NAT 10-1-21

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)

8a. Individual's current gender identity (defined as one's inner sense of one's own gender) (Select one)

- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ Transgender Female (male to female)
- ☐ Transgender Male (female to male)
- ☐ Something else that was not named. Please specify (Document Details in Notes)
- ☐ Choose not to disclose

8b. Individual's sex assigned on their birth certificate at birth (Select one)

- ☐ Female
- ☐ Male
- ☐ Something else that was not named. Please specify (Document Details in Notes)
- ☐ Choose not to disclose

8c. Individual's sexual orientation (defined as one's identification of emotional, romantic, sexual, or affectional attraction to another person) (Select one)

- ☐ Bisexual
- ☐ Lesbian, Gay or Homosexual
- ☐ Straight or Heterosexual
- ☐ Something else that was not named. Please specify (Document Details in Notes)
- ☐ Don't know
- ☐ Choose not to disclose

9. Individual's Ethnicity

- ☐ 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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- ☐ 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
- ☐ 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
- ☐ Homeopathist
- ☐ 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-Skip to 4.A.1
- [ ] 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports in managing the care of the RESPIRATORY condition

- [ ] 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports 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
- [ ] Spasms
- [ ] Spinal Stenosis
- [ ] 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports 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:

- [ ] None-Skip to 4.J.1
- [ ] Abscesses
- [ ] 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports 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.3
- ☐ 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 beyond that available from existing or accessible informal and formal supports 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.3
- [ ] 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 beyond that available from existing or accessible informal and formal supports 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. SUPERVISION

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

2a. Does the individual require supervision? Document Details in Notes.

- [ ] No-Skip to 9.A.4
- [ ] Yes-Complete 9.A

2b. 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? Document Details in Notes.

- [ ] 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), gm (Gram), (Percentage), mEq (Milli-equivalent), mg (Milligram), Puffs, %

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
	C = Continuous
3D = (TID) 3 times daily	O = Other
4D = (QID) four times daily	
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 medications 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), gm (Gram), (Percentage), mEq (Milli-equivalent), mg (Milligram), Puffs, %

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
	C = Continuous
3D = (TID) 3 times daily	O = Other
4D = (QID) four times daily	
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 need additional assistance in managing Medications, OR is this need currently addressed in their OPTIONS care plan?

- [ ] Don't know
- [ ] No
- [ ] Yes-Document Details in Notes

12. Does the individual use herbs or other remedies?

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

13. 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, OR is this need currently addressed in their OPTIONS care plan?

- ☐ No
- ☐ Yes-Document Details in Notes

10. ACTIVITIES OF DAILY LIVING (ADLs)

10.A. Bathing

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

- ☐ 1 - Independent-Skip to 10.B.1a
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance. Skip to 10.A.1c

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 managing BATHING, OR is this need currently addressed in their OPTIONS care plan?

- ☐ No
- ☐ Yes-Document Details in Notes

10.B. Dressing

1a. 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.C.1a
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance. Skip to 10.B.1c

1b. 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

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

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

1d. 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

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

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

1f. Assistive devices/ adaptive equipment used for DRESSING? Document Details in Notes

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

1g. Does the individual need additional assistance in managing DRESSING, OR is this need currently addressed in their OPTIONS care plan?

- ☐ No
- ☐ Yes-Document Details in Notes

10.C. Grooming

1a. 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.D.1a
- ☐ 2 - Limited Assistance
- ☐ 3 - Total Assistance. Skip to 10.C.1c

1b. 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

1c. GROOMING/ PERSONAL HYGIENE: Assistance currently provided by what INFORMAL supports? Document Details in Notes

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

1d. GROOMING/ PERSONAL HYGIENE: Assistance currently provided by what FORMAL supports?

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

1e. How often is GROOMING/ PERSONAL HYGIENE support available? Document Details in Notes

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

1f. Are assistive devices/ adaptive equipment used for GROOMING/ PERSONAL HYGIENE? Document Details in Notes

- ☐ No
- ☐ Yes

1g. Does the individual need additional assistance in managing GROOMING, OR is this need currently addressed in their OPTIONS care plan?

- ☐ No
- ☐ Yes-Document Details in Notes

10.D. Eating

1a. EATING: Ability to eat/ drink; cut, chew, swallow food; and to use any needed assistive devices

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

1b. 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

1c. 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

1d. EATING: Assistance currently provided by what INFORMAL supports? Document Details in Notes

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

1e. EATING: Assistance currently provided by what FORMAL supports?

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

1f. How often is EATING support available? Document Details in Notes

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

1g. 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

1h. Does the individual need additional assistance in managing EATING, OR is this need currently addressed in their OPTIONS care plan?

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

10.E. Transfer

1a. 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.F.1a
- [ ] 2 - Limited Assistance
- [ ] 3 - Total Assistance. Skip to 10.E.1c

1b. 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

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

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

1d. TRANSFER: Assistance currently provided by what FORMAL supports?

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

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

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

1f. 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

1g. Does the individual need additional assistance in managing TRANSFERS, OR is this need currently addressed in their OPTIONS care plan?

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

10.F. Toileting

1a. TOILETING: Ability to manage bowel and bladder elimination.

