 feet). Indicates needs help with zippers, buttons, shoes, laying out of clothes, cutting meat, opening prepackaged items, and arranging clothes or emptying bedpan/bedside commode. With Bathing, Physical Help Limited to Transfer Only – Indicates physical assistance is needed to move from one surface to another (ex. in and out of shower), but no assistance is needed with bathing activity or assistance needed less than 50% of the time (excluded washing the back and hair).

EXTENSIVE ASSISTANCE – Indicates hands-on assistance or continuous step-by-step direction is necessary for transfer (weight bearing includes few weight bearing steps with pivot), and pertaining to eating and/or setting up the meal at least 50% of the time, and to transfer and/or personal hygiene to include persons who frequently toilet in inappropriate places.
Walking - Indicates the need for physical assistance with ambulation; this need includes unsteadiness with ambulation, assistance with the application of a brace or prosthesis without which a client could not walk. If a client is wheelchair bound, it indicates physical or verbal support is needed for wheelchair use. It also indicates necessary extensive continuous verbal/hands-on direction to prevent wandering, whether because of the client's habitual tendency or his/her inability to find strategic locations (i.e., bathroom, dining room). Wandering indicates non-goal directed locomotion.
Dressing - Indicates the client needs physical assistance or continuous verbal step-by-step directions in relation to appropriate dressing at least 50% of the time. Such assistance may be needed by a client who frequently dresses inappropriately for the physical environment (i.e., many layers of clothes when the temperature does not warrant them).
Bathing - Physical Help in Part of Bathing Activity - Indicates necessity hands on physical assistance or continuous step by step direction is needed in bathing 50% or more of the time (excludes washing of back and hair).

TOTAL DEPENDENCE – Indicates transfer requires total human support: non-weight bearing or only able to pivot. Indicates a client's total inability for walking, even though the ability remains to stand and bear weight or, if wheelchair bound, indicates total inability to operate or manually propel the wheelchair. Indicates total hands-on assistance is required in bathing, is totally dependent on another for feeding and toileting.

Codes:

- Walking/Mobility: Includes ambulation and wheelchair (electric or manually propelled) performance. A client's environment should be considered when evaluating this ADL. A client's endurance should be considered when evaluating the ability to walk or propel a wheelchair.
- Dressing: Assessment should focus on client's ability to dress self
- Eating: relates to activities client is capable of accomplishing within a reasonable length of time for a meal. The amount of food consumed in order to ensure adequate nutritional intake should also be considered.
  In the home, "setting up the meal" is defined as a person's ability to take prepared food, warm it and serve it for eating. Since these activities would not be appropriate in nursing facilities or residential care facilities due to licensing and certification standards, facility staff should evaluate client's ability to accomplish these activities.
- Toilet Use: Indicate how client uses the toilet (i.e. commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

Note Regarding Ostomy Care: when assessing a client who has a colostomy or ileostomy, make sure that you query the client/caregiver regarding how the client personally cares for the ostomy. Once you determine the level of ability then apply the appropriate score.

If bowel/bladder training is in progress, indicate this in the comment section of the continence section. If toileting is done at bedside, using bedpan or commode, indicate in the comments section if the client has any measure of independence.

- Transferring: Indicates how client moves between surfaces, i.e., to/from bed, chair, wheelchair, standing position (excludes to/from toileting).
- Bathing: This activity rates the maximum amount of physical assistance client requires in order to achieve safe and adequate hygiene. Code the maximum amount of assistance client receives. Physical help in part of bathing activity (washing off) indicates client needs assistance in a part of the bathing activity at least 50% of the time (excludes washing of back and hair.)
- Personal Grooming: Indicates a need for assistance to take care of grooming and personal hygiene needs, including combing hair, brushing teeth, denture care, shaving, applying makeup, washing/drying face and hands, fingernail care and help with period (menses care). It includes washing hair in the sink at home or in a beauty/barber shop, but does not include bathing or taking a shower.

63. **Bladder and Bowel Incontinence**: These categories are to be used to code the pattern of bladder and bowel continence/control during the last 14-day period. Use the codes provided on the *AIM* Assessment Form.

Note: If client is incontinent, but self-care indicated, this does not constitute a deficit.

Note Regarding Ostomy Care: when assessing a client who has a colostomy or ileostomy, make sure that you query the client/caregiver regarding how the client personally cares for the ostomy. Once you determine the level of ability then apply the appropriate score.

64. **Health and Safety**: This section has been re-written to address CURRENT LIMITATIONS as a result of a Specific Disease or Health and Disability Category. This means they are LIMITED in their daily activities as a result of their condition. Ex. If the individual IS NOT LIMITED by High Blood Pressure, do not check HBP.

    Please refer to the Health Assessment Limitations Due to Any of the Following sheet. If the client has several conditions that fall under one category, they will only receive one check mark for THAT category. However, they can receive a check for more than one category.

65. **# RX Medications:**
66. **# Falls:**
67. **Do you have:**

    Prescriptions from more than one Doctor?

    Prescriptions filled at more than one Pharmacy?

    Nutritional concerns as determined by a healthcare professional?

    Less than a 3 day supply of food on hand?

    Were you seen at the ER or admitted to a Hospital, rehab Facility or NH in the last 6 months?

68. **Do you live with? (All people in same household):**

    An Independent Spouse/Partner/Adult

    1 or 2 Dependent Children < 18

    More than 2 Dependent Children

    Dependent Adult/Spouse/Partner

    Live Alone

    It is important to know the living arrangement the client has. It can be a determining factor for the kind of services placed in the home. Start off by asking client if he lives with anyone. If "Yes", follow with, "Whom do you live with?" If client is living alone then case manager needs to determine if it is a safe environment. Please choose and answer ONLY ONE of the Living Arrangements question-and-answer pairs. If client lives with spouse, then determine if spouse is dependent on the client or not and choose the "spouse - questions" that best applies. If client lives with spouse AND others, then choose one of the "spouse - questions".

69. **Where do you live?**

    Boarding Home/Assisted Living/Group home

    Rented Room or Apartment

    Home

    In a Shelter

    Homeless

70. **Transportation**

    Has Transportation – If client has a vehicle they operate.

    Needs Transportation – If client needs to find transportation to get places.

    Needs Transportation and Escort – If client has to find transportation and someone to assist them.

    Needs Specialized Transport – If client needs an ambulance or other specialized vehicle to transport them.

    Client's ability to be self-sufficient depends on transportation, especially for those living in rural communities. Important to ask client as many of these questions as necessary to determine their

transportation needs. If client cannot get medications or food or keep a doctor's appointment, then her health status is at risk. Answer as many questions as are pertinent to this client.

71. **Age (from DOB)** – Field will be calculated in AIM taken from the DOB
72. **Income and Number-In-Household from Client Screen:** - Field will be calculated in AIM taken from the Income screen.

In the last 6 months have you:

73. **Missed a rent/mortgage payment because you did not have the money?**
74. **Missed a utilities payment because you did not have the money?**
75. **Gone without medication because you could not afford it?**
76. **Gone without food because you could not afford it?**
77. **How close is your nearest support person?**
78. **Have anyone you can call if you need help or assistance?**

Live 20 or more miles from the following?

79. **Shopping (grocery, clothing, personal care items, etc.**
80. **Pharmacy**
81. **Your doctor**
82. **Hospital**
83. **Have you ever been denied services based on where you live?**

Nutritional Screening
http://www.healthcare.uiowa.edu/igec/tools/nutrition/determineNutrition.pdfhttp://www.healthcare.uiowa.edu/igec/tools/nutrition/determineNutrition.pdf

84. **Do you have an illness or condition that has made you change the kind or amount of food you eat?**
85. **Do you eat fewer than 2 meals a day?**
86. **Do you eat few (to none) fruits or vegetables, or milk products?** This question presents the most problems for providers. The intent of this question is to see if the client has a well-balanced diet to include fruits or vegetables, or milk. It is not looking for a specific number on a daily basis. You want to know if the client has little to none in their diet – if so, answer "yes". If they answer that they eat more than a few, that would be "no".
87. **Do you have 3 or more drinks of beer, liquor, or wine almost every day?**
88. **Do you have tooth or mouth problems that make it hard for you to eat?**
89. **Do you sometimes not have enough money to buy the food you need?**
90. **Do you eat alone most of the time?**
91. **Do you take 3 or more different prescribed or over the counter drugs per day?**
92. **Without wanting to, I have lost or gained 10 pounds within the last 6 months?**
93. **Are you sometimes physically unable to shop, cook, or feed yourself?**
94. ***Homebound:** Homebound status is established if an individual resides at home, is unable to drive, does not have access to transportation, and may be at risk for institutionalization.
95. ***Living Alone:** A one person household where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting.
96. **General Comments**: These comments can only be viewed by the owning provider. They are "catch-all" comments.
97. **Medical Comments**: These comments can only be viewed by the owning provider. They are "catch-all" health related comments.
98. **JUSTIFICATION Comments**: Section for various justification comments.

NON-WEIGHTED QUESTIONS This questions are not part of any standard scoring. They are self-explanatory. If you have questions, please contact your AAA/ADRC.

CONSENT TO RELEASE INFORMATION May be completed if it fulfills your requirements.

FAMILY CAREGIVER SECTION

1. **How is CAREGIVER related to the CARE RECEIVER? I am the CR's _____**
2. **Does the FAMILY CAREGIVER qualify for respite and other funded services?** Y/N See FORM *Eligibility for Title III-E Services – Family Caregiver*
3. **Does the GRANDPARENT or RELATIVE RAISING A CHILD qualify for funded services?** Y/N See FORM *Eligibility for Title III-E Services – Seniors Raising Children*
4. **Due to a cognitive or other mental impairment, does the Care Receiver require substantial supervision to maintain their health and safety?** Y/N See FORM *Eligibility for Title III-E Services – Family Caregiver*
5. **SENIOR is Raising a Child with a severe disability?** Y/N See FORM *Eligibility for Title III-E Services*
6. **Caregiver has been hospitalized or has visited ER in the past 6 months?** Y/N
7. **Caregiver has not had an annual check-up in the past 6 months?** Y/N
8. **Caregiver has more than 2 limiting current health problems?** Y/N (Use the same criteria as the Health and Safety Section on page 3 of the Assessment and Question 64 explanation above.)
9. **Caregiver has chronic mental health issues?** Y/N
10. **Caregiver household is multi-generational?** Y/N
11. **Caregiver's income has been reduced as a result of caregiving?** Y/N
12. **Caregiver's expenses have significantly increased as a result of caregiving?** Y/N
13. **Caregiver's living arrangements create difficulty in providing care?** Y/N
14. **Caregiver has no one to provide respite/relief?** Y/N
15. **Caregiver has no one to call for help or assistance?** Y/N
16. **Caregiver provides** (blank) **hours of hands on care for Care Recipient per week:** 10-60+ active hours of service to Care Receiver(s).
17. **Caregiver: Is in crisis** Never, Rarely, Sometimes, Frequently, Always
18. **Caregiver: Has a Care Receiver that requires constant supervision** Never, Rarely, Sometimes, Frequently, Always
19. **Caregiver: Feels that because of the time spent with Care Receiver, doesn't have time for self** Never, Rarely, Sometimes, Frequently, Always
20. **Caregiver: Feels stressed between providing care and trying to meet other responsibilities (work/family)** Never, Rarely, Sometimes, Frequently, Always
21. **Caregiver: Feels strained when around relative** Never, Rarely, Sometimes, Frequently, Always
22. **Caregiver: Feels uncertain about what to do about relative** Never, Rarely, Sometimes, Frequently, Always

SAMS ILA (NSI) 2010

0. Cover Sheet

0.A. Client Identification

1. What is the date of the assessment?

_____/_____/_____

2. Specify the type of assessment, or the reason for the assessment.

- ☐ 1 - Initial assessment
- ☐ 2 - Reassessment

3. Where was the client interviewed?

- ☐ 1 - Home
- ☐ 2 - Hospital
- ☐ 3 - Nursing facility
- ☐ 4 - Other

4. Describe where the client was interviewed.

_____

_____

_____

_____

5. What is the name of the person conducting this assessment?

_____

6. What is the name of the agency the assessor works for?

_____

7. What is the client's last name?

_____

8. What is the client's first name?

_____

9. What is the client's middle initial?

_____

10. Enter the client's name suffix.

_____

11. Enter the client identifier for the client.

_____

12. Enter the client's 'also known as' name.

_____

13. What is the client's ethnicity?

- ☐ 1 - Hispanic or Latino
- ☐ 2 - Not Hispanic or Latino
- ☐ 3 - Unknown

14. What is the client's race?

- ☐ 1 - American Indian/Native Alaskan
- ☐ 2 - Asian
- ☐ 3 - Black/African American
- ☐ 4 - Native Hawaiian/Other Pacific Islander
- ☐ 5 - Non-Minority (White, non-Hispanic)
- ☐ 6 - Hispanic/Latino - White
- ☐ 7 - Other

15. Enter the client's telephone number.

_____

16. What is the client's Social Security Number?

_____-_____-_____

17. What is the client's date of birth?

_____/_____/_____

18. Enter the age of the client in years.

☐

19. What document was used to verify the client's age?

- ☐ Birth certificate
- ☐ Driver's license
- ☐ Employment identification card
- ☐ Military/veteran's identification card
- ☐ Notarized affidavit
- ☐ Passport
- ☐ Self Declaration (Must Complete Age Declaration on Signature Page)
- ☐ Social Security or Medicare card
- ☐ U.S. census records
- ☐ Wedding or divorce decree
- ☐ Other (Answer Next Question if this is chosen)

20. What other document was used to verify the client's age?

21. What is the client's gender?

- [ ] M - Male
- [ ] F - Female

22. Enter the client's residential street address or Post Office box.

23. Enter the client's residential city or town.

24. Residential zip code.

25. What county does the client reside in?

26. If different from residential address, enter the client's mailing street address or Post Office box.

27. If different from residential address, enter the client's mailing city or town.

28. If different from residential address, enter the client's mailing state.

29. If different from residential address, enter the client's mailing ZIP code.

30. What is the name of the client's caregiver?

31. What is the relationship of the primary helper to the client?

- [ ] Daughter/Daughter-in-law
- [ ] Grandparent (55+)
- [ ] Husband
- [ ] Non-relative
- [ ] Other elderly non-relative (60+)
- [ ] Other elderly relative (60+)
- [ ] Other relative
- [ ] Relationship Missing
- [ ] Son/Son-in law
- [ ] Wife

0.B. Emergency Contact Information

1. What is the name of the client's primary care physician?

2. What is the work phone number for the client's primary care physician?

3. Name of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.

4. Relationship of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.

5. Address of Friend or Relative (other than Spouse/Partner) to contact in an Emergency.

6. Work Telephone Number of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.

7. Home Telephone Number of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.

8. Cell Number of Friend or Relative (other than Spouse/Partner) to contact in case of an Emergency.

9. What is the name of a second relative or friend of the client?

10. What is the work phone number of the second relative or friend of the client?

11. What is the home phone number of the second relative or friend of the client?

_____

12. What is the e-mail address of a Family Member?

_____

0.C. Directions to Client's Home

Directions on how to get to the client's home.

_____

_____

_____

_____

1. Intake

1.A. Standard Data

1. Did someone help the client or answer questions for the client?

- [ ] Y - Yes
- [ ] N - No

2. What is the name of the person that helped the client during this assessment?

3. What is the helper's relationship to the client?

4. Was communication/language assistance needed for this assessment?

- [ ] Y - Yes
- [ ] N - No

5. Specify the client's primary language.

- [ ] English
- [ ] Spanish
- [ ] French
- [ ] Italian
- [ ] German
- [ ] Russian
- [ ] Other

6. What type of communication/language assistance was needed for this assessment?

1.B. Legal Representative

1. Does the client have a power of attorney?

- [ ] Y - Yes
- [ ] N - No

2. What is the name of the client's power of attorney?

3. Enter the work phone number of the client's power of attorney.

4. Enter the home phone number of the client's power of attorney.

5. Does the client have a DPOA for health care?

- [ ] Y - Yes
- [ ] N - No

6. What is the name of the client's DPOA for health care?

7. Enter the work phone number of the client's DPOA for health care.

8. Enter the home phone number of the client's DPOA for health care.

9. Does the client have a DPOA for finances?

- [ ] Y - Yes
- [ ] N - No

10. What is the name of the client's DPOA for finances?

11. Enter the work phone number of the client's DPOA for finances.

12. Enter the home phone number of the client's DPOA for finances.

13. Does the client have a representative payee?

- [ ] Y - Yes
- [ ] N - No

14. What is the name of the client's representative payee?

_____

15. Enter the work phone number of the client's representative payee.

_____

16. Enter the home phone number of the client's representative payee.

_____

17. Does the client have a legal guardian?

- [ ] Y - Yes
- [ ] N - No

18. What is the name of the client's guardian?

_____

19. Enter the work phone number of the client's guardian.

_____

20. Enter the home phone number of the client's guardian.

_____

21. Does the client have a living will?

- [ ] Y - Yes
- [ ] N - No

22. Name of person holding copy of DPOA/Living Will.

_____

23. Telephone number of person holding copy of DPOA/Living Will.

_____

24. Address of person holding second copy of DPOA/Living Will.

_____

_____

_____

_____

25. If the client does not have a living will, was information provided about advanced directives?

- [ ] Y - Yes
- [ ] N - No

1.C. Assessment Information

1. Select the client's current marital status.

- [ ] A - Single
- [ ] B - Married
- [ ] C - Separated
- [ ] D - Widowed
- [ ] E - Divorced
- [ ] F - Unavailable

2. Indicate the type of residence that the client currently resides in.

- [ ] A - House/mobile home
- [ ] B - Private apartment
- [ ] C - Private apartment in senior housing
- [ ] D - Residential care home
- [ ] E - Nursing home
- [ ] F - Unavailable
- [ ] Z - Other

3. Is the client NSIP eligible for home delivered meal reimbursement? (Regardless of whether or not they need meals, if they are over the age of 60 or meet one of the conditions on the next question, you will generally check yes.)

- [ ] Yes
- [ ] No

4. For what reason is the client NSIP eligible for home delivered meals?

- [ ] Disabled individual residing in an elderly housing which serves congregate meals
- [ ] Age 60+ or Tribal Age
- [ ] Spouse of someone who is NSIP eligible

1.D. Social Screening

1. Select the client's current living arrangement.

- [ ] A - Lives Alone (3)
- [ ] B - With spouse/partner
- [ ] C - Lives with spouse and child
- [ ] D - With child/children
- [ ] F - With others (2)

2. If b, c, or d is checked: Ask if any of the person(s) that live with you are able to assist with your care? (If No, score 2)

- [ ] No (2)
- [ ] Yes

3. What is the name of the client's spouse/partner?

_____

_____

_____

_____

4. How many people are there in the client's household?

- ☐ A - One person
- ☐ B - Two people
- ☐ C - Three people
- ☐ D - Four or more people

5. Does the client have any children nearby?

- ☐ Y - Yes
- ☐ N - No (2)

6. Does the client have contact with family often enough?

- ☐ Y - Yes
- ☐ N - No (3)

7. Does the client have contact with friends often enough?

- ☐ Y - Yes
- ☐ N - No (2)

8. Is there a friend or relative that could take care of the client for a few days?

- ☐ Y - Yes
- ☐ N - No (3)

9. When the client makes a decision about something, how does s/he do it?

- ☐ A - Independently and alone
- ☐ B - Independently after talking to family/friends (1)
- ☐ C - Follow advice of family/friends (2)
- ☐ D - Dependent (3)
- ☐ E - Information unavailable (Choose only if consumer not able to answer score 3)

10. Is the client currently employed?

- ☐ Yes
- ☐ No
- ☐ Full time

11. Is the client participating in any of the following services or programs?

- ☐ Statewide Medicaid Waiver/CHOICES
- ☐ Homemaker program
- ☐ Home Health Aide
- ☐ Nursing
- ☐ Speech therapy
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Home delivered meals
- ☐ PERS - Personal Emergency Response System
- ☐ Senior companion
- ☐ Weatherization
- ☐ Congregate meals
- ☐ Adult day services
- ☐ Food stamps
- ☐ Fuel Assistance
- ☐ Telephone lifeline
- ☐ Medicaid
- ☐ SSI
- ☐ QMB/SLMB
- ☐ QI-1
- ☐ Personal care
- ☐ Respite care
- ☐ Minor Home Repairs
- ☐ Assistive Devices
- ☐ Private Duty
- ☐ 504 USDA program
- ☐ Extra help for Part D Medicare
- ☐ Other

12. Does the client want to apply for any of the following services or programs?

- ☐ B - Medicaid waiver
- ☐ C - Homemaker program
- ☐ I - Home delivered meals
- ☐ J - Emergency lifeline
- ☐ L - Weatherization
- ☐ M - Congregate meals
- ☐ O - Adult day services
- ☐ R - Fuel Assistance
- ☐ T - Medicaid
- ☐ U - SSI
- ☐ 1 - Personal care
- ☐ 2 - Respite care
- ☐ 3 - Minor Home Modifications
- ☐ 4 - Assistive Devices
- ☐ 5 - Private Duty
- ☐ O - Other

Enter Social Score

_____

_____

_____

_____

1.E. Health Screening

1. How does the client rate his/her health?

- ☐ A - Excellent
- ☐ B - Good
- ☐ C - Fair (2)
- ☐ D - Poor (3)
- ☐ E - Information unavailable

2. In the past year, how many times has the client stayed overnight in a hospital?

- ☐ 1 - Not at all (0)
- ☐ 2 - Once (1)
- ☐ 3 - 2 or 3 times (2)
- ☐ 4 - More than 3 times (3)

3. In the past 6 months has the client stayed in a nursing home, residential care home, or other institution?

- ☐ Y - Yes (2)
- ☐ N - No

4. Indicate which of the following conditions/diagnoses the client currently has.

- [ ] Addiction
- [ ] Alcoholism/substance abuse
- [ ] Allergies
- [ ] Alzheimer's disease
- [ ] Anemia
- [ ] Ankle/leg swelling
- [ ] Anxiety disorder
- [ ] Any psychiatric diagnosis
- [ ] Aphasia
- [ ] Arteriosclerosis heart disease (ASHD)
- [ ] Arthritis/rheumatic disease/gout
- [ ] Asthma
- [ ] Blood-related problems
- [ ] Breathing disorders
- [ ] Bruises
- [ ] Cancer
- [ ] Cardiac dysrhythmias
- [ ] Cataract
- [ ] Cerebral palsy
- [ ] Chronic pain
- [ ] Chronic weakness/fatigue
- [ ] Congestive heart failure
- [ ] Contractures
- [ ] Coronary artery disease
- [ ] Decubitus
- [ ] Deep vein thrombosis
- [ ] Depression
- [ ] Developmental disability
- [ ] Diabetes
- [ ] Diabetic retinopathy
- [ ] Dialysis
- [ ] Digestive problems
- [ ] Drug resistance (MRSA/VRE)
- [ ] Edema
- [ ] Emphysema/COPD/asthma
- [ ] Expressive communication
- [ ] Fibromyalgia
- [ ] Frailty
- [ ] Frequent falls
- [ ] Gastritis or related condition
- [ ] Glaucoma
- [ ] Hearing impairment
- [ ] Heart problems
- [ ] Hemiplegia/Hemiparesis
- [ ] High cholesterol
- [ ] Hip fracture
- [ ] HIV
- [ ] Hypertension
- [ ] Hyperthyroidism
- [ ] Hypotension
- [ ] Hypothyroidism
- [ ] Immune system disorders
- [ ] Incontinence, bladder
- [ ] Incontinence, bowel
- [ ] Incontinent
- [ ] Liver disease
- [ ] Macular degeneration
- [ ] Manic depression (bipolar disease)
- [ ] Memory Loss
- [ ] Missing limb (e.g., amputation)
- [ ] Multiple sclerosis
- [ ] Muscle or bone problems
- [ ] Nausea/vertigo
- [ ] Neurological condition
- [ ] Non-Alzheimer's dementia
- [ ] Osteoporosis
- [ ] Other cardiovascular disease
- [ ] Other eye condition
- [ ] Other fracture (except hip/spine)
- [ ] Other neurological
- [ ] Other significant illness
- [ ] Paralysis
- [ ] Paraplegia
- [ ] Parkinson's disease
- [ ] Pathological bone fracture
- [ ] Peripheral vascular disease
- [ ] Pneumonia
- [ ] Quadriplegia
- [ ] Receptive communication
- [ ] Renal failure
- [ ] Respiratory disease
- [ ] Schizophrenia
- [ ] Seizure disorder
- [ ] Speech impairment
- [ ] Stroke
- [ ] TB
- [ ] Thyroid disease
- [ ] Transient ischemic attack (TIA)
- [ ] Traumatic brain injury
- [ ] Tremors
- [ ] Urinary problems
- [ ] Urinary tract infection
- [ ] Vision problems
- [ ] None of the Above

5. Enter any comments regarding the client's medical conditions/diagnoses.

_____

_____

_____

_____

6. Is the client limited in what s/he can do because of this health problem?

- ☐ Y - Yes (3)
- ☐ N - No

7. How often does bad health, sickness, pain, or disability stop the client from doing things s/he would like to do?

- ☐ A - Never
- ☐ B - Sometimes (1)
- ☐ C - Often (2)
- ☐ D - Always (3)

8. Has the client fallen in the past three months?

- ☐ Y - Yes (3)
- ☐ N - No

9. In a typical week, during the last 30 days, how often did the client go outside of their residence (no matter for how short a period of time)?

- ☐ A - Two or more days a week
- ☐ B - One day a week or less (2)

10. Does the client use a walker/cane to get around?

- ☐ Y - Yes (3)
- ☐ N - No

11. Does the client use a wheelchair to get around or is bedbound?

- ☐ Y - Yes (3)
- ☐ N - No

12. Does the client have problems with hearing that are NOT corrected with aids/devices?

- ☐ Y - Yes (1)
- ☐ N - No

13. If the client has hearing aids/devices, are they in working order?

- ☐ Y - Yes
- ☐ N - No

14. Does the client have problems with vision that are not corrected with aids/devices?

- ☐ Y - Yes (1)
- ☐ N - No

15. If the consumer uses vision aids/devices, are they in working order?

- ☐ Y - Yes
- ☐ N - No

16. Does the client have problems with speech that are not corrected with aids/devices?

- ☐ Y - Yes (1)
- ☐ N - No

17. Describe any aids/devices used by the client to correct speech problems.

_____

_____

_____

_____

18. If the consumer uses speech aids/devices are they in working order?

- ☐ Y - Yes
- ☐ N - No

19. Does the client often feel sad or blue?

- ☐ Y - Yes (3)
- ☐ N - No

20. How many prescription medications does the client take?

☐

21. Is the number of Medications the client is taking 3 or more?

- ☐ Y - Yes (1)
- ☐ N - No

22. What was the client's response when asked, 'What year is it?'

- ☐ A - Correct answer
- ☐ B - Incorrect answer

23. What was the client's response when asked, 'What month is it?'

- ☐ A - Correct answer
- ☐ B - Incorrect answer

24. What was the client's response when asked, 'Where are we now?'

- ☐ A - Correct answer
- ☐ B - Incorrect answer

25. Indicate worker's judgment of client's overall mental clarity/cognitive functions.

- [ ] 1 - Good
- [ ] 2 - Fair (2)
- [ ] 3 - Poor (3)

26. In the past six months, has the client lost more than 10 pounds without trying?

- [ ] Yes (2)
- [ ] No

Enter Health Screening Score.

_____

_____

_____

_____

1.F. Nutrition Screening

1. Has the client made any changes in lifelong eating habits because of health problems?

- [ ] Y - Yes (2)
- [ ] N - No (0)

2. Does the client eat fewer than 2 meals per day?

- [ ] Y - Yes (3)
- [ ] N - No (0)

3. Does the client eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day?

- [ ] Y - Yes (1)
- [ ] N - No (0)

4. Does the client eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day?

- [ ] Y - Yes (1)
- [ ] N - No (0)

5. Does the client have 3 or more drinks of beer, liquor or wine almost every day?

- [ ] Y - Yes (2)
- [ ] N - No (0)

6. Does the client have biting, chewing or swallowing problems that make it difficult to eat?

- [ ] Y - Yes (2)
- [ ] N - No (0)

7. Does the client sometimes not have enough money to buy food?

- [ ] Y - Yes (4)
- [ ] N - No (0)

8. Does the client eat alone most of the time?

- [ ] Y - Yes (1)
- [ ] N - No (0)

9. Does the client take 3 or more different prescribed or over-the-counter drugs per day?

- [ ] Y - Yes (1)
- [ ] N - No (0)

10. Without wanting to, has the client lost or gained 10 pounds in the past 6 months?

- [ ] Y - Yes (2)
- [ ] N - No (0)

11. Is the client not always physically able to shop, cook and/or feed themselves (or able to get someone to do it for them)?

- [ ] Y - Yes (2)
- [ ] N - No (0)

Total score of Nutritional Risk Questions.

[ ]

What is the client's nutritional risk score rating?

- [ ] High risk (6-19)
- [ ] Moderate risk (3-5)
- [ ] No risk (0-2)

2. Functional Assessment

2.A. Activities of Daily Living (ADL)

1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform BATHING (include shower, full tub or sponge bath, exclude washing back or hair)?

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Requires assistance sometimes (1)
- [ ] 3 - Mostly dependent (1)
- [ ] 4 - Totally dependent (1)
- [ ] 5 - Activity does not occur (1)

Is the help the client receives bathing enough?

- [ ] Y - Yes
- [ ] N - No

2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform DRESSING?

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Limited Assistance (1)
- [ ] 3 - Extensive Assistance (1)
- [ ] 4 - Total Dependence (1)
- [ ] 5 - Activity did not occur (1)

Is the help the client receives dressing enough?

- [ ] Y - Yes
- [ ] N - No

3. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TOILET USE?

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Sometimes dependent (1)
- [ ] 3 - Mostly dependent (1)
- [ ] 4 - Totally dependent (1)
- [ ] 5 - Activity does not occur (1)

Is the help the client receives using the toilet enough?

- [ ] Y - Yes
- [ ] N - No

4. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform getting out of bed/chairs/transferring?

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Minimal assistance required (1)
- [ ] 3 - Mostly dependent (1)
- [ ] 4 - Totally dependent (1)
- [ ] 5 - Activity does not occur (1)

Is the help the client receives getting in and out of bed/chairs enough?

- [ ] Y - Yes
- [ ] N - No

5. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform EATING?

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Sometimes dependent (1)
- [ ] 3 - Mostly dependent (1)
- [ ] 4 - Totally dependent (1)

Is the help the client receives eating enough?

- [ ] Y - Yes
- [ ] N - No

6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform WALKING IN HOME?

- [ ] 0 - Independent
- [ ] 1 - Supervision (1)
- [ ] 2 - Limited Assistance (1)
- [ ] 3 - Extensive Assistance (1)
- [ ] 4 - Total Dependence (1)
- [ ] 5 - Activity did not occur (1)

Is the help the client receives getting around the home enough?

- [ ] Y - Yes
- [ ] N - No

How many ADL impairments does the client have (Count or Total)?

[ ]

2.B. Instrumental Activities of Daily Living (IADL)

1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MEAL PREPARATION?

- [ ] 0 - Independent
- [ ] 1 - Sometimes dependent (1)
- [ ] 2 - Mostly dependent (1)
- [ ] 3 - Totally dependent (1)
- [ ] 4 - Activity does not occur (1)

Is the help the client receives preparing meals enough?

- [ ] Y - Yes
- [ ] N - No

2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform SHOPPING?

- [ ] 0 - Independent
- [ ] 1 - Somewhat dependent (1)
- [ ] 2 - Mostly dependent (1)
- [ ] 3 - Totally dependent (1)
- [ ] 4 - Activity does not occur (1)

Is the help the client receives shopping enough?

- [ ] Y - Yes
- [ ] N - No

3. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MANAGING MEDICATIONS?

- [ ] 0 - Independent
- [ ] 1 - Needs reminders (1)
- [ ] 2 - Somewhat dependent (1)
- [ ] 3 - Totally dependent (1)
- [ ] 4 - Activity does not occur (1)

Is the help the client receives taking medication enough?

- [ ] Y - Yes
- [ ] N - No

4. Specify the client's ability to MANAGE MONEY.

- [ ] 0 - Completely independent
- [ ] 1 - Needs assistance sometimes (1)
- [ ] 2 - Needs assistance most of the time (1)
- [ ] 3 - Completely dependent (1)
- [ ] 4 - Activity does not occur (1)

Is the help the client receives managing money enough?

- [ ] Y - Yes
- [ ] N - No

5. Rank the client's ability to use the TELEPHONE.

- [ ] 0 - Independent
- [ ] 1 - Able to perform but needs verbal assistance (1)
- [ ] 2 - Can perform with some human help (1)
- [ ] 3 - Can perform with a lot of human help (1)
- [ ] 4 - Cannot perform function at all without human help (1)

Is the help the client receives using the telephone enough?

- [ ] Y - Yes
- [ ] N - No

6. Specify the client's ability to perform HEAVY HOUSEWORK CHORES.

- [ ] 0 - Independent
- [ ] 1 - Needs assistance sometimes (1)
- [ ] 2 - Needs assistance most of the time (1)
- [ ] 3 - Unable to perform tasks (1)
- [ ] 4 - Activity does not occur (1)

Is the help the client receives performing heavy household chores enough?

- [ ] Y - Yes
- [ ] N - No

7. Specify the client's ability to perform LIGHT HOUSEKEEPING.

- [ ] 0 - Independent
- [ ] 1 - Needs assistance sometimes (1)
- [ ] 2 - Needs assistance most of the time (1)
- [ ] 3 - Unable to perform tasks (1)
- [ ] 4 - Activity does not occur (1)

Is the help the client receives doing housework enough?

- [ ] Y - Yes
- [ ] N - No

8. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSPORTATION?

- [ ] 0 - Independent
- [ ] 1 - Somewhat dependent (1)
- [ ] 2 - Mostly dependent (1)
- [ ] 3 - Totally dependent (1)

Is the help the client receives using transportation enough?

- [ ] Y - Yes
- [ ] N - No

9. Does the client have any of the following devices or equipment used to help perform the above ADL/IADL?

- [ ] Artificial limb
- [ ] Bath stool
- [ ] Bedside commode
- [ ] Cane
- [ ] Dentures
- [ ] Extended shower head/Hand held shower
- [ ] Eyeglasses
- [ ] Grab bars
- [ ] Hearing aid
- [ ] Hospital bed
- [ ] Lift chair
- [ ] Nebulizer
- [ ] Oxygen
- [ ] Raised toilet seat
- [ ] Ramp
- [ ] Walker
- [ ] Wheelchair
- [ ] Other

10. Any of Other devices or equipment not listed, if other.

_____

_____

_____

_____

How many IADL impairments does the client have (Count or Total)?

Total Score (Social + Health+ADL/IADL)

_____

_____

_____

_____

3. Financial Resources

3.A.i. Client Resources

1. Specify the client's monthly social security income.

$

2. Specify the client's monthly SSI income.

$

3. Specify the client's monthly retirement/pension income.

$

4. Specify the client's monthly interest income.

$

5. Specify the client's monthly VA benefits income.

$

6. Specify the client's monthly wage/salary/earnings income.

$

7. Specify the client's other monthly income.

$

3.A.ii. Spouse Resources

1. Specify the monthly social security income of the client's spouse.

$

2. Specify the monthly SSI income of the client's spouse.

$

3. Specify the monthly retirement/pension income of the client's spouse.

$

4. Specify the monthly interest income of the client's spouse.

$

5. Specify the monthly VA benefits income of the client's spouse.

$

6. Specify the monthly wage/salary/earnings income of the client's spouse.

$

7. Specify other monthly income of the client's spouse.

$

3.A.iii. Total Resources

1. Specify the client's MONTHLY income.

$

2. What is the client's monthly income?

- ☐ $1,178 or less
- ☐ $1,420 or less
- ☐ $1,662 or less
- ☐ $695 or less
- ☐ $937 or less

3. How many people in the household does the client support on his/her income?

4. What is the client's TOTAL MONTHLY HOUSEHOLD income?

$

5. Based on the Range, Is the CLIENT'S income level below the national poverty level?

- ☐ Yes
- ☐ No

3.B. Monthly Housing Costs

1. Specify the client's monthly rent.

$

2. Specify the client's monthly mortgage.

$

3. **Specify the client's monthly property tax.**

$

4. **Specify the client's monthly heat bill.**

$

5. **Specify the client's monthly utilities bill.**

$

6. **Specify the client's monthly house insurance cost.**

$

7. **Specify the client's monthly telephone bill.**

$

8. **Specify the client's other monthly costs.**

$

9. **What is the consumer's estimated total medical monthly expenses(e.g. health insurance premiums, hospital and doctor bills, prescription costs)?**

$

10. **Enter the client's total monthly housing expenses.**

$

3.C. Savings/Assets

1. **What is the client's savings account/CD/investments balance?**

$

2. **What is the client's checking account balance?**

$

3.D. Health Insurance

1. **Enter the client's Medicare number.**

2. **Does the client have Medicare A health insurance?**

☐ Yes
☐ No

3. **Does the client have Medicare B health insurance?**

☐ Y - Yes
☐ N - No

4. **Does the client have Medigap health insurance?**

☐ Y - Yes
☐ N - No

What is the name of the client's Medigap health insurer?

5. **Does the client have Medicare D health insurance?**

☐ Y - Yes
☐ N - No

What is the name of the client's Medicare D company/plan?

6. **Does the client have LTC health insurance?**

☐ Y - Yes
☐ N - No

What is the name of the client's LTC health insurer?

7. **Does the client have other health insurance?**

☐ Y - Yes
☐ N - No

What is the name of the client's other health insurer?

3 Comments

Comment on the client's current financial situation.

4. Health Assessment

4.A. Current Health Status

1. Describe the client's allergies, if any.

2. Describe the client's special diet(s).

3. Does the client smoke or chew tobacco regularly?

- ☐ Deferred
- ☐ Don't know
- ☐ No
- ☐ Yes

4.B. Medication Use

1. List all prescribed and non prescribed medications taken by the client in the last 7 days.

a. Name and Dose: Record the name of the medication and dose ordered.

b. Form: Code the route of administration using the following list:

1 = by mounth (PO)	7 = topical
2 = sub lingual (SL)	8 = inhalation
3 = intramuscular (IM)	9 = enteral tube
4 = intravenous (IV)	10 = other
5 = subcutaneous (SQ)	11 = eye drop
6 = rectal (R)	12 = transdermal

d. Frequency: Code the number of times per period the med is administered using the following list:

PR = (PRN) as necessary	OO = every other day
1H = (QH) every hour	1W = (Q week) once each week
2H = (Q2H) every 2 hours	2W = 2 times every week
3H = (Q3H) every 3 hours	3W = 3 times every week
4H = (Q4H) every 4 hours	4W = 4 times each week
6H = (Q6H) every 6 hours	5W = 5 times each week
8H = (Q8H) every eight hours	6W = 6 times each week
1D = (QD or HS) once daily	1M = (Q month) once/mo.
2D = (BID) two times daily	2M = twice every month
(includes every 12 hours)	C = Continuous
3D = (TID) 3 times daily	O = Other
4D = (QID) four times daily	
5D = 5 times daily	

a. Name and Dose	b. Form	c. No. Taken	d. Freq	e. Comments

1. Continued

2. How does the client remember to take his/her medications?

5. Mental Health/Behavior/Cognition

5.A. Mental Health Services

1. In the past year, has the client received (or is the client currently receiving) mental health treatment or counseling?

- ☐ Y - Yes
- ☐ N - No

2. What kinds of services has the client received, or what kinds of services is the client receiving now?

_____

_____

_____

_____

5.B. Behavior

1. Does spouse, partner, caregiver or other person, including this assessor, suggest that the client has memory or emotional problems?

- ☐ Y - Yes
- ☐ N - No

2. How often does the client get lost or wander?

- ☐ 1 - Less than daily
- ☐ 2 - Daily
- ☐ 3 - Multiple times per day
- ☐ 4 - Never

3. How often is the client physically abusive to him/herself?

- ☐ 1 - Less than daily
- ☐ 2 - Daily
- ☐ 3 - Multiple times per day
- ☐ 4 - Never

4. How often is the client physically abusive to others?

- ☐ 1 - Less than daily
- ☐ 2 - Daily
- ☐ 3 - Multiple times per day
- ☐ 4 - Never

5. How often is the client verbally abusive to him/herself or others?

- ☐ 1 - Less than daily
- ☐ 2 - Daily
- ☐ 3 - Multiple times per day
- ☐ 4 - Never

6. How often does the client exhibit socially inappropriate/disruptive behavior?

- ☐ 1 - Less than daily
- ☐ 2 - Daily
- ☐ 3 - Multiple times per day
- ☐ 4 - Never

7. How often does the client experience hallucinations/delusions?

- ☐ 1 - Less than daily
- ☐ 2 - Daily
- ☐ 3 - Multiple times per day
- ☐ 4 - Never

5.C. Cognition

1. How often does the client have problems with his/her short term memory?

- ☐ 1 - Less than daily
- ☐ 2 - Daily
- ☐ 3 - Multiple times per day
- ☐ 4 - Never

2. How often does the client have problems making him/herself understood?

- ☐ 1 - Less than daily
- ☐ 2 - Daily
- ☐ 3 - Multiple times per day
- ☐ 4 - Never

3. How often does the client have problems with long term memory?

- ☐ 1 - Less than daily
- ☐ 2 - Daily
- ☐ 3 - Multiple times per day
- ☐ 4 - Never

4. How often does the client have problems understanding others?

- ☐ 1 - Less than daily
- ☐ 2 - Daily
- ☐ 3 - Multiple times per day
- ☐ 4 - Never

5. How often does the client have problems with decision making?

- ☐ 1 - Less than daily
- ☐ 2 - Daily
- ☐ 3 - Multiple times per day
- ☐ 4 - Never

6. Home Environment

6.A. Environmental Checklist

1. Does the client have problems with dangerous stairs or floors in his/her home?

- [ ] Y - Yes
- [ ] N - No

2. Is it difficult for the client to get to the entrance of his/her home?

- [ ] Y - Yes
- [ ] N - No

3. Is it difficult for the client to get to the bathroom or bedroom in his/her home?

- [ ] Y - Yes
- [ ] N - No

4. Does the client have problems with the major appliances or toilet in his/her home?

- [ ] Y - Yes
- [ ] N - No

5. Does the client have problems with the heating or cooling in his/her home?

- [ ] Y - Yes
- [ ] N - No

6. Does the client have problems getting water or hot water in his/her home?

- [ ] Y - Yes
- [ ] N - No

7. Does the client have difficulties keeping his/her home free from odor or pests?

- [ ] Y - Yes
- [ ] N - No

8. Does the client need a smoke alarm in his/her home?

- [ ] Y - Yes
- [ ] N - No

9. Does the client have problems with electrical hazards in his/her home?

- [ ] Y - Yes
- [ ] N - No

10. Does the client have problems with poor lighting in his/her home?

- [ ] Y - Yes
- [ ] N - No

11. Does the client have problems with an unsafe stove in his/her home?

- [ ] Y - Yes
- [ ] N - No

12. Does the client have problems with loose slippery rugs in his/her home?

- [ ] Y - Yes
- [ ] N - No

13. Does the client have problems with inadequate locks on the doors and/or windows in his/her home?

- [ ] Y - Yes
- [ ] N - No

14. Does the client have problems keeping his/her home clean and free of clutter?

- [ ] Y - Yes
- [ ] N - No

15. Does the client have any other environmental problems in his/her home?

- [ ] Y - Yes
- [ ] N - No

16. Describe any other environmental problems.

_____

_____

_____

_____

17. In the case of an emergency, would the client be able to get out of his/her home safely?

- [ ] Y - Yes
- [ ] N - No

18. In the case of an emergency, would the client be able to summon help to his/her home?

- [ ] Y - Yes
- [ ] N - No

19. Comment on the client's home environment in general and establish a safety evacuation plan if necessary.

_____

_____

_____

_____

Title : _____ Date

Title : _____ Date