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

1b. 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

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

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

1d. TOILETING: Assistance currently provided by what FORMAL supports?

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

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

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

1f. 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

1g. Does the individual need additional assistance in managing TOILETING, OR is this need currently addressed in their OPTIONS care plan?

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

10.G. Bladder and Bowel Continence

1a. 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

1b. Does the individual need additional assistance in managing BLADDER, OR is this need currently addressed in their OPTIONS care plan?

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

1c. 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

1d. Does the individual need additional assistance in managing BOWELS, OR is this need currently addressed in their OPTIONS care plan?

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

1e. Does the individual use incontinency products?

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

10.H. Walking

1a. 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. Skip to 10.A.8c

1b. 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

1c. Does the individual need additional assistance in managing WALKING, OR is this need currently addressed in their OPTIONS care plan?

- [ ] 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, OR is this need currently addressed in their OPTIONS care plan?

- [ ] 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, OR is this need currently addressed in their OPTIONS care plan?

- [ ] 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 STAIRS, OR is this need currently addressed in their OPTIONS care plan?

- ☐ 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

1d. Does the individual need additional assistance in managing MEALS, OR is this need currently addressed in their OPTIONS care plan?

- ☐ Don't know
- ☐ No
- ☐ Yes-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

2d. Does the individual need additional assistance in managing LIGHT HOUSEKEEPING, OR is this need currently addressed in their OPTIONS care plan?

- [ ] Don't know
- [ ] No
- [ ] Yes-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

3d. Does the individual need additional assistance in managing LAUNDRY, OR is this need currently addressed in their OPTIONS care plan?

- [ ] Don't know
- [ ] No
- [ ] Yes-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

4d. Does the individual need additional assistance in managing SHOPPING, OR is this need currently addressed in their OPTIONS care plan?

- [ ] Don't know
- [ ] No
- [ ] Yes-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

5d. Does the individual need additional assistance in managing TRANSPORTATION, OR is this need currently addressed in their OPTIONS care plan?

- [ ] Don't know
- [ ] No
- [ ] Yes-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

6d. Does the individual need additional assistance in managing MONEY, OR is this need currently addressed in their OPTIONS care plan?

- [ ] Don't know
- [ ] No
- [ ] Yes-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

7d. Does the individual need additional assistance in managing TELEPHONE, OR is this need currently addressed in their OPTIONS care plan?

- [ ] Don't know
- [ ] No
- [ ] Yes-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

8d. Does the individual need additional assistance in managing HOME MANAGEMENT, OR is this need currently addressed in their OPTIONS care plan?

- [ ] Don't know
- [ ] No
- [ ] Yes-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

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
- [ ] Stressed/Overwhelmed
- [ ] 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.

- [ ] None
- [ ] 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. EMERGENCY PLANNING

18.A. EMERGENCY PLANNING

1. Is individual meal dependent?

- ☐ Yes
- ☐ No

2. Is individual medication dependent?

- ☐ Yes
- ☐ No

3. Is individual electricity dependent?

- ☐ Yes
- ☐ No

4. Is individual transportation dependent?

- ☐ Yes
- ☐ No

5. Is individual attendant dependent?

- ☐ Yes
- ☐ No

6. Is individual oxygen dependent?

- ☐ Yes
- ☐ No

7. Is individual mobility dependent?

- ☐ Yes
- ☐ No

19. INDIVIDUAL/ SPOUSE/ HOUSEHOLD FINANCIAL DATA

19.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 monthly interest/ dividends income:

7. Individual's monthly public assistance:

8. Individual's monthly VA benefit income:

9. Individual's monthly wage/ salary/ earnings/self-employment income:

10. Individual's monthly net rental income:

11. Individual's monthly railroad retirement benefit income:

12. Individual's monthly annuity, trust, estate income:

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

14. What is individual's monthly income for alimony?

15. What is the consumer's monthly Medicare Part B premium?

19.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.

19.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 wage/ salary/ earnings/self-employment income of spouse RESIDING with the individual:

8. Monthly net rental income of spouse RESIDING with the individual:

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

10. What is the spouse's monthly alimony support?

11. What is the spouse's monthly Medicare Part B premium?

19.D. HOUSEHOLD INCOME

1. Cost Share Rate.

0

2. Enter Consumer's Cost Share Percentage from 19.D.1 above.

3. Poverty Indicator

1

4. Enter Consumer Poverty Indicator from 19.D.3 above. If NAT Consumer Poverty Indicator =1, then check "Yes", if 0 check "No", if not calculated check "Don't Know".

- ☐ Don't know
- ☐ No
- ☐ Yes

19.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

20. NEEDS ASSESSMENT SUMMARY

20.A. LCD & NAT OUTCOME

1. Has level of care assessment been completed and individual determined Nursing Facility Clinically Eligible?

- ☐ No
- ☐ Yes

2. Has the individual had a change in condition that warrants a new Level of Care determination?

- ☐ No
- ☐ Yes-Document Details in Notes

3. Based on the NAT, what Locus of Care/Care Program is recommended?

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

4. NAS Score

5. What is the client's total Needs Assessment Score (NAS), from 20.A.4, rounded to nearest whole number?

20.